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**Mental health consumers' evaluation of
recovery-oriented service provision**

**A thesis submitted in fulfilment of the requirements
for the degree of**

Doctor of Philosophy

from

University of Wollongong

by

Sarah Louise Marshall

School of Psychology

2008

THESIS CERTIFICATION

I, Sarah L. Marshall, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Sarah. L. Marshall

September 2008

ABSTRACT

Consumers have rarely been involved in the evaluation of recovery oriented service provision. This is somewhat surprising considering the increasing emphasis on recovery focused service delivery both in Australia and internationally (Australian Health Ministers, 2003; Slade, Amering, & Oades, 2008). This thesis addresses this gap by involving consumers in the evaluation, critique and ongoing improvement of the Collaborative Recovery Model received in case management settings across three eastern Australian states.

The Collaborative Recovery Model has been used as a model to train mental health staff in evidence-based practices and constructs consistent with the recovery movement to assist them to effectively support the recovery process of people with chronic and recurring mental disorders. Key aspects of this model include two guiding principles ‘recovery as an individual process’ and ‘collaboration and autonomy support’ and four skills-based components 1) change enhancement; 2) collaborative needs identification; 3) collaborative goal striving and 4) collaborative task striving and monitoring (Oades et al., 2005). This thesis incorporates three key studies as part of the overall evaluation.

Study one (self-report questionnaire) sought to gain the broader perceptions of consumers’ and case managers’ regarding engagement in and perceived importance of recovery-focused practice received with staff trained in the Collaborative Recovery Model, when compared to consumers’ and case managers’ perceptions around receiving services as usual (non Collaborative Recovery Model trained staff). A questionnaire was developed and completed by 92 consumers and 97 case managers. Preliminary findings suggest that consumers working with Collaborative Recovery Model trained staff were able to identify significant changes to service delivery in relation to the frequency with which they were: encouraged to take responsibility for recovery, collaborated with staff and completed homework activities to assist them to achieve their goals. In contrast to findings for consumers, case managers did not report that they engaged in activities consistent with the Collaborative Recovery Model more frequently when they had received training. The vast

majority of consumers and case managers appeared to value, or place importance on key parts of the Collaborative Recovery Model.

Study two (semi structured interviews) sought to explore in detail consumers' perceptions regarding the Collaborative Recovery Model as received in case management settings and its use in relation to supporting their personal recovery journey. Twenty two consumers were purposively sampled. Findings provided insight into processes considered valuable by consumers. For example, with respect to goal striving and homework activities consumers discussed benefits in relation to providing a sense of direction for life, encouraging ownership and responsibility, benefits of formal documentation and positive feelings of achievement and personal growth, among others. Concerns were offered by some participants such as appropriateness of the terminology 'homework' and some consumers preference for the term 'life' over the term 'recovery.' Other concerns reflected a deeper need for improved transfer of the Collaborative Recovery Model in practice within mental health services, as opposed to criticism of the conceptual model per se.

Study three (focus group meetings) incorporated a reflexive design bringing together groups of consumers to discuss key findings from study one and two. The central aim was to generate further feedback to inform improvement of the Collaborative Recovery Model and its use and delivery in services. Eighteen consumers were purposively sampled. Findings offered further support for many earlier concerns and recommendations, for example concerns around terminology and transfer of training issues. Additional concerns and ideas were also raised including the inadequacy of orientation to the Collaborative Recovery Model, concerns around the existing format of goal and homework sheets and suggestions for redevelopment of sheets into a book format, owned and individualised by consumers.

In summary, consumers were able to perceive some recovery-focused changes following staff training in the Collaborative Recovery Model. Consumers and case managers valued the key guiding principles and components of this model. However consumers wanted to be more empowered and involved in use of the model from the outset such as through an equivalent training/introductory session, a peer led group to introduce and share

experiences of recovery and use of a hand held diary to record goal striving to be personalised and owned by consumers. Such directions around empowering consumers to take more responsibility for usage of the model and hence their own recovery may also hold promise for addressing difficulties regarding transfer of the Collaborative Recovery Model from theory into practice within mental health services.

ACKNOWLEDGMENTS

Firstly I would like to thank and acknowledge all the people who took the time to share their experiences as part of this research. It is only through their willingness to provide us with insight into their experiences that we can truly begin to understand and evaluate mental health service delivery, in turn informing better services for others with mental illness in the future. I would also like to thank the researchers with whom I worked at various stages of this research, in particular Tony Turner, Donna Huntriss, Cathy Mackie and Anne Garton. It has been a pleasure getting to know and working with each of you-you have been an inspiration to me.

Secondly I would like to thank my research supervisors Dr Lindsay Oades and Dr Trevor Crowe. Trevor thank you for always being there when I have been lost, stuck or simply needed to talk. Thank you also for your ongoing professional guidance, support and laughs over the years. To Lindsay, thank you for offering me the opportunity to embark on this research, believing in me, guiding me, sharing your wisdom but at the same time providing me adequate space to learn and grow as a researcher. I feel truly honoured to have had the opportunity to work with each of you and believe that I have grown immensely both professionally and personally under your guidance during the course of undertaking this research. I hope that we can continue to work together over the coming years. A particularly memorable part of this journey for me was feeling that I was a valued and contributing member of the research team-both in relation to the AIMhi HSS project and more recently when engaging in associated research projects within the Illawarra Institute for Mental Health (iiMH). I can only hope that I have managed to impart at some level this same sense of being a valued and contributing member of this research to the people with mental illness who I have worked with and who have taken part in this thesis.

Thank you to Professor Frank Deane, Director of the Illawarra Institute for Mental Health who has been a great source of encouragement and support over the years. Thank you for your kindheartedness and words of advice along the journey. Also to my fellow students and staff at the iiMH who have assisted in many ways and offered caring words,

particularly when the going has, at times, been tough. I have always felt that I have been a valued part of the research community at the iimH and this has made the journey all the more memorable. Thanks to Marie Johnson for her kindness, administrative assistance and for always being there to help out over the years-I greatly appreciate everything that you have done. Preparation of this thesis was supported by the Australian Integrated Mental Health Initiative (AIMhi)-High Support Stream funded by the National Medical Research Committee (NHMRC) Health Partnerships grant number 219327. Thanks also to the Schizophrenia Fellowship of Queensland and Schizophrenia Fellowship of New South Wales for their kind financial assistance in the way of monetary grants that contributed funds for consumers and consumer researchers to take part in this research.

Importantly I would like to thank and acknowledge my family including my mum and dad Stephen Marshall, Susan Marshall and sisters Melissa Marshall and Josephine Marshall. Thank you for believing in me, encouraging me to follow my dreams and being there for me through the ups and downs over the years. Without your love and support I would not have had the courage to embark on this unknown, exciting and challenging journey in the first place. Also to my loving friends and grandmother Audrey Wright who have always been there, supported and believed in me over the years. Thanks also to my extended family who have been so supportive of my research endeavours and to the adorable Sasha, who was always there for a hug and sat by my side during the long days at the desk.

Lastly but not leastly I would like to thank my husband Lindsay Leeser. You have been a constant tower of strength in my life. Your unwavering support, encouragement and love has been truly amazing-thank you for all the little things that you have done and continue to do to make my life easier, particularly during times of stress. You are the best!

I would like to dedicate this thesis to the loving memory of my mum, Susan Mary Marshall. Her passion and courage in her own life as well as endless love, support and encouragement of me in my own remain with me forever.

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ABBREVIATIONS

AIMhi HSS	Australian Integrated Mental Health Initiative High Support Stream Project
CEO-CRM	Consumer Evaluation of Collaborative Recovery Model questionnaire
CGT	Collaborative Goal Technology
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
DACTS	Dartmouth Assertive Community Treatment Scale
NSW	New South Wales
NHMRC	National Health and Medical Research Council
QLD	Queensland
SEO-CRM	Staff Evaluation of Collaborative Recovery Model questionnaire

CHAPTER 1:

INTRODUCTION

The Collaborative Recovery Model was developed as a mental health worker training program bringing together evidence-based practices and constructs consistent with the recovery movement to assist the recovery of people with chronic and recurring mental disorders. Despite the increasing emphasis on recovery as a guiding vision for mental health service, few models of care have attempted to operationalise the principles of recovery into practice (Onken et al., 2006; Torrey & Wyzik, 2000). The Collaborative Recovery Model training program to date has targeted staff in community based mental health settings. This research draws on the perspectives of mental health consumers in order to contribute to the evaluation and ongoing improvement of the Collaborative Recovery Model and its use and delivery in mental health services. More broadly, this research aims to understand how professionals can assist consumers' recovery processes within community mental health contexts. Whilst the tradition of asking consumers to comment on their experiences of mental health services is historically not new, at this time research involving consumers in the evaluation of recovery-oriented practice appears rarely, if at all in the literature.

Close collaboration with a number of consumer researchers has been required to undertake this research. Their involvement has been considered integral to the success of the research with the focus of the Collaborative Recovery Model on supporting recovery. Other authors have highlighted the importance of consumer involvement at every stage in 'recovery research' (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). This research has involved consumers throughout the entire research process, within certain limitations of financial and time constraints.

It has also been explicitly recognised that whilst the key focus of this evaluation is on hearing the perspectives of consumers, their voice is not the only legitimate one. This viewpoint is discussed in more detail elsewhere (see section 2.3.4). Staff members' perspectives of the Collaborative Recovery Model are sought, in addition to the perspectives of mental health consumers, by way of a self-rated questionnaire as part of study one of this thesis.

In undertaking this research considerable value has also been placed on the potential opportunity to empower consumers as part of the actual research process. It has been

hoped that this project would be a positive opportunity for consumer participants. Evidence is emerging that supports the concept that collaborative practices may have a positive psychological impact on consumer researchers, with reports of increased empowerment (Dickerson, 1998; Telford & Faulkner, 2004) and self esteem (Morrell-Bellai & Boydell, 1994). Other authors have made preliminary suggestions that research participation can itself hinder or support recovery (Ralph & Corrigan, 2005). Evaluative research in mental health has traditionally overlooked these possibilities, or deeper opportunities to bring about positive change through the processes of actively collaborating with research participants.

Another key feature of this research has been the focus on the ‘action’ component of the evaluation, consistent with more contemporary conceptualisations of evaluation such as formative evaluation (Patton, 1997). This is elaborated in chapter 2, section 2.1 In recent years evaluation has come to emphasise possibilities for improvement, moving beyond a more traditional focus on examining reasons for a program’s success (Patton, 2002). Some authors have suggested that consumers in particular may value improvement of services as a key aim of collaborative research (Carrick, Mitchell, & Lloyd, 2001). This is hardly surprising since service users could be considered the stakeholders most likely to benefit from improved services, which better meet their needs. Consumers’ desire to improve services may further be linked to their longing to assist other people living with mental illness (Telford & Faulkner, 2004). Hence, this research focuses on seeking consumers’ perspectives with a view to evaluating and improving the Collaborative Recovery Model and its use and delivery in mental health services into the future. Whilst completion of this research occurs within a definitive time frame, findings and recommendations arising from this research informing improved ways of working are expected to continue beyond the life of this research.

This research consists of three separate, but inter-related studies:

- 1) a brief self-report questionnaire completed by both consumers and mental health staff who, in theory, are actively working within the Collaborative Recovery Model in services, as well as consumers and mental health staff who are receiving services as usual in case

management settings; 2) semi structured interviews undertaken with consumers working with case managers trained in the Collaborative Recovery Model; and 3) face-to face-focus group meetings undertaken with consumers working with case managers trained in Collaborative Recovery Model .

1.1 TERMINOLOGY

Recovery has been described by some authors as a process whereby people build meaningful lives in the community. There is a recognition that recovery can take place even though a person may continue to experience psychiatric symptoms (Gawith & Abrams, 2006; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Ralph & Corrigan, 2005). Whilst it is recognised that there is no single definition of recovery, for the purpose of consistency throughout this research the following definition of psychological recovery, has been selected “psychological recovery refers to the establishment of a fulfilling and meaningful life and a positive sense of identity founded on hopefulness and self determination ” (Andresen, Oades, & Caputi, 2003, p. 588). Recent recovery literature often describes recovery as more than, or different to clinical symptoms. This is also in keeping with understandings of recovery as discussed throughout this thesis.

Whilst many definitions of case management have emerged, (Thornicroft, 1991) case management has been broadly defined in this thesis as a means of coordinating the care of severely mentally ill people in the community (Marshall, Gray, Lockwood, & Green, 2004). This includes the range of models which are proposed to fall under the umbrella term of case management. For example clinical, strengths-based and assertive community treatment. In keeping with this broad definition, case management is viewed to potentially encompass services that are provided in public mental health services, as well as non-government organisations.

The term consumer is used in this thesis to refer to people living with mental illness who are currently using, or have used mental health services. Whilst this term is widely accepted to describe people living with mental illness, (Hensley, 2006) often within the context of service use (Australian Health Ministers, 2003; Telford & Faulkner, 2004) it is acknowledged that there is considerable debate around its use (Bond, Drake, Mueser, &

Latimer, 2003; Hensley, 2006; Lloyd, King, Bassett, Sandland, & Savige, 2001; Stocks, 1997). For instance some authors have suggested that the term consumer can be limiting and disempowering, even though it may have some advantages over alternate terms such as patient (Hensley, 2006). Other authors suggest that concern regarding the use of the term may in particular be related to receiving mental health services (Telford & Faulkner, 2004) as notions of consumerism entail choice, which may be inconsistent with mental health service delivery. Some authors have undertaken research with people with mental illness in an attempt to understand which terms are preferred within the context of service delivery (Lloyd, King, Bassett, Sandland, & Savige, 2001; Mueser, Glynn, Corrigan, & Baber, 1996).

Furthermore, the term “consumer researcher,” is typically used to describe people with mental illness undertaking research activities. Whilst this serves a purpose, by highlighting the importance of involving people with mental illness in research activities, this distinction may not only have positive effects. For example, use of such language may make it difficult for consumer researchers to be viewed as truly equal to their fellow researchers.

Alternatively, the opposite may be true. Regardless such possibilities need to be considered by researchers. In summary it is recognised that even within the language used to describe people with mental illness, there is the potential for negative impacts and stigmatisation. This needs to be recognised, debated and subsequently addressed. However, at present no clear evidence was found for a preferred term. Therefore for the purpose of understanding and consistency the term “consumer” is used in this thesis, with recognition of the necessary debate around its usage.

The terms collaborative/participatory research are used in this thesis to refer to active involvement of participants at any, or all levels of research activity (from research design, to data collection and analysis and dissemination of findings). It is also highlighted that an ideal, in particular for “recovery” research, is to involve people with mental illness as co-researchers throughout the entire research process (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

The Collaborative Recovery Model was originally developed to train mental health staff in evidence-based practices and constructs consistent with the recovery movement to assist them to effectively support the recovery process of people with chronic and recurring mental disorders (Oades et al., 2005). The Australian Integrated Initiative High Support Stream Project, or AIMhi HSS project for short is used to describe the larger National Health and Medical Research Council (NHMRC) funded project evaluating the effectiveness of the Collaborative Recovery Model in assisting the recovery of adults with chronic and recurring mental illness, across various mental health services in Australia. All consumers and mental health staff taking part in the studies within this thesis were participants in the AIMhi HSS project (Oades et al., 2005).

1.2 OUTLINE OF RESEARCH REPORT

Chapter 2 provides an outline of the broad context for this thesis-including the historical development of evaluation research, the consumer and recovery movements, and growing impact of these movements on mental health policy, practice and research activities. Researcher attempts to deal with the evaluation of services from a recovery orientation are also highlighted.

Chapter 3 specifically investigates the extent of consumer involvement and focus on recovery concepts across all existing models of case management. This includes a review of Ovid Medline (R), Psychinfo and Cinahl databases in order to locate previous research on case management that draws on consumer perspectives and/or is undertaken from a recovery framework.

Chapter 4 briefly describes the Collaborative Recovery Model and associated training for staff. This provides a context of understanding for this thesis.

Chapter 5 outlines the rationale for this thesis and provides an overview of the three studies comprising this research.

Chapter 6 (Study one) details the method, results and discussion relevant to a self-report questionnaire collected from the 92 consumers and 127 staff members participating in the AIMhi HSS project, in three eastern states of Australia. This questionnaire aims to examine consumers' and case managers' perceptions regarding engagement in and perceived importance of recovery-focused support practices with staff trained in the Collaborative

Recovery Model. These findings are compared to consumers' and case managers' perceptions around receiving services as usual (i.e. non Collaborative Recovery Model trained staff).

Chapter 7 (Study two) outlines the methodology, findings and discussion arising from in-depth interviews undertaken with mental health consumers working with Collaborative Recovery Model trained mental health staff. This study aims to explore in depth consumers' perceptions of the actual interactions that occur between consumers and staff in case management contexts, within the context of evaluating the Collaborative Recovery Model (including process information contributing to both helpful, as well as any unhelpful experiences). It also aims to obtain feedback that can contribute to the improvement of the model and its use and delivery in service settings. It is anticipated that the method of choice will allow for a richer source of descriptive data than in study one.

Chapter 8 (Study three) details the methodology, findings and discussion arising from face-to-face focus group meetings held with consumers working with Collaborative Recovery Model trained staff. During focus group meetings key findings from studies one and two were presented back to mental health consumers and discussed, with a focus on any concerns/unhelpful aspects raised by consumers during earlier studies. Consumers were also encouraged to share their direct experiences of working with Collaborative Recovery Model trained staff. Discussion was geared towards generating feedback to inform future refinement and improvement of the model, including its use and delivery in services. Focus groups also provided an opportunity to further validate and offer some interpretation and confirmation around key findings as part of studies one and two.

Chapter 9 summarises key findings from the suite of three studies comprising this research. Implications and limitations arising from these studies are discussed. Key recommendations and future research directions are also offered.

CHAPTER 2:

MENTAL HEALTH SERVICE EVALUATION
BREAKING WITH TRADITION,
TOWARDS ‘RECOVERY’

“If you have come to help me you are wasting your time. But if you’ve come because your liberation is bound up with mine, then let us work together” (Lilla Watson, cited in Wadsworth & Epstein, 2001, p. 199).

Consumers of mental health services are increasingly being recognised as critical partners in all aspects of health care provision and evaluation, with a recovery based system clearly on the agenda in many nations (Australian Health Ministers, 2003; Mental Health Commission, 1998; New Freedom Commission on Mental Health, 2003). The formation of true partnerships between consumers and other key stakeholders has also been stressed as critical for paving the way to more effective services, which meet the needs of consumers, (Liberati, 1997; Trivedi & Wykes, 2002) supporting individuals’ recovery journeys (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Whilst this has been widely acknowledged, active change has been slow among the mental health service system and academic community.

This chapter will begin by tracing the historical development of evaluation frameworks and recognising the impact of traditional medical based approaches in mental health. The “consumer movement” will be introduced as one key movement, which has significantly challenged traditional mental health practice, contributing to the increased involvement of consumers at all levels of mental health care, including evaluation and research activities. The costs and benefits of consumer participation will be reviewed, with particular reference to research activities and recovery oriented care. The “recovery movement” is presented as a separate but related movement, further challenging traditional methods of service delivery and evaluation within the mental health sector. Particular emphasis is placed on exploring the specific role of recovery within mental health contexts, and the emerging evidence base, which can assist both services and individual clinicians in providing recovery oriented care. Researcher attempts to deal with the evaluation of services from a recovery orientation are also highlighted.

2.1 HISTORICAL OVERVIEW OF EVALUATION FRAMEWORKS

The meaning and purpose of evaluation has changed over time and means different things to different people. Evaluation has been broadly described as a “a means of knowing what works and what does not work when providing care” (Goh & Singh, 2005, p.111). Patton (2002) suggests that when people judge and examine accomplishments and effectiveness, this is the process of engaging in evaluation. In contrast evaluative research has been described as any attempt to judge or enhance human helpfulness through the systematic collection of data (Patton, 2002). Program evaluation began in the 1900’s, with educational testing carried out by Thorndike and colleagues. At this early stage evaluations simply focused on finding out whether programs were effective, primarily by assessing the achievement of goals and objectives. This was termed “summative evaluation” and typically involved experimental designs in the form of quantitative outcome studies (Patton, 2002).

Over time evaluation research has been reconceptualised, importantly to involve a focus on program improvement, appropriately termed “formative evaluation,” which moves beyond attempting to identify what works as part of any particular program (Patton, 1997). In keeping with this shift Patton has provided a more recent and specific definition of program evaluation as follows, “program evaluation is the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming” (Patton, 2002, p.10). This definition clearly emphasises the process of acting on findings as a key part of program evaluation, moving beyond making judgments about a program’s success.

Other authors have noted that a key part of any evaluation is a continuing commitment to exploring the possibilities of improvement or making things better (Goh & Singh, 2005).

Patton (1996) has more recently identified another three examples of evaluation use that move beyond the formative and summative framework termed “knowledge generation”, “developmental evaluation” and “using the evaluation process.” “Knowledge generation”

refers to using evaluations to influence thinking about issues in a general sense, hence contributing to knowledge. An example of this type of evaluation could be clarifying a program's model or testing theory. "Developmental evaluation" refers to ongoing work with a program towards continuous improvement (long-term focus). This type of model aspires to continuous progress, ongoing adaptation and responsiveness, as opposed to a final summative decision. "Using the evaluation process" or "process use" recognises that for some researchers the purpose of evaluations may be more about the actual process of engaging in the evaluation, rather than the actual findings. For example, the process of engaging in evaluation can be used to enhance dialogue and negotiation between stakeholders with varying perspectives. The evaluation process in a sense becomes part of the intervention and may support (or hinder) the program intervention (Patton, 1996).

Patton (2002) discusses the nature of knowledge creation and evaluation in relation to democracy and democratic principles. This includes recognition of the enduring impact that participatory evaluation can have on participants. For example, in relation to how they learn to think and act and their capacity to engage in democratic processes. Researchers undertaking evaluations of mental health services and programs would do well to consider the distinction between generating knowledge and the important issue of the impact of research activities on participants. In particular it is suggested that the impact of the research process on participants will, and should take on increasing importance among researchers in the mental health field, with the shift towards recovery-oriented services. This point is discussed in more detail elsewhere (see section 2.4.5)

Guba and Lincoln (1989) have also traced the development of evaluation, recognising historical shifts in the meaning of evaluation over time. They suggest that evaluative activity began with a focus on "measurement", involving collection of quantitative data, moved on to "description" or identification of the features or components of a program and came to focus on "judgment," or the assessment of the quality of a program by comparing standards and actual effects. They describe areas of inadequacy in earlier generations of evaluation including a management bias-where the goals and intentions of policymakers form the standards for assessing program success, failure to use findings in practice and no

dialogue with and between stakeholders, whilst their interests are at stake. Hence they proposed fourth generation evaluation, also referred to as constructivist evaluation as an alternative, contemporary theory of evaluation.

The fourth generation model of evaluation places an emphasis on putting findings into practice (has a formative component), but appears to differ the most from earlier models in its emphasis on legitimising the views of all relevant stakeholders in the evaluative process. In particular, emphasis is placed on involving individuals who have most at stake or risk in the evaluation process.

Wadsworth and Epstein (2001) summarised the ethical principles of fourth generation evaluation as follows:

1. a fundamental respect for all stakeholders as human beings;
2. determination to seek the perceptions of all stakeholders;
3. commitment to understanding that stakeholders values may vary but that common ground should be sought in identifying valued action;
4. rigor and skepticism should be sought to avoid drawing preliminary conclusions, which could do injustice to people's perceptions or valued actions; and
5. a commitment to collaborative research to enhance positive understandings and the possibility of desirable social change. Commitment to decrease misunderstanding and creation or perpetuation of unfair or harmful practices.

Whilst Patton (2002) and Guba and Lincoln's (1989) key areas of emphasis in summative and fourth generation evaluation differ respectively between moving towards desired change and broadening of evaluative activity to include all relevant stakeholders, there is clear evidence that each can support the other. In other words consideration of multiple stakeholders' perspectives and an improvement/formative focus in evaluation activity is likely to result in the development of more effective programs. This is partly because evaluations do consider the views of all stakeholders, including the people who are most likely to benefit from program improvement.

The opportunity to improve services is a key reason repeatedly emphasised in the literature when providing a rationale for consumer involvement in health research (Birkel, Hall, Lane, Cohan, & Miller, 2003; Department of Health, 2000; Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998; Lloyd & King, 2003; Salyers & Macy, 2005; Townend & Braithwaite, 2002). Some authors have suggested that mental health consumers in particular may value improvement of services as a key aim of collaborative research (Carrick, Mitchell, & Lloyd, 2001) and that one of the key aims of collaborative inquiry is to “elucidate and improve the nature of practice in some arena of action” (Patton, 2002, p. 183).

Illes & Sutherland (2001, p. 66) describe action research as “a way of using research in an interventionist way, so that the researcher is both a discoverer of problems and solutions, and is involved in decisions about what is to be done and why”. They go on to state that action research forms the foundation of many approaches to change and has been widely applied in management, as well as health research. Further action research has successfully been used in a variety of change programs.

Appreciative inquiry, which has its beginnings in the early 1980’s is another form of inquiry with a formative focus. This form of inquiry focuses on identifying what works best in an existing organisation (as opposed to searching for deficits) and moves to visualising a positive image of a desired future. There is also an emphasis on collaboration and involvement among all stakeholders with the view that dialogue can transform participants, allowing for discovery with respect to organisational directions into the future (Barrett, 1995).

In summary, the meaning of evaluation has evolved over time and more recent evaluation models include an emphasis on the perspectives of multiple stakeholders (as in fourth generation evaluation and appreciative inquiry) and a focus on program improvement (as in summative evaluation, appreciative inquiry and fourth generation evaluation). As described by Patton (1996) some evaluative activity may actually focus on the process of the evaluation, and may be more concerned about the impact of evaluation on program participants as a primary purpose of research activity. Other types of evaluation may be

concerned with ongoing or continuous improvement and less concerned with summative evaluations at a given point in time, or alternatively may focus on generating or enhancing general knowledge about a given program or aspect of a program.

Evaluation is not only a technical endeavour that has evolved over time, but also an inherently political activity conducted in contexts where various stakeholders have differing investments in the outcome (Rossi & Freeman, 1993). This is hardly surprising since programs such as those in mental health contexts exist within a political and economic system. Various stakeholder groups will have vested interest in a range of possible areas, for example costs, whether the program removes human suffering, and the operating principles. Patton (1996) recommend three key requirements for evaluation that support democracy- inclusion, dialogue and deliberation. This places a new perspective on evaluative activity, and encourages researchers to look beyond making what might be portrayed as purely technical method and measurement decisions, to consider deeper issues of distribution of power among researchers and other stakeholders, including intended consumers. With the rise of the recovery movement, related issues of redistribution of power among multiple stakeholders are increasingly coming to the forefront across all levels of mental health service delivery, including evaluation. In particular there has been a revaluing of the experiences of people with mental illness, both in relation to their personal experience of living with and recovering from mental illness, as well as their experiences as consumers of services.

2.2 THE REIGN OF MEDICAL APPROACHES AND CHALLENGE OF RECOVERY

Some authors suggest that the perspectives of ‘medical’ and ‘recovery’ models stand in significant tension with one another in terms of concepts, values and language (Roberts & Wolfson, 2004). Medical models have often been described as being narrowly focused on the areas of disease, treatment and biological reductionism (Roberts & Wolfson, 2004). Similarly when applied to mental health, medical models have been criticised as focusing primarily on control and reduction of mental illness (Ralph, David, Kathryn, & Edmund, 2002). In contrast, recovery models are commonly described as being more focused on the

individual. For example placing value on the notion of expert by experience, and areas such as health and wellbeing (Ralph, David, Kathryn, & Edmund, 2002; Roberts & Wolfson, 2004).

Whilst there are clearly contrasts and comparisons which can be drawn between traditional medical approaches and recovery based approaches, depictions of ‘recovery’ and ‘medical’ models are often overly simplistic. As suggested by some authors this may be more likely to generate tension within the academic community, rather than facilitating support for change (Roberts & Wolfson, 2004). The view presented here is not that medical models are no longer relevant as mental health services reorient themselves to support recovery. Neither is it argued that a ‘medical model’ should somehow be replaced with something called a ‘recovery model.’ For example, when writing about their recovery people have often highlighted the importance of managing their symptoms, as one important aspect of their recovery process (Fisher, 1994; Onken, Dumont, Ridgway, Dornan, & Ralph, 2006). Therefore when working within a recovery framework, a focus on symptoms is likely to maintain relevance for many people. However it is suggested that professionals and researchers alike must rethink and broaden traditional ways of working, evaluative practices and ways of conceptualising evidence based practice if recovery is to become a reality within mental health services.

As suggested by other authors, the introduction of recovery to the mental health system ‘raises the bar’ and “challenges service systems to grapple not only with assumptions about psychiatric disorder, chronicity and healing but also with what it takes to truly help individuals build real lives and the roles and limits of the system in this process” (Pennsylvania Office of Mental Health and Substance Abuse Services, 2005, p. 67). Diagnoses for chronic illnesses such as schizophrenia have traditionally been perceived as a ‘life sentence’, bringing with them predictions that people affected by such illnesses would live a life saturated with problems, pessimism and stigma (Roberts & Wolfson, 2004). Hence when mental health systems were initially established they were based around such premises, that people with mental illness would inevitably spiral downward, or at best have their deterioration slowed somewhat (Ralph, David, Kathryn, & Edmund, 2002). Whilst longitudinal studies of people with mental illness research have shown that this is not an

accurate portrayal (DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987) this thinking has had a long lasting influence on the mental health system, (Fisher & Chamberlain, 2004) including research activities that evaluate these systems of care.

2.2.1 Illness and symptoms retain relevance but a focus on positive mental health is crucial

A key area of comparison often raised between traditional methods of care for people with mental illness and recovery oriented services is the varying emphasis placed on symptomology, and symptom reduction. This is worth visiting for a number of reasons. Firstly, because historically the emphasis placed on reducing or eliminating symptoms and returning people to their previous level of functioning, has had a clear impact on evaluative activity. In particular it has greatly impacted the key areas or outcomes, which have traditionally been considered worthy of investigation. Indeed, it has been noted that psychiatric symptoms are traditionally the most researched outcome domain in mental health treatment research (Iyer, Rothmann, Vogler, & Spaulding, 2005). Secondly, to highlight that a focus on managing symptoms retains relevance, but is no longer sufficient as mental health systems reorient themselves towards supporting recovery. Within this context there is a clear need to a shift beyond illness and symptom-based approaches to the development of positive mental health (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Indeed, a recovery approach may actually place more emphasis on areas other than medical treatment, such as daily life and peer support (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005).

There are good reasons why a focus on symptoms and symptom management has been viewed as retaining relevance from a recovery framework. Firstly, people writing about their experiences of recovery have often emphasised the importance of managing their symptoms when working towards their recovery (Fisher, 1994; Onken, Dumont, Ridgway, Dornan, & Ralph, 2006). Furthermore as recognised by other authors, assisting people to gain mastery over symptoms can provide hope for the future, and can assist in pursuit of

personal goals (Mueser et al., 2002), both identified as key concepts across individuals' recovery journeys (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Worth noting from a recovery perspective is that there is no assumption that people will manage their symptoms only or primarily by pharmacological means, for instance personal coping strategies may be preferable for some people (Ralph & Corrigan, 2005). Lending support to these suggestions Deegan (2005) undertook interviews with 29 people with mental illness in the United States to learn about their resilience in their use, or lack of use of psychiatric medications. She found that many interviewees talked about their use of non-pharmaceutical "personal medicine", or self care activities which did not necessarily replace psychiatric medication, but were often used usefully in conjunction to reduce symptoms and avoid undesirable outcomes such as hospitalisations.

A recovery framework also challenges the professional perspective as the only legitimate source of knowledge and expertise. In particular people with 'lived' experience of both mental illness and mental health services are considered critical stakeholders in the delivery and evaluation of mental health care. This point is discussed in considerable detail later in this chapter (see section 2.4).

2.2.2 Challenging the tradition of what counts as 'evidence based practice'

Delays in moving beyond a medical focus in evaluation research are partly understandable within the context of the evidence based practice movement, which has called for services that deliver treatment approaches that are more 'scientifically grounded.' Traditionally, evidence based practices (EBP) have been closely aligned with a medical approach, emphasizing 'objectivity' and external scientific reality (Fisher & Ahern, 2002). EBP can be broadly understood as interventions for which there is consistent scientific evidence showing improvement on measures of client outcomes (Drake et al., 2001). Even within the context of EBP there has been some recognition of political influence around who decides what counts as evidence, and how evidence is generated and used (Simons, 2004).

Consumers and families have traditionally been excluded from EBP and have been viewed as 'subjects' to be studied (Birkel, Hall, Lane, Cohan, & Miller, 2003), rather than people

who can comment on their experiences of mental illness and treatment in a meaningful way.

Classification of EBP relies on a hierarchy, which proposes what is considered the most unequivocal evidence of efficacy or effectiveness (Anthony, Rogers, & Farkas, 2003). Efficacy involves testing the outcomes of an intervention under ideal circumstances (Dickey, Herman, & Einsen, 1998) in the form of Randomised Controlled Trials (RCT's). In contrast effectiveness studies assess treatment outcomes in real life settings that replicate actual practice such as hospitals and clinics (Iyer, Rothmann, Vogler, & Spaulding, 2005). Under an RCT approach subjects are randomly and blindly allocated to experimental and control groups. Both groups are measured before and after a particular intervention is given to the experimental group. Observed differences are perceived as attributable to the intervention (Simons, 2004).

2.2.3 Potential benefits of combining qualitative & quantitative methods in evaluation research

Traditionally EBP has been steeped in tradition and qualitative and subjective methodologies have typically been excluded from research investigations (Anthony, Rogers, & Farkas, 2003). However, more recently some researchers have recognised the benefits of expanding methodologies to include qualitative methods as part of RCT (Rutter et al., 2004; Schumacher et al., 2005). There are even examples of research studies where consumers have been consulted using qualitative methods (Bradley, Wiles, Kinmonth, Mant, & Gantley, 1999). The reasons provided for including qualitative methods in evaluation research are numerous. For example, to show how an intervention or program works, to clarify reasons for success or failure, to elucidate potential barriers to change and to identify areas for improvement (Bradley, Wiles, Kinmonth, Mant, & Gantley, 1999).

Some authors have suggested that a combination of qualitative and quantitative methodologies may be useful in evaluation research as each have different strengths and weaknesses, therefore usefully complementing each other (Patton, 2002; Ralph & Corrigan, 2005). For example, qualitative methodologies commonly provide detailed information from a limited number of people, which reduces the generalisability of results, but increases

the depth of understanding. In contrast quantitative methods can measure the reactions of large numbers of people to a restricted number of questions-leading to broad generalisable findings (Patton, 2002).

In describing the potential benefits of combining qualitative and quantitative methodologies Patton states that “qualitative findings in evaluation illuminate the people behind the numbers and put faces on the statistics, not to make hearts bleed, though that may occur, but to deepen understanding” (2002, p. 10). Other authors have suggested that exploring the person’s “lived experience” is particularly well suited for locating the meanings that people place on events and processes (Miles & Huberman, 1994). For example, program interviews can begin to answer questions such as-“what does the program look and feel like to the people involved? What are their experiences in the program? What thoughts do people knowledgeable about the program have concerning program operations, processes, and outcomes? What are their expectations? What changes do participants perceive in themselves as a result of their involvement in the program?” (Patton, 2002, p. 341).

Realist review is a relatively new method of systematic review designed for complex interventions or programmes (Pawson et al., 2005). Realist review, rather than focusing on what works, seeks to answer the question of how complex programmes work (or why they fail) in particular contexts or settings. The basic evaluative questions is what works for whom in what circumstances? This approach has no preference for qualitative or quantitative methods, rather it sees merit in both. A marrying of methodologies allows both the processes and impacts of interventions to be investigated. Furthermore realist review rejects the notion that RCT’s should be viewed as the ideal for research endeavours, highlighting that multiple methods are needed to illuminate the richer picture (Pawson et al., 2005).

There are practical examples of qualitative and quantitative methodologies being usefully combined in the health evaluation literature. For example, Schumacher et al (2005) conducted a qualitative analysis of audio taped intervention sessions within the context of an RCT trial for a pain control program. As a result of including the qualitative component researchers were better able to clarify the processes of the intervention and intervention

tools used by patients and family members. They were also able to ascertain why the intervention was deemed ineffective for some patients. Rogers et al (2005) interviewed physicians and patients as part of a RCT of people who were completing a program for self management of inflammatory bowel disease. This proved effective in identifying the nature of interactions, or processes that occurred between patients and their physicians, as well as identifying the possible reasons for lack of change in patient satisfaction as part of the consultative process.

In another RCT (Rutter et al., 2004) the effectiveness of two types of care management were explored using an RCT and interviews with clinicians. In one condition health care providers were part of an integrated multidisciplinary team approach, in the other condition health care providers operated more within a broker model, externally to the team. Interestingly the RCT showed no significant differences between two methods of care (outcomes examined were duration of inpatient care during previous six months, number of admissions, improvement of symptoms, social function, satisfaction with care and costs). However, interviews with clinicians showed dissatisfaction with the brokerage model and areas of inefficiency and duplication of effort. In this instance it is easy to see how failure to include the qualitative component as part of the trial would have resulted in very different findings and recommendations.

Qualitative means of inquiry have also been highlighted as particularly appropriate when knowledge is required in relation to little understood personal, interpersonal and social processes, (Ridgway, 2001) such as is the case with the recovery process (Ralph & Corrigan, 2005). Clearly there is still much to learn about recovery, in particular how recovery processes can be supported, as well as how recovery might be inadvertently hindered within the context of therapeutic relationships. The lack of research in this area has been noted by other authors (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). This further highlights the potential strengths of including qualitative methodologies when attempting to enhance understanding as to how the recovery process can be supported in mental health service settings.

Also noteworthy within an evaluation context are researcher attempts to move beyond identification of outcome dimensions, to capture actual processes received within the context of providing particular programs or services. The identification of processes, or the specific content of care contributing to desired outcomes (whether achieved or otherwise) are clearly important if services are to be improved. Other authors have recognized the link between process information and service improvement in evaluation research (Buck & Alexander, 2006; Burns et al., 1999). For example, Buck and Alexander (2006) conducted a study examining consumers' perceptions of therapeutic relationships. They combined outcome and process information, with the aim of informing service improvement. They discuss that even the best quantitative measure cannot reveal what consumers desire in their relationships with mental health staff. They go on to state that "elucidating relationship processes in case management services, especially from the consumer's perspective, is critical in advancing a better understanding of best practices in relationship development" (Buck & Alexander, 2006, p. 479).

Some contemporary conceptualisations of evaluation such as formative and constructivist evaluation also focus on program improvement as a key aim of evaluation research. Hence some authors have argued that evaluation research should look at the processes underlying service provision, or formative aspects of the service, as well as outcome criteria (Barnes, Stein, & Rosenberg, 1999). Clearly there are benefits to identifying process information in addition to outcome criteria, if services/programs deemed to be effective are to be more easily generalised to new settings.

2.2.4 Consumer participation in identification of research 'outcomes'

Traditionally researchers and professionals have been involved in the identification of outcome domains, to the exclusion of consumers and carers. Outcome domains have conventionally been narrowly focused on areas such as symptom reduction, changes in amount/type of medication, social and occupational functioning, (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002) treatment compliance, prevention of relapses and number and length of hospitalisations (Drake et al., 2001). More recently there has been some movement towards involvement of consumers within the context of outcome studies and

evaluations and recognition around the importance of identifying outcome areas relevant to consumers (Drake et al., 2001).

When discussed with consumers, in contrast to professionals or researchers, outcomes are typically consistent with those valued by many citizens in society-for example “safe housing, good healthcare, adequate money, and roles such as worker, friend, intimate partner and parent” (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005, p. 93). Other authors have discussed outcome dimensions of importance to consumers such as quality of life, self-esteem, empowerment, well-being, employment, independence and satisfying relationships (Bond et al., 2001; Drake et al., 2001).

It is clear that in many cases consumers, family members and mental health clinicians do not agree on the relative importance of clinical and service outcomes (Ridgway, 1988). Therefore it is important to ensure that each key stakeholder group is consulted. In one relevant RCT (Wykes, 2003) the study design began as a study of ‘compliance therapy,’ however, involvement of consumers shifted the focus of the study and desired outcomes entirely. From consumers’ perspectives complying with medication regimes was inconsistent with their own agenda. Following intensive discussion between consumers and researchers, the main outcomes of this RCT refocused on increasing consumer empowerment (measured using a consumer constructed empowerment measure) and increasing the therapeutic alliance with the clinical team (measured using the Working Alliance Inventory) (WAI, Hovarth & Greenberg, 1989).

It has been argued that recovery oriented systems in particular should be accountable to outcomes and results that are deemed important by consumers (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). There are practical instances where consumers have been directly involved in the identification of relevant outcome domains and development of measurement tools (Oades, Viney, Malins, Strang, & Eman, 2005), as well as in the development of system performance indicators, with a specific focus on facilitating recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2006). Some authors have suggested that recovery oriented services are closely intertwined with implementing

services that have demonstrated effectiveness in improving consumer outcomes (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005).

Even outside of recovery contexts, there is increasing recognition that consumers' opinions are critical in determining effective services and furthermore that consumers should be involved in identifying desirable outcome dimensions. For example, the Institute of Medicine acknowledges that the true test of the quality of health care is whether it helps the patients, or people it intends to help (IOM, 2001 cited in Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005) and some authors in the medical field have argued that medical outcomes should be determined by their importance to patients and families (Eddy, 1989). Ideally, effective selection of outcomes will be built through consultation with multiple key stakeholders (Campbell, 1996; Cradock, Young, & Forquer, 2002). Consumers are one critical stakeholder group that should be consulted, in particular within the context of recovery focused service delivery, as supported by other authors (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Likewise consultation of family members and or carers is likely to take on increasing prominence within a recovery based framework.

2.2.5 When 'evidence-based practice' and 'recovery' meet

Evidence based practice has also been discussed specifically in relation to a recovery framework. Much of the existing published research on EBP was conceived or implemented before the recovery movement became the driving vision for mental health services (Anthony, Rogers, & Farkas, 2003; Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005). Hence such practices do not necessarily include the sorts of epistemologies that may enhance knowledge around recovery. Furthermore lived experience of consumers has not traditionally been valued as part of the evaluation process (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005). Despite this, recovery oriented services and evidence based practices have not always been described as mutually exclusive (Anthony, Rogers, & Farkas, 2003; Solomon & Stanhope, 2004; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). To the contrary, some authors have suggested that recovery and evidence based practice principles are critical for effective service delivery-drawing on scientific

practices and the lived experience of people with mental illness (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005).

It has, however, been argued that researchers' current understanding of what is considered EBP will need to be broadened if recovery based services are to be informed. Anthony et al., (2003) discuss their recommendations as to what researchers and policy makers should consider, as they conduct EBP research whilst honouring recovery oriented service systems. This includes recommendations in eight key areas: 1) emphasis on outcomes that focus on recovery and are of importance to consumers, 2) supplementation of quantitative research with qualitative methods and subjective approaches, 3) investigation of why existing evidence based practice has rarely demonstrated a positive impact on recovery outcomes, 4) use of quasi experimental and correlational research, 5) increased focus on understanding the therapeutic relationship, 6) enhanced understanding of specific program practices responsible for observed outcomes, 7) testing of applicability in various cultural and contextual conditions, and 8) a focus on examining underlying philosophy or values specific to particular programs (Anthony, Rogers, & Farkas, 2003).

Many of these key areas raised here by Anthony, of particular importance within EBP from a recovery framework, have also been raised as important by researchers in the health and/or mental health fields more generally. For example, as discussed earlier (see section 2.2.4) health researchers are increasingly becoming aware of the importance of including consumers in the identification of outcome dimensions. Further, qualitative research methods are increasingly being recognised as beneficial in addition to quantitative methods in evaluation research-even alongside traditional RCT's. There has also been discussion among researchers of the benefits of identifying specific processes or program practices that contribute to observed outcomes (Pawson et al., 2005). Even the emphasis on understanding the consumer/provider relationship has broader applications to mental health research more generally. It has consistently been documented that the quality of the therapeutic alliance is perhaps the most reliable predictor of treatment outcome, regardless of therapeutic approach (Crits-Christoph et al., 2006).

Some key areas raised by Anthony et al, above (2003) remain more specific to recovery-based research. For example the emphasis on philosophy and values and investigation of why EBP has rarely impacted positively on recovery outcomes. These eight areas raised by Anthony and colleagues are expected to take on increasing importance to greater numbers of researchers, as the focus on recovery shifts from being a vision for service delivery, to being viewed as a practical necessity that must be adhered to, if services are to be improved to support individuals' recovery processes.

It is expected that researchers will continue to be challenged to broaden their notions of what counts as evidence and hence their research methodologies and practices when evaluating recovery oriented services. For instance, a focus on managing symptoms retains relevance, but is no longer sufficient as mental health systems reorient themselves towards supporting recovery. Indeed some research indicates that consumers tend to prioritise social goals over symptomatic relief (Torrey et al., 2005). Improved research practices are also likely to see the increased involvement of consumers and families in the identification of relevant outcome domains. A revaluing of qualitative methodologies is also proposed within a recovery context. In particular the potential benefits of usefully combining more traditional quantitative methodologies in evaluation research with qualitative methodologies. Qualitative methodologies are likely to be of particular relevance for tracking people's recovery processes, identifying helpful and unhelpful processes within the context of supporting recovery, as well as directing service improvement into the future.

2.3 CONSUMER PARTICIPATION: AN OVERVIEW

2.3.1 Tracing the consumer movement

The beginnings of the consumer movement has been documented as early as the late nineteenth and early twentieth centuries in the United States (Chamberlin, 1990). At this time a number of former patients and their families began protesting about the inhumane treatment of the mentally ill in hospitals (Van Tosh, Ralph, & Campbell, 2000). This included individuals such as Elizabeth Packard, Elizabeth Stone (Chamberlin, 1990), Dorothy Dix (Everett, 1994) and Clifford Beers (Van Tosh, Ralph, & Campbell, 2000) advocating for the rights of people with mental illness.

Development of the modern American ex-patients movement or psychiatric patients liberation began at late as the 1970's, with little or no knowledge of earlier historical roots (Chamberlin, 1990). At this time a number of individuals in various regions of the United States began to recognise that people with mental illness were being denied basic rights, were being discriminated against and were described using devaluing language. A pioneering aspect of this movement was agreement about the need to change the dehumanising practice of involuntary hospitalisation, in particular for individuals who were not considered dangerous (Frese & Davis, 1997). In contrast to preceding movements, the majority of individuals at this time had lived experience of mental illness, as opposed to being interested parties acting on their behalf (Everett, 1994).

Established groups began to be formed from the early 1970's in various parts of the United States with names such as "Insane Liberation Front" and "The Mental Patients' Liberation Project". The first Conference on Human Rights and Psychiatric Oppression was held in 1973 and continued annually until 1985. "Madness Network News" was also published, expressing the views of psychiatric survivors. By means such as these the movement continued to grow. Many individual local consumer groups were formed, focusing on areas as diverse as organising support groups, advocating for the mentally ill in hospital, lobbying for law change, public speaking and publishing newsletters (Chamberlin, 1990). In 1979 the National Alliance for the Mentally Ill (NAMI) was formed by and for families with mental illness, and by 1992 the United States Government had established the Center for Mental Health Services. This service did then and continues to provide a significant amount of support for the consumer movement, funding both the National Mental Health Consumers' Self-Help Clearinghouse and the National Empowerment Centre, which are central in assisting with the coordination of consumer activities (Frese & Davis, 1997).

The 'consumer movement' has been talked about broadly as a worldwide liberation movement with common ideas and goals. This movement has focused on aspects such as the rights of the mentally ill to be treated as people-not as an illness, consumers' rights to accurate information and collaboration in treatment decisions, as well as attempting to combat stigma and change community attitudes towards the mentally ill. It has been

suggested that where consumer groups differ the most is in how they seek to bring about change (Epstein & Olsen, 1998). For instance some groups focus on providing self-help and support groups such as drop-in centers, others provide legal advice, emergency accommodation, internet support groups or web sites providing information about relevant research. Some consumers work as service providers and others in partnership with mental health professionals. In some countries coordinated consumer bodies have been established to ensure the consumer voice is heard and acted on. This diversity has been identified as supporting the strength of the consumer movement in its current state (Epstein & Olsen, 1998).

2.3.2 Health services and consumers coming together

The consumer movement has significantly contributed to increased involvement of consumers in mental health services, from planning to service delivery and evaluation and research, as well as contributing to the protection of individuals rights (Van Tosh, Ralph, & Campbell, 2000). This movement recognises consumers ' unique expertise and therefore contributions that they can make as recipients of services (Crawford, 2001; Lloyd & King, 2003; Telford & Faulkner, 2004). Increasing emphasis on involving the patient/consumer in health services is also evident in the medical field generally (Goodare & Lockwood, 1999; Liberati, 1997).

Across the world mental health services in particular are undergoing significant changes in philosophy and direction in response to the growing influence of the consumer participation movement (Gawith & Abrams, 2006). Consumer participation in mental health services is clearly highlighted in policy documents in Australia (Australian Health Ministers, 1992, 1997, 1998, 2003) and New Zealand (Mental Health Commission, 1998; Ministry of Health, 2001) as well as other regions including the United States (New Freedom Commission on Mental Health, 2003) and Europe (Department of Health, 1999).

Furthermore, consumer participation has increasingly come to be valued at multiple levels within mental health services (for example the individual level, service delivery, planning and evaluation and policy levels). For example, in Australia the most recent Third National

Mental Health Plan clearly states under Outcome 25 that services require “increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality” (Australian Health Ministers, 2003, p. 24). This is similarly echoed in the New Zealand National Mental Health Sector Standards under Standard 9, with a call for meaningful consumer involvement within all levels of the mental health service system including planning, implementation and evaluation (Ministry of Health, 2001).

There are wide ranging reasons for the increasing focus on consumer participation in mental health services. Firstly the need for participation is grounded in the belief that people with mental health problems are disadvantaged and that participation in the system is a necessary and potential avenue for empowerment (Lloyd & King, 2003; Lord & Dufort, 1996) and may be beneficial in reducing power imbalances (Church, 1992). There is also a strong belief that consumers have a fundamental right, as consumers, to be involved in shaping and determining treatment, where the central purpose is to benefit them (Mental Health Commission, 2002; Tobin, Chen, & Leathley, 2002). Consumer involvement is also important with respect to recognising and valuing the contributions that can be made by people with ‘lived experience’ of service involvement (Lammers & Happell, 2003). Involvement of consumers also has the potential of increasing service innovation, responsiveness to changes in the market place, accountability, enhanced quality of care and protection of consumer rights (Lloyd & King, 2003; Salzer, 1997).

2.3.3 Avenues for consumer participation in mental health services

Some authors have attempted to describe consumer participation in services by identifying the various possible levels of involvement. Lloyd and King (2003) have discussed two key levels of consumer participation in services, the micro and macro level. The micro level covers consumer participation in the clinical process, including planning and treatment decisions. The macro level, on the other hand, refers to involvement in broader decisions about the way in which services operate, moving towards more of a representative role (beyond personal treatment), and including planning and reform processes.

Lord (1989) identified three levels of consumer participation, the first two levels drawing similarities with that of Lloyd and King. The three levels include the individual treatment or service level, the agency or organisation level, including involvement on boards and committees, as well as a third potential level of consumer involvement-in community, regional and national planning and policy making decisions. Lloyd and King (2003) go on to describe eleven practical ways of involving consumers and carers in the delivery of services including development of promotional material, individual service plans, evaluation of services and programmes, completion of surveys, involvement in forums, membership of committees, as staff and consultants, training of staff, promotion/prevention and early intervention, research and evaluation and programme development.

2.3.4 Beyond the consumer-hearing all relevant voices

Researchers seeking to evaluate and improve mental health services and programs must include the consumer perspective, among other key stakeholders. For example mental health staff, carers and family members viewpoints are also likely to be important (Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998; Jacobson & Curtis, 2000). A number of authors have suggested that that collaborative and supportive partnerships between multiple stakeholder groups (such as consumers, families, health professionals and policy makers) will be crucial in driving a recovery based service system (Fisher & Chamberlain, 2004; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

The most recent mental health plan in Australia states that there should be “increased levels of full and meaningful consumer, carer and family participation in policy, and in service planning, delivery and evaluation at all levels with evidence of improvement in quality” (Australian Health Ministers, 2003, p. 24). The New Freedom Commission Report in the United States also specifically emphasises the need to collaborate with families in the planning and evaluation of treatment and support services (New Freedom Commission on Mental Health, 2003).

Some authors have emphasised, in view of shifts towards involving families and consumers in research that there will however, be a continuing place for ‘trained researchers’, in

particular for ensuring that rigor is maintained in the research process and results are interpretable (Carrick, Mitchell, & Lloyd, 2001). Increasingly, with the growth of consumers receiving appropriate training in undertaking research, it is argued that ‘trained researchers’ could include consumers or non-consumers. The key issue for consideration should be whether the researcher has the relevant training and skills to undertake particular research activities.

2.4 SPOTLIGHT ON CONSUMERS’ EMERGING PLACE WITHIN RESEARCH ENDEAVOURS

Traditionally patients or consumers have been involved in research as ‘subjects’ but never as co-researchers (Goodare & Lockwood, 1999) representing an unequal balance of power. Shifts are starting to occur in the health field, with some recognition of the benefits of forming a more equal partnership with consumers in health research (Faulkner & Thomas, 2002). Over the past two decades consumers have increased their presence in the public health sector, with a growing number participating in research and evaluation (Van Tosh, Ralph, & Campbell, 2000).

2.4.1 Levels of consumer participation in the research process

A distinction has been made between the various potential levels of consumer involvement in research. Hanley et al (2000) describe three key levels including consultation, collaboration and user control. Consultation is where consumers are asked their views, collaboration involves more of a partnership between consumers and researchers throughout the research process, and user-controlled research involves professional researchers only if invited by consumers. Other authors have made similar suggestions for example ‘lip service involvement’ (similar to consultation in the previous example), where consumer consultation is minimal and ultimate control of the project is not shared. Secondly ‘partnership involvement’ where collaboration occurs at all levels and a more equal partnership is described (Trivedi & Wykes, 2002). Further distinctions have been made between the various stages of research that consumers can potentially be involved in- from research design, to collecting data and carrying out research, to data analysis and dissemination of findings (Telford & Faulkner, 2004).

An ideal that researchers can strive for, in particular for recovery research is to consult consumers about their experiences and involve consumers actively throughout the research process. However this is not to devalue research efforts that genuinely seek to obtain the perspectives and experiences of consumers. Indeed, historically speaking it was not that long ago that consumers viewpoints were excluded from research efforts entirely. Care should therefore be taken with terms such as ‘lip service involvement.’ Language such as this may actually create divides in the research community and do little to encourage consumer involvement in research activities. Further such language may demean research attempts that genuinely seek to examine the consumer perspective.

Patton (2002) suggested that since there is no definitive definition of ‘participatory’ or ‘collaborative’ research, it is up to individuals to clarify the meanings of such terms, within any given setting. He goes on to describe seven principles of genuine participatory and collaborative inquiry, suggesting that these may form a starting point for discussion among stakeholders of key areas of focus for a particular study (Patton, 2002, p. 185). A summary of these key principles are listed below:

1. the inquiry process involves participants in learning inquiry logic and skills;
2. participants own the inquiry-they are actively involved in making major focus and design decisions;
3. participants work together as a group-facilitator supports group cohesion and collective inquiry;
4. all aspects of inquiry (from design to analysis of data) are undertaken so as to support meaningfulness and understandability for all participants;
5. the researcher acts as a facilitator, collaborator and learning resource. Participants are treated and considered as equals;
6. the facilitator recognises and values participants knowledge and perspectives and helps participants to value their own, as well as others expertise; and
7. status and power differences between various stakeholders are minimised wherever possible.

The terms collaborative/participatory research as used in this thesis are defined elsewhere (see section 1.1). The stance taken in this thesis is that consumer involvement in evaluating and improving mental health services *at any level* is deemed as valuable, as long as consumers' perspectives are genuinely sought. However it is recognised that an ideal, particularly for 'recovery' research is to seek consumers' perspectives about services/treatment and to involve them as co-researchers throughout the research process. Other authors have noted that this is particularly important for 'recovery' research (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

2.4.2 Rationale for consumer involvement in research

The value of consumer involvement in research activities has been emphasised in the medical (Chalmers, 1995; Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998; Faulkner & Thomas, 2002; Goodare & Lockwood, 1999; Goodare & Smith, 1995; Hanley et al., 2000; Heymann, 1995; Liberati, 1997; Oliver, 1995; Williamson, 2001) as well as the mental health literature (Carrick, Mitchell, & Lloyd, 2001; Gordon, 2005; Linhorst & Eckert, 2002; Lloyd & King, 2003; Ochocka, Janzen, & Nelson, 2002; Telford & Faulkner, 2004; Trivedi & Wykes, 2002; Wykes, 2003), and similarities are clear in terms of rationale provided for involvement. Generally speaking it has been suggested that scientific rigour is of little value if results and research findings are unintelligible and/or irrelevant to consumers they are designed to help (Carrick, Mitchell, & Lloyd, 2001).

Authors in the medical field have recognised that consumers have unique skills and experience from living with a particular illness, as well as from being on the receiving end of services, which can complement the perspectives of researchers (Goodare & Lockwood, 1999). It has also been argued that collaborative research can be a valuable resource for improvements to preventing disease, to treatment and quality of care (Liberati, 1997). Some authors have suggested that forming partnerships with patients is necessary for the production of more relevant research (Liberati, 1997) that identifies research areas that matters to patients, which may be overlooked by researchers (Chalmers, 1995; Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998) thus potentially driving more effective health care (Goodare & Lockwood, 1999; Hanley et al., 2000).

In referring to clinical trials in the medical field some authors have bluntly suggested:

Clinical trials cannot be done without patients, and the whole purpose of conducting trials is to benefit patients. These two indisputable statements should mean that patients should be at the front of researchers' minds when they design, conduct, and report medical research. But they rarely are. Too often patients are forgotten in the complex business of conducting research. We argue that patients should help to decide which research is conducted, help to plan the research and interpret the data, and hear the results before anybody else. (Goodare & Smith, 1995, p. 1277).

Researchers in the medical arena have also discussed the potential benefits of involving consumers at the varying levels of research activity. For example, involving consumers in the design phase may not only assist in developing research that is sensitive to consumers needs but may encourage other consumers to become involved (aiding recruitment) (Goodare & Smith, 1995; Heymann, 1995). Involving consumers in the dissemination of results may encourage patients to request new treatments and practices, speeding up acceptance into clinical practice (Hanley et al., 2000) where results are considered important to patients (Goodare & Smith, 1995).

Similar rationale has been provided when arguing for increased consumer involvement in mental health research specifically, when compared to health research in general. A key reason repeatedly emphasised is the opportunity to improve services (Birkel, Hall, Lane, Cohan, & Miller, 2003; Department of Health, 2000; Entwistle, Renfrew, Yearley, Forrester, & Lamont, 1998; Lloyd & King, 2003; Salyers & Macy, 2005; Townend & Braithwaite, 2002; Trivedi & Wykes, 2002). Some authors have suggested that consumers in particular may value improvement of services as a key aim of collaborative research (Carrick, Mitchell, & Lloyd, 2001). This is hardly surprising as consumers could be considered the stakeholders most likely to benefit from improved services, which better meet their needs. Other authors have argued that consumers' desire to improve services is likely to be linked to the desire not only to improve their own lives, but also the lives of others with mental illness (Telford & Faulkner, 2004).

Other reasons for involvement include recognition of ‘expertise by experience’ (Telford & Faulkner, 2004) both in terms of living with mental illness, as well as being on the receiving end of services (Morrell-Bellai & Boydell, 1994). In one report consumer/survivors emphasised the importance of consulting consumers as the primary customers of mental health services, above and beyond other stakeholders in the system (Campbell, Ralph, & Glover, 1993).

For consumer researchers there is the potential to gain new skills and training as well as financial reward for the expertise they offer. The process of engaging in participatory research may also have benefits to individual consumer participants (Boll, 1995). Some authors have suggested that the process of being actively engaged in the research may be empowering (Dickerson, 1998) and may promote increased self esteem (Morrell-Bellai & Boydell, 1994), particularly as consumers are so often accustomed to being the objects of study (Telford & Faulkner, 2004).

2.4.3 Potential benefits of consumer involvement in research activities

Potential benefits of involving consumers throughout the different levels of the research process have been highlighted. For example, collaborating with consumers at the design level can help ensure that areas of importance to them are addressed (Linhorst & Eckert, 2002; Townend & Braithwaite, 2002) by influencing what questions are asked and in what manner (Rose, 2003) and may alter the focus of an evaluation (Corrigan & Garman, 1997). There has been some suggestion that mental health consumers may be unlikely to reveal their true feelings and thoughts about mental health services to non-consumer researchers and health professionals working in the system due to learned fear of potential consequences of doing so. Thus involving consumer researchers in collection of data has been presented as one possible way of enhancing the validity of responses from consumers (Campbell, Ralph, & Glover, 1993). Furthermore if consumers are involved in the design stage they are more likely to feel some ownership over the evaluation, and remain committed towards the evaluation process (Boll, 1995).

Direct involvement in data collection is likely to generate more honest responses from consumers (Gill, Pratt, & Librera, 1998; Morrell-Bellai & Boydell, 1994) and may encourage them to take part (Heymann, 1995) leading to a reduction in drop out rates (Townend & Braithwaite, 2002). Involvement in the analysis and interpretation of data will help ensure that meanings are consistent with consumer perspectives (Allam et al., 2004; Linhorst & Eckert, 2002). It has also been suggested that using consumers to disseminate findings may prompt consumers to request new treatments and evidence based practices, increasing their take up into the delivery of services (Williamson, 2001). Awareness of benefits at multiple levels have led some researchers to argue that it is important for consumers to be involved throughout the research process (Linhorst & Eckert, 2002; Townend & Braithwaite, 2002).

There are some more demonstrable effects of consumer involvement beginning to emerge, in particular at the data collection level of mental health evaluation research. Clark et al (1999) involved four individuals with severe mental illness in the process of interviewing other consumers, with a comparison group of staff interviewers as part of a RCT. They found significant differences between the groups, with those clients interviewed by consumer researchers more likely to give extremely negative responses about services. Polowczyk et al., (1993) found similar results in their comparative study of consumer and staff interviewers when administering a satisfaction survey.

Systematic reviews of electroconvulsive therapy (ECT) have also shown that consumer-led studies show lower rates of perceived benefit than clinician-led studies (Rose, Wykes, Leese, Bindman, & Fleischmann, 2003). Such findings may indicate that consumers may provide a more accurate portrayal of services when other consumers are involved in the data collection, rather than service professionals and lends more demonstrable evidence to the suggestions of other researchers (Gill, Pratt, & Librera, 1998; Morrell-Bellai & Boydell, 1994). Alternatively, it could potentially indicate that negativity is more encouraged when peers are involved in the data collection. Further research is needed in order to more clearly demonstrate the nature of such findings.

Whilst there have been many benefits proposed for involving consumers in research, there is a need, where possible, to more systematically assess the impact of consumer involvement in research. As discussed here such evidence is already starting to emerge at the level of consumer involvement in data collection. As demonstrable effects become clearer at other levels of the research process, researchers may be more readily encouraged to engage in participatory research. Other authors have suggested that the academic community and funding organisations likely require more direct evidence of the effect of consumer involvement in research activities (Wykes, 2003). Obviously this will not always be possible or necessary and sometimes narrative evidence, from stakeholders involved in collaborative research will be more than sufficient to validate claims. For example, reported benefits of learning new skills and receiving financial payment, are unlikely to be suitable for further demonstrable research studies.

2.4.4 Potential costs of involving consumers in research activities

There are a range of potential costs associated with consumer involvement in research activities such as the increased time commitment and financial costs of paying consumers (Trivedi & Wykes, 2002), possibility of triggering psychotic symptoms (Linhorst & Eckert, 2002) and potentially having some people unable to participate due to severe psychotic symptoms (Dickerson, 1998). Other authors have suggested that a potential downside of collaborative research is the ongoing commitment required to engage in this type of research, which is likely to be demanding of researchers as they come to terms with competing objectives (Oliver, 1992). Perhaps this would be particularly true of researchers who are new to this area. However, it is also possible that researchers engaging in collaborative research may learn to value this type of research and may see the ongoing commitment to collaboration as a worthwhile process.

The possibility of researchers becoming mentally unwell, or triggering psychotic symptoms must be considered. This could partially be addressed or reduced by careful planning of appropriate support for researchers. For example, Morrell-Bellai and Boydell (1994) reported that two of the consumer researcher assistants that they employed withdrew because of 'stress' related to the research. However, they go on to state that the results of

their research indicate that they provided too little support to consumer researchers. There is a growing literature to guide researchers in this area of developing adequate support (Faulkner, 2004; Linhorst & Eckert, 2002; Trivedi & Wykes, 2002).

Whilst the financial outlay to pay consumers has been raised by some authors as a ‘cost’ of engaging in collaborative research (Trivedi & Wykes, 2002) it could also be viewed as a necessary requirement. For example, for valuing the expertise and knowledge that consumers’ bring to the research enterprise. In light of this consumer researchers should be paid for their expertise and contributions, as would any other stakeholder involved in the research process.

2.4.5. Consumer involvement considered with recovery on the research agenda

The next section of this chapter is devoted to more fully exploring the concept of recovery and its clear place within the mental health service system. It is discussed briefly here as consumer participation is closely tied to the concept of recovery, with various authors recognising that active collaboration with consumers is crucial within a recovery oriented service system (Anthony, 2000; Fisher & Chamberlain, 2004; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Collaborative approaches to evaluation are important within a recovery framework for many reasons, perhaps most importantly in relation to honouring and respecting the knowledge and lived experience that comes from actually ‘recovering’ from a mental illness. Recovery, consistent with consumer accounts, is after all owned and driven by the consumer. Services can orient themselves to support this process, but awareness of how and whether this is occurring requires the input of people with lived experience of both recovery and services.

Anthony (2000) states that within a recovery era, lack of consumer participation is of prime concern, as effective service development must be guided by and based on the experiences of people in recovery, and what they have found to be helpful in progressing towards their own recovery. Other authors have suggested that from a recovery-orientation services and

professionals need to let go of urges to become experts and use their expertise to help people who are 'recovering' from mental illness understand and describe what works for them (Glover, 2005). Consumers must become critical stakeholders not only in the development of, but also in the evaluation of recovery-oriented services and treatment. The need for collaboration with consumers when undertaking recovery research has been made by other authors (Ralph & Corrigan, 2005), with some emphasising the need for collaboration at all levels of research activity within a recovery framework (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

An area rarely highlighted in the literature, but considered worthy of researcher attention is whether collaborative research approaches may, in and of themselves, potentially support or hinder the recovery process of individual participants. Intuitively this seems possible, at least for some people. Certainly collaborative approaches to research would seem more likely to support recovery for both consumer researchers and participants than more traditional approaches, which include participants only as 'subjects' to be researched on. Other authors have made preliminary suggestions that participation in research can itself hinder or support recovery (Ralph & Corrigan, 2005).

There is also emerging evidence that collaborative practices may have a positive psychological impact on consumer researchers, with reports of increased empowerment (Dickerson, 1998; Telford & Faulkner, 2004) and self esteem (Morrell-Bellai & Boydell, 1994) in existing studies. Empowerment in particular has been discussed in the literature as a common indicator of recovery. Self-determination and responsibility are also common features of recovery (Andresen, Oades, & Caputi, 2003; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002) that are likely to be supported by research that actively engages consumers in the research process.

There are perceived benefits to involving a range of stakeholders in the evaluation of mental health services. Consumers are focused on in this chapter as one critical voice that must be included if mental health services are to be improved to better meet the needs of individuals they intend to serve. However, consumer involvement is becoming particularly

important as the mental health system reorients itself to foster and support individuals' recovery journeys. Whilst the rationale for consumer involvement in evaluation is strong in both mental health, as well as health fields in general-the impact of consumer involvement needs to be more systematically examined across all levels of research activity.

2.5 METHODS AND EVALUATION MODELS THAT SUPPORT COLLABORATIVE INQUIRY

2.5.1 Evaluation models supporting collaborative inquiry

There are a number of evaluation models that are particularly consistent with participatory or collaborative approaches to evaluation. For example participatory action research (or PAR), empowerment evaluation, utilisation-focused evaluation (Linhorst & Eckert, 2002) and user focused monitoring (Sainsbury Centre for Mental Health, 2003). Each will be briefly described. User Focused Monitoring (or UFM) was developed by the Sainsbury Centre for Mental Health and is a programme of ongoing evaluation and re-evaluation that provides an opportunity to monitor whether changes are taking place in the quality of services, from a consumer perspective. Active consumer participation is essential to this form of ongoing evaluation. It is specified that a 'large proportion' of consumers must be involved, in a range of stages of the research process (for example question development, data analysis). Each evaluation is extensive, taking approximately 12 months (Sainsbury Centre for Mental Health, 2003). For practical examples of UFM see Rose (2001) and Rose and colleagues (1998).

Empowerment Evaluation involves the use of evaluation concepts, techniques and findings to foster improvement and self-determination among participants. It can be applied to individuals, organisations, communities, societies or cultures but typically focuses on programs (Fetterman, 2001). Program participants conduct their own evaluations with outside evaluators serving as coaches or additional facilitators. This model of evaluation is cyclical, with an emphasis on evaluation becoming a routine inbuilt part of the planning and evaluation process (Fetterman, 2002). This evaluation model draws on both qualitative and quantitative methods and has been conducted in a wide array of settings and programs, for example substance abuse prevention, welfare reform, battered women's shelters and accelerated schools (Fetterman, 1999).

Utilisation focused evaluation provides an evaluative process, strategy and framework for reaching decisions about key aspects of an evaluation in relation to content, focus and methods (Patton, 1997) . It focuses on bringing together evaluators and ‘intended consumers’ to collaborate in making design and data collection decisions. This is done in order to increase consumers’ understanding and interest in the evaluation, and to increase their commitment to facilitating findings in to practice. Intended consumers or stakeholders are considered to be people who will use the information that the evaluation produces- e.g. clients, program staff, funders, administrators, board members and community representatives (Patton, 2002). Differing from other models discussed here, the emphasis on collaborative practices does not extend to involving stakeholders at all levels of the evaluation process. Limited examples of utilisation focused evaluation are available outside of the mental health field (for instance Kalafat, 2004; Schwitzer, 1997; Smith, 1995).

Participatory Action Research (PAR) has been described as a form of applied research that actively encourages people in the organisation or community under investigation to participate with research scientists/professional researchers throughout the entire research process, from problem formulation to the application and assessment of results (Davyddj, Whyte, & Harkavy, 1993; Whyte, 1991). Participants are considered valued collaborators based on their history and direct experience with the research area, or problem under study (White, Nary, & Froehlich, 2001). There are limited examples of PAR being undertaken in the mental health field with consumers of services (Davidson, Stayner, Lambert, Smith, & Sledge, 1997; Ochocka, Janzen, & Nelson, 2002).

2.5.2 Qualitative methods as one avenue for supporting collaborative inquiry

There are a number of research methods that support collaborative inquiry. For instance co-operative (Heron, 1996) and heuristic inquiry (Douglass & Moustakas, 1985) which each emphasise working with people rather than on people, treating people as humans, rather than objects to be studied. Feminist methods have also been described as participatory, as have qualitative methodologies (Patton, 2002). Potential opportunities to support collaborative inquiry through the use of qualitative methods will be explored in some depth here, since it is particularly relevant for this research.

Qualitative methods have been described as particularly helpful for supporting collaborative inquiry, in part because these methods are usually more accessible, easier to understand and teachable for the lay person. This is clearly important for research which attempts to engage people with limited knowledge and training in research activities, (Patton, 2002) such as may be the case when mental health consumers are engaged in research activities. Qualitative methods may also be particularly suitable for collaborative inquiry as they increase the likelihood of capturing the person's personal constructs, meaning and broader experiences when compared to quantitative methods-that focus on narrower quantified perceptions regarding fixed constructs. As stated succinctly by Patton "qualitative methods are often used in evaluations because they tell the program's story by capturing the participants' stories" (2002, p. 10). This is particularly the case with open ended questioning that permits one to understand the world as viewed by participants, and may occur as part of surveys, interviews or focus groups. Indeed, the main purpose of undertaking open-ended questioning is to allow researchers to capture and understand others' perspectives, without predetermining points of view through prior selection of questionnaire categories (Patton, 2002).

Clearly even open-ended questioning can vary in terms of degree of structure and ability for capturing individual meanings of participants. For example, open-ended questions asked as part of surveys/questionnaires may be limiting in capturing individual meaning, as it requires considerable effort on the part of the participant. Furthermore responses cannot be probed or clarified and in some instances the writing skills of participants may be limiting. Pre determined interview guides (which provide specific areas/questions for discussion during an interview) may also be 'more' or 'less' structured, allowing participants to have varying degrees of input, in relation to guiding discussion (Patton, 2002). When undertaking interviews as part of collaborative research, particularly where there are inexperienced researchers involved and/or where there are multiple people undertaking interviews, there are potential benefits of having predetermined standardised questions. For example, standardised interview guides could potentially guard against possible variations in skills and interviewing techniques. Another good reason for retaining some structure, is

that analysis may be enhanced, by making participants' responses easier to find and compare across participants (Patton, 2002).

Potential imitations of structured interview guides could be overcome by involving consumers directly in their development. This would assist in ensuring that areas for discussion remain relevant to consumer participants. There are examples of this occurring in the literature. For example, Oades and colleagues (2005) conducted focus groups with 20 consumer participants to identify consumer-driven questions based around criteria that consumers use to evaluate mental health services. Themes generated from the analysis of these focus groups were then used to devise an interview guide, which was subsequently used to guide a number of individual interviews with another larger group of consumer participants. Similar collaborative principles could be applied for the development of quantitative measurement tools, which retain relevance to people with mental illness.

To the extent that consumers in particular have been found to value action based research, which involves creating meaningful change, (Carrick, Mitchell, & Lloyd, 2001) the strengths of including qualitative methods, as well as quantitative methods in evaluation research are highlighted. Qualitative methods such as interviews and focus groups are particularly well suited for obtaining detailed information from consumers about the strengths and weaknesses of particular programs, as well as identified areas for improvement (Patton, 2002; Schwarz, Landis, Rowe, Janes, & Pullman, 2000). Some authors have suggested that focus group methodologies in particular may be helpful when attempting to engage consumers in the quality improvement process (Schwarz, Landis, Rowe, Janes, & Pullman, 2000). There has also been some discussion that focus group methods may be particularly suited to collaborative inquiry as some participants may feel more comfortable, and therefore be more likely to participate in group settings with other consumers, therefore making them a favourable choice for marginalised groups in the community (Patton, 2002).

Whilst qualitative methods may be particularly beneficial for supporting collaborative inquiry for the reasons outlined above, clearly researchers utilising qualitative and/or

quantitative methodologies can each support or fail to support collaborative inquiry. For example, development of questionnaire items derived in consultation with consumers, drawing on their 'lived experience' is clearly collaborative, as opposed to questionnaire items designed solely by professionals or researchers. For other evaluative research such as Randomised Controlled Trials or outcome based studies, involvement of consumer participants throughout the research process, including the design stage, would be advantageous in assuring that research remains relevant to consumers of services. Useful inclusion of pre-existing outcome tools or measures could be discussed with consumers in the design stage to ensure relevancy.

2.6 MAKING WAY FOR 'RECOVERY'

2.6.1 Defining 'recovery'-from past to present

Medical and rehabilitation models define 'recovery' as an absence of symptoms and a return to previous level of functioning respectively. This is consistent with layman's understandings that emphasise being restored to the former state, or getting back to how you were before the illness (Bellack, 2006). Such a definition implies that people can do the same things and feel the same as they did before they were ill (Whitwell, 1999). These understandings of recovery which evolved from a clinical/disease model differ greatly from consumer understandings of recovery, which emerged later within the literature (Bellack, 2006). The earliest writings of recovery, that conceptually reflected a focus beyond symptoms can be traced back to the literature from as early as 1770 (Onken, Dumont, Ridgway, Dornan, & Ralph, 2006). Some authors have suggested that it was not until the 1980's when the recovery movement became more prominent in mental health circles, that newer concepts of recovery came to the forefront (Anthony, 2000) and traditional definitions of recovery began to be challenged (Bellack, 2006).

Two key bodies of knowledge were instrumental in driving more recent conceptualisations of recovery (Anthony, 2000). Firstly the writings of people who had experienced and gone on to live meaningful and contributing lives with mental illness (Anonymous, 1989; Deegan, 1988; Leete, 1989). Secondly the empirical work of Harding and colleagues (Anthony, 2000). This included long-term outcomes studies that showed that people with

severe mental illness such as schizophrenia could recover over time and experience positive outcomes (Anthony, Rogers, & Farkas, 2003). These writings and empirical studies provided renewed hope for individuals living with mental illness about the possibility of recovery and living a contributing and meaningful life, even with limitations caused by illness.

Numerous definitions of recovery have emerged in the literature. For example, Deegan (1988) describes recovery as “a process, a way of life, an attitude, and a way of approaching the day’s challenges.” Andresen and colleagues suggested the following definition of psychological recovery after reviewing articles on the concept of recovery and consumer narratives “psychological recovery refers to the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination ” (2003, p. 588). Anthony’s widely accepted contemporary definition of recovery involves “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993).

Whilst clearly there is no single definition of recovery, commonalities across the use of this term are that recovery is often described as more than, or different from the eradication of clinical symptoms. Indeed it has been recognised that recovery can take place even though a person may experience psychiatric symptoms (Gawith & Abrams, 2006; Ralph & Corrigan, 2005). In making this distinction it is also recognised that self management of symptoms will form an important part of the recovery process for a significant number of individuals (Onken, Dumont, Ridgway, Dornan, & Ralph, 2006).

Understanding recovery, or providing a conceptual definition becomes increasingly important as services shift towards a recovery vision, attempting to support individuals’ recovery journeys. Complexities of attempting to measure or ascertain whether services and staff are supporting individuals’ recovery processes is discussed elsewhere (see section 2.6.8).

2.6.2 Commonalities across individuals' recovery journeys

Helpful factors in the recovery journey

Whilst recovery has been described as a deeply personal journey, commonalities have also emerged as consumers have shared their experiences of this process (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). A number of researchers have devoted time and effort towards understanding the recovery process from the perspective of consumers and the underlying factors that can facilitate this process (for instance Blanch & Fisher, 1993; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Sullivan, 1994; Tooth, Kalyanasundaram, & Glover, 1997; Torgalsboen, 2001; Young & Ensing, 1999). In addition there are individual case studies or consumer accounts of recovery that have been published in the literature that provide valuable insight into the process of recovery (for example Deegan, 1988; Leete, 1989; Lovejoy, 1982).

Andresen et al (2003) sought to identify common themes of recovery from consumers' accounts, as part of a literature review. Key processes of recovery identified by the authors were finding hope, re-establishing identity, finding meaning in life and taking responsibility for recovery. Similarly Davidson et al (2005) undertook a concept analysis of the consumer psychiatric rehabilitation literature to identify common concepts related to recovery. They identified all of the themes of Andresen et al., (2003), and in addition incorporating illness, overcoming stigma, being empowered, exercising citizenship, managing symptoms and being supported by others. In relation to management of symptoms, this literature review indicated that whilst complete symptom remission was not necessary for recovery, that management of symptoms, by some means was essential for recovery to occur (Davidson, O'Connell, Tondora, & Lawless, 2005). Importantly it was identified that recovery occurs in interaction with, and can be supported by others (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002) such as friends, peers, professionals or other community members (Davidson, O'Connell, Tondora, & Lawless, 2005).

In a review of personal accounts of recovery Ralph and Corrigan (2005) identified a number of common aspects of the recovery journey that map onto those identified by Davidson (2005) and Andresen (2003). These include redefining sense of self, being

supported by others, renewing a sense of hope and commitment, accepting one's illness, being involved in meaningful activities and expanded social roles, renewing responsibility for one's life, overcoming stigma and exercising citizenship. Sullivan (1994) interviewed 46 consumers to find out what facilitated their recovery. Helpful themes emerging from this study included medication, community support services/case management, self-will and self-monitoring, vocational factors and spirituality. Spirituality has also been identified as a helpful factor in other research (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Tooth, Kalyanasundaram, & Glover, 1997).

Onken and colleagues (2002) have undertaken one of the largest existing studies with mental health consumers with a view to identifying factors that hinder and support recovery. This National Research project was undertaken with 115 consumers participating in focus group meetings across nine states in the United States. Key factors identified as supporting recovery and examples within each domain include having basic material resources (such as a respectable home and safe and affordable housing), viewing the self/whole person as more than the mental illness (for example a focus on positive traits, attitudes, resilience and personal resources), having a sense of hope, meaning and purpose in life (for instance having goals and meaningful service choices), having choice and self determination across areas of life (e.g. more job choices and freedom regarding whether and how to participate in services) and independence (e.g. having affordable housing/car/job and basic human and civil rights).

In addition key areas relating to interpersonal interaction identified include: social relationships-having at least one person who believes in you as a person, not an illness (e.g. personal ties/intimate relationships and supportive and accepting kin), having meaningful activities (e.g. meaningful employment opportunities, volunteer work), the importance of peer support (e.g. role models and mentors and consumer run services), formal services can support recovery (e.g. no waiting/flexible services and services tailored to the individual), formal service system staff can support recovery (e.g. continuity/one on one relationships/availability and relationships that foster self empowerment). Such elements,

as described above, are the means by which consumers go about achieving a satisfying and meaningful life (Onken et al., 2002).

Hindering factors in the recovery journey

A limited number of researchers have sought to identify factors that may hinder or impede the process of recovery as part of their research investigations (e.g. Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Smith, 2000; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Tooth, Kalyanasundaram, & Glover, 1997). However, understanding what hinders recovery, in addition to what supports it is clearly important for future researchers to consider, in particular as mental health services attempt to learn how to improve services to better support individuals' recovery.

Tooth et al (1997) identified a number of barriers to recovery in their interviews with 57 consumers in Australia. Responses were largely focused around mental health service provision. For example, having mental health workers focus on their deficits, negative messages conveyed by staff and unequal distributions of power and controlling staff. In addition medication and side effects were viewed as barriers by some consumers, whilst others viewed medication as an important aspect of their recovery.

Hindering factors described in the Onken et al (2002) study are extensive. Many of these findings mirror helpful aspects (discussed in section 2.6.2). For example, one hindering factor is lack of basic material resources (e.g. poverty and unsafe and unaffordable housing), as opposed to helpful factors-having access to basic material resources (such as a respectable home and safe and affordable housing). Other hindering factors include failure to focus on the self/whole person beyond the illness (e.g. negative beliefs, attitudes and labelling), feelings of hopelessness (e.g. having dreams/goals and desires demeaned and poor quality services), lack of choice (e.g. lack of choices regarding basic needs and unemployment/underemployment), lack of independence (e.g. paternalistic orientation of the system and involuntary and long term hospitalisation), poor social relationships (e.g. inadequate social network/social isolation and emotional withdrawal/personal isolation), lack of meaningful activities (e.g. lack of training and education opportunities and exploitation of volunteer work), lack of peer support (e.g. lack of funding and professional

mistrust of peer support), formal services (e.g. culture that is pathology/illness focused/dominance of a medical model and lack of holistic orientation), and formal service system staff (e.g. discontinuity/burnout/overworked staff). Clearly further work is needed by researchers to further understand and investigate the way in which recovery is hindered, as well as how it is supported.

2.6.3 Recovery within the mental health system-a clear agenda

It is widely acknowledged that recovery is an individual process, owned by the person (Anthony, 1993; Davidson, 2004) and as such cannot be imposed on any individual (Deegan, 1988). It is also known that recovery extends well beyond the boundaries of formal mental health service settings (Tooth, Kalyanasundaram, & Glover, 1997) and it is important that this is recognised by mental health staff (Anthony, 1993). Indeed many individuals who have recovered have done so without services (Ralph & Corrigan, 2005).

However, it is also known that recovery is inherently a social process (Ralph & Corrigan, 2005) and mental health services and individuals working within services are one potential dimension, which can clearly support or hinder individuals' recovery journeys (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Some authors have used the term 'recovery-oriented care' to refer to what services and staff can do to support recovery, as opposed to 'recovery' as a process owned by the consumer, to emphasise this important distinction (Davidson, 2004). The Collaborative Recovery Model is based on the assumption that collaborative relationships can help support individuals' recovery journeys (see section 4.1.1 for further discussion).

Recovery is increasingly being emphasised as a guiding vision for mental health service delivery in various regions of the world (Australian Health Ministers, 2003; Mental Health Commission, 1998; New Freedom Commission on Mental Health, 2003; Slade, Amering, & Oades, 2008). For example, the New Freedom Commission Report in the United States specifies that the overarching goal of transforming mental health systems must be to promote recovery. Two major principles are proposed to bring about this transformation. Firstly providing services and treatments that focus on the consumer and their family, secondly a system which focuses on facilitating recovery, building coping resources and

resilience, moving beyond a narrow focus on symptoms and illness (New Freedom Commission on Mental Health, 2003). The Australian Mental Health Plan (2003-2008) also clearly specifies that a recovery orientation should drive service delivery. This document asserts:

Recovery is both a process and an outcome and is essential for promoting hope, well-being, and a valued sense of self determination for people with mental illness. A recovery orientation emphasises the development of new meaning and purpose for consumers and the ability to pursue personal goals. Mental health service providers should operate within a framework that supports recovery. (Australian Health Ministers, 2003, p. 11).

2.6.4 Frequency with which the term ‘recovery’ has been appearing in the scientific literature

Further indication of the growing interest in the concept of recovery is supported by the increasing frequency by which the term has been appearing in the scientific literature. Table 1 displays frequency counts of studies reported in two yearly blocks from 1990-2007 for the following search terms 1) ‘recovery and mental health services’ and 2) ‘recovery and mental illness’ (truncation symbols were used) entered into Psycinfo, Cinahl and Medline (R) databases. Results show a clear increase in the frequency of published studies in the recovery area from 1990 to 2007 both in the area of recovery generally, as well as more specifically with reference to mental health services research.

Table 1

Frequency counts for ‘recovery’ related literature from 1990-2007 reported by search term and database

Search term	Recovery and mental health services (truncated)			Recovery and mental illness (truncated)		
	Studies reported by database			Studies reported by database		
Year range	Psychinfo	Medline	Cinahl	Psychinfo	Medline	Cinahl
1990-1992	17	8	3	19	8	2
1993-1995	30	24	13	30	22	25
1996-1998	52	25	17	81	32	43
1999-2001	78	58	52	117	43	56
2002-2004	155	105	91	174	73	81
2005-2007	285	392	354	333	276	316

2.6.5 Professionals working as ‘recovery supporters’-emerging evidence

Clearly the mental health system can learn much about how recovery can be supported from the growing evidence base drawing on personal accounts, as well as empirical investigations of recovery in collaboration with consumers (see section 2.6.2). For example, the literature on recovery clearly indicates that recovery is supported by providing hope, helping people take responsibility and focusing beyond the illness towards building a meaningful life (Torrey & Wyzik, 2000).

There is also a small, but emerging literature focusing more specifically on enhanced understanding of the role of mental health professionals and services in supporting and hindering individuals’ recovery journeys (e.g. Borg & Kristiansen, 2004; Chinman et al., 1999; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Substance Abuse and Mental Health Services Administration, 2005). For example, in Onken et al (2002) 115 mental health consumers shared their experiences in relation to how the health system had impacted negatively and/or positively on their recovery journeys.

In summarising the findings the authors describe a recovery-oriented system as one that is:

Person oriented and respects people's lived experience and expertise. It promotes decision-making and self-responsibility. It addresses people's needs holistically and contends with more than their symptoms. Such a system meets basic needs and addresses problems in living. It empowers people to move towards self-management of their condition. The orientation is one of hope with an emphasis on positive mental health and wellness. A recovery-oriented system assists people to connect through mutual self-help. It focuses on positive functioning in a variety of roles and building, or rebuilding positive relationships. (2002, p. 75)

Aspects of the service system and clinician/client relationship that were hindering to the recovery journey were also discussed. Key elements of unhelpful service systems included a culture and service orientation overly focused on medications, a lack of focus on spirituality, crisis oriented services, as well as paternalistic approaches. Key features of unhelpful relationships included lack of meaningful consumer involvement in treatment, staff burnout or staff being overworked, inadequate training and knowledge among staff, issues of distrust and paternalistic relationships.

Borg and Kristiansen (2004) undertook a qualitative study involving interviews with 15 consumers focusing on characteristics of helping relationships in mental health services. Common factors identified by interviewees included professionals who conveyed optimism and hope and encouraged the person's belief in him/herself, shared power in the relationship and acknowledged the wisdom and knowledge of actually living with a mental illness, were readily available when needed and held open attitudes about the range of assistance that helps, as well as professionals who went beyond the common expectations associated with the therapist/client relationship. Going beyond expected roles was often conveyed as the worker exposing their own 'human' side within the relationship. Some interviewees in this study identified workers who had supported their recovery, whilst others spoke of their experiences of hopelessness and humiliation within the context of therapeutic relationships.

At the end of 2004 the Substance Abuse and Mental Health Services Administration held a conference; one of the aims of this conference was to identify the essential characteristics of effective recovery-oriented services. Consumers, family members, researchers, policy makers, public officials and service providers were invited to attend. Attendees came up with ten characteristics of recovery oriented services including: those which encourage self-direction of consumers, individualised and person centered services, services which empower consumers, holistic services (which encompass the varied aspects of an individuals' life), nonlinear services (in recognition that recovery is not a step by step process), strengths based services, services which recognise the value of peer support, respectful services (including the protection of consumer rights and elimination of discrimination and stigma), and services which encourage personal responsibility and provision of hope (Substance Abuse and Mental Health Services Administration, 2005).

Other researchers have begun to discuss the implications of recovery for the mental health system. For example, Anthony (1993) discusses the role of supportive others in facilitating recovery and building trusting and empathetic relationships. He raises the possibility of structuring health settings so recovery 'triggers' are present and providing adequate information to consumers at appropriate stages of recovery, as well as recognising the whole range of human emotions intrinsic to the recovery process. Onken (2006) suggests that a move towards recovery oriented services requires a shift from a deficit model with 'maintenance' as the goal to one where growth, resilience and pursuit of a full and meaningful life are considered both possible and likely. Farkas et al (2005) have detailed aspects they consider essential in working with consumers, with recovery at the forefront. For example, they identify four key values that support recovery including a focus on the person, person involvement, self-determination/choice and growth potential.

2.6.6 When recovery and the mental health system meet-emerging practices

With our somewhat limited knowledge of recovery oriented services at this point in time (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002) it is hardly surprising that there are few models of care that have attempted to operationalise recovery principles in practice (Anthony, 2000). However, there has been some progress in certain countries. In New

Zealand guidelines for recovery competencies have been developed and staff are beginning to be trained in line with these guidelines (O'Hagan, 2001). In Australia recovery initiatives have been taking place in various states and territories, although there is still much work to be done in this area consistent with national policy around recovery-focused service delivery (Rickwood, 2004). In some areas of the United States workers are being educated around recovery principles with recovery modules incorporated into their core training. This covers areas such as exploring the concept of recovery, challenging assumptions, and exploring the role of the professional in supporting the recovery journey (Jacobson & Curtis, 2000). As part of an educational initiative in New York, 'consumer recovery educators' have been paired with local consumers and have trained and educated hospital staff around the principles of recovery (Bassman, 2000).

In Ohio substantial progress has been made towards providing recovery-oriented services. The 'Ohio Mental Health Consumer Outcomes System' was developed to support recovery and resilience in mental health systems. One purpose for developing this system was to guide the development of individual treatment plans between consumers and health workers, and to monitor progress over time (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005; Ohio Department of Mental Health, 2004). More recently Onken and colleagues have developed the Recovery Oriented System Indicators (ROSI) system assessment (Onken, Dumont, Ridgway, Dornan, & Ralph, 2006) which is devised as a core set of indicators that measure elements of a recovery facilitating environment at the system level. This measure also has the potential to educate and make health professionals more aware about important elements that facilitate and hinder recovery (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005).

The Florida Self Directed Care Program (as outlined in Fisher & Chamberlain, 2004) is an example of an approach to providing public mental health services that allows individuals to have a high degree of self-determination in choosing the services and providers necessary to support their recovery. Under this system 100 consumers in Florida were given the opportunity to control public mental health funds in the way in which they consider best supported their personal recovery journey. People taking part in this program were offered

independent advice and guidance to assist them around decision making (Fisher & Chamberlain, 2004).

Programs such as those described above clearly break from traditional practice, and indicate the extent to which the recovery and consumer movement has impacted on the mental health system in certain parts of the world. It is also clear that much more work is needed in this area, and collaborating with people living with mental illness will be paramount in aiding further understanding of how professionals and service systems support, and inadvertently hinder individuals' recovery journeys (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Roberts & Wolfson, 2004). Some authors have suggested that qualitative methodologies in particular have a role to play in terms of clarifying further what the process of recovery involves and how mental health services, supports and systems can be reoriented to facilitate recovery (Davidson, Ridgway, Sean, Topor, & Borg, 2008).

2.6.7 Moving 'recovery' beyond policy, into practice

The degree to which a vision of recovery has moved from a policy level to actively being incorporated into practice within mental health services is typically unclear. Onken (2006) has indicated that in some circumstances services have done little more than change the language, bringing recovery into the mission statements and descriptions of programs. Glover (2005) also raises concern about simply renaming services as 'recovery oriented' and continuing to deliver medically focused services.

There has been some suggestion that active engagement towards providing recovery oriented care may be slow coming. For example, in a review of mental health services in New Zealand it was suggested that whilst recovery was a fundamental part of mental health thinking and funding, large numbers of staff and services appeared uninterested or unchallenged in actively working within a recovery framework with consumers (Gawith & Abrams, 2006).

Furthermore feedback has not always been positive in rare instances where consumers' have been given the opportunity to talk about the role of health services and providers as

part of their recovery journey. For example, Tooth et al (2003) found that two thirds of the fifty seven people who were interviewed as part of their Australian study reported that health professionals had had a negative impact on their recovery. Similarly Onken et al., (2002) found that mental health services contained much more ‘hindering’ content in relation to recovery, than in any other domain (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). With the exception of limited research examples such as these, consumers have had minimal opportunities to voice their opinions about their experiences of services within the context of supporting their recovery (Borg & Kristiansen, 2004). This is identified as an important gap in the literature, which will need to be addressed if services are to be improved to support recovery.

2.6.8 The dilemma of measuring ‘recovery’

As stated by Robert McNamara- “the challenge is to make the important measurable not the measurable important” (attributed to former US Secretary of State Robert McNamara, cited in Roberts & Wolfson, 2004, p. 41). With a recovery vision clearly coming to the forefront for service provision, there is a growing need to ascertain or evaluate the success of mental health services by the degree to which individuals’ recovery journeys are being supported. More recently some progress has been made in this area with the development of measures that attempt to capture personal or individual recovery, as well as to assess the recovery orientation of services at a system level (Onken, Dumont, Ridgway, Dornan, & Ralph, 2006).

For example, in a recent review of recovery based measures nine measures of individual recovery were identified, as well as four measures of recovery facilitating environments (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005). All measures cited in this review involved consumers in their development, to varying degrees and some had multiple versions applicable for completion by various stakeholders (such as carers, family members and health professionals). Examples of individual recovery measures cited in this review include the Consumer Recovery Outcomes System (CROS 3.0) developed by the Colorado Health Networks Partnership and Mental Health Recovery Measure (MHRM) (Young & Bullock, 2003). Examples of measures of recovery facilitating environments identified as

part of the review (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005) include the AACP ROSE-Recovery Oriented Service Evaluation developed by the American Association of Community Psychiatrists, and Recovery Oriented Systems Indicators Measure (ROSI) (Dumont, Ridgway, Onken, Dornan, & Ralph, 2005).

How researchers approach the task of evaluating recovery-oriented practices and programs will depend partly on how they conceptualise recovery, variably as an outcome or a process. Consumers commonly conceptualise recovery as a non-linear process occurring over time (Bellack, 2006) and many consider outcome definitions of recovery to be unsatisfactory. Descriptions of recovery as an outcome typically focus on domains such as work and housing, improved well-being and quality of life. A 'process' understanding of recovery recognises that all consumers are "in recovery" and focuses less on reaching an end state of "recovery" and more on identifying indicators of recovery such as hope, well-being and spirituality (Ralph & Corrigan, 2005).

Liberman and colleagues (2002) for example, have provided an operational/outcome based definition of recovery which requires assessments of outcomes in dimensions of symptomology, vocational functioning, independent living and social relationships. This definition is described as a preliminary starting point rather than a finished product and requires further refinements of identified dimensions. The authors also recognise that categorical definitions are not the only way to reliably measure recovery. However, this definition clearly moves beyond an illness focus and includes outcome domains that consumers' have often identified as important, making it potentially useful as part of outcome evaluations. The stages of recovery instrument (STORI) is an example of another recently developed instrument which attempts to measure recovery as described by mental health consumers. The development of this measure is based on a five-stage model drawn from consumers' own accounts of their recovery, published in the literature (Andresen, Caputi, & Oades, 2006).

At this point in time, in respect to our understanding of recovery and attempts to support this process researchers may benefit from attempting to capture the process of recovery, as well as measuring potential outcome dimensions. A focus on both may help overcome the

inherent limitations of focusing on one or the other (Ralph & Corrigan, 2005). What is clear within the context of recovery research is that consumers are crucial stakeholders, who should be considered equal partners in all stages of the research enterprise. This includes, but is not limited to, design of any newly emerging recovery based measures as well as study design for mental health service evaluation research in general (for example discussion and selection of relevant outcomes domains and recovery measures).

In summary mental health services are starting to recognise the benefits of providing recovery-based services. However, what services are actually doing and what this actually means at a practical service level requires further clarification. Indeed, many services which desire to support individual's recovery processes, currently face the challenge and uncertainty of how to move forward consistent with this direction (O'Connell, Tondora, Croog, Evans, & Davidson, 2005) .

2.7 CONCLUSIONS

Mental health service evaluation has, up until the present time, primarily been undertaken within a dominant medical framework. This has traditionally seen consumers and families excluded from evaluation activity. It has also led to researchers valuing particular practices and methodologies, such as randomised controlled trials and quantitative methodologies under the guise of 'evidence based practice'. However, within the context of the consumer movement, as well as the more recent recovery movement, issues of power and the rightful place of the consumer, as well as their families in evaluation and research activity are increasingly being acknowledged. There has been a revaluing, among some researchers in medical and mental health fields regarding collaborative forms of inquiry. It is suggested that there are benefits, where possible, to combining more traditional outcome based research with other qualitative forms of enquiry when undertaking evaluative research.

Forming active partnerships with consumers is emphasised as particularly critical within the context of evaluating recovery-oriented services, ideally across the entire research process. The importance of this partnership is further emphasised as there is currently a relative scarcity of research, which has focused specifically on understanding how mental

health staff can support individuals' on their recovery journeys. Forming partnerships to facilitate deeper understanding will be necessary as services continue to work towards shifting 'recovery' from a service vision, to a practical reality within mental health service contexts.

The next chapter provides a brief historical overview of the development of case management practices, as well as outlining the numerous models falling under the umbrella term of case management. It also focuses specifically on an investigation of the extent of consumer involvement and focus on recovery concepts across all existing models of case management. This includes key findings from a recent literature review undertaken by the author of this thesis and colleagues (Marshall, Crowe, Oades, Deane, & Kavanagh, 2007).

CHAPTER 3:

WHERE IS THE RECOVERING CONSUMER IN EVALUATIONS OF MENTAL HEALTH CASE MANAGEMENT?

“Authentic consumer voices can help to inform and improve not only case management services, but also the recovery process in general” (Buck & Alexander, 2006, p. 479)

It has been argued that consumers are crucial partners in terms of directing more effective services, which support individuals' recovery processes. Indeed 'recovery' is becoming a guiding vision for mental health service delivery in many nations (Slade, Amering, & Oades, 2008). Furthermore policy is increasingly recognising the need for consumer participation in mental health services at multiple levels, including evaluation activities, if quality services are to be realised (Australian Health Ministers, 2003). Even though consumer participation is a cornerstone of the recovery movement, it has only been extended to the research process in limited ways.

Clearly increasing opportunities to hear the voices of service users, in the evaluation of case management activities, will be beneficial in directing improved services which both meet the needs of service users and better support individuals' recovery processes. However, it is currently unclear as to the degree to which existing research has already been encouraging consumer participation within evaluation around case management practices. Furthermore, it is uncertain as to the degree to which existing research has sought to examine the effectiveness of case management practices from a recovery framework.

This chapter will begin by setting the context for case management with a brief historical account of its development, and description of existing models. Limitations of previous evaluations in this area, primarily in the form of outcome research, will be highlighted from a recovery framework. This chapter will move onto summarise the findings from a recent review undertaken by the author of this thesis and colleagues (Marshall, Crowe, Oades, Deane, & Kavanagh, 2007) investigating the extent to which case management evaluation has been undertaken consistent with the emphasis on recovery-based practice and consumer participation, within mental health services (see Appendix A).

3.1 BACKGROUND TO CASE MANAGEMENT PRACTICES

The rise of case management approaches in the western world

Substantial changes have occurred in the delivery of psychiatric and mental health care in the Western world over the past 30 or so years. In particular the closing of large mental institutions where people with mental illness were traditionally placed (Rosen & Teesson, 2001). During the period of institutionalisation most of the basic needs of people with mental illness such as food, shelter and health care were met by the hospital system (Anthony, Cohen, Farkas, & Cohen, 2000). In the early 1960's increasing pressure from civil libertarians saw a focus on community care for people with mental illness in the United States (Onyett, 1992). Since this time similar shifts towards provision of community based care, as opposed to institutionalisation of people with mental illnesses, have taken place in other parts of the industrialised world (Thornicroft & Bebbington, 1989). For instance, by the 1980's in the UK provision of care for the mentally ill had shifted from asylum settings to small inpatient/outpatient units and support services in local community settings (Marshall & Creed, 2000). In 1993, in Australia, the Human Rights Commissioners report highlighted issues of abuse within institutional care and broader neglect of people with mental illness within community settings (Human Rights and Equal Opportunity Commission, 1993). In the wake of this report mental health policy and government-driven reform processes supported the move away from institutional care of people with mental illness, to provision of care in the community (Groom, Hickie, & Davenport, 2003).

Case management has been described as a response to the deinstitutionalisation movement (Stanard, 1999). Case management had its beginnings in the United States as early as 1970, as a means of coordinating the care of people with mental illness living in community settings (Adair et al., 2003; Marshall, Gray, Lockwood, & Green, 2004). Case management approaches have been slower to emerge in other parts of the western world. For example, it was not until the early 1990's in the UK that 'case management' began to emerge as a model of care where each long term patient was required to have a key worker who was primarily responsible for maintaining contact and ensuring that peoples needs were addressed (Marshall & Creed, 2000; Marshall, Gray, Lockwood, & Green, 2004; Tyrer,

1998). In contrast case management services in Australia were first provided in New South Wales in the early 1980's (Rosen & Teesson, 2001).

Reviewing the various models and approaches to case management

Many definitions of case management have emerged (Thornicroft, 1991) and aspects of case management have not been well defined or agreed upon. Indeed there is much variation among the type of interventions that are practiced under the guise of 'case management' activities (Harvey & Fielding, 2003). Case management has been described broadly by Thornicroft et al (1991, p. 125) as "a generic term that encompasses the following functions: the co-ordination, integration, and allocation of individualized care within limited resources." Confusion and disagreement about how case management is best defined is certainly understandable within the context of the wide array of 'case management' models which have emerged since the 'broker' model of case management first arose in the US in the 1960's (Rohde, 1997). Since this time, a variety of other models of case management have evolved. The most prominent of those reported in the literature include Clinical Case Management, Assertive Community Treatment (or ACT), Intensive Case Management (or ICM) and the Strengths Model. Each will be briefly described.

The early days- 'broker' and 'clinical' models of case management

The 'broker' model was the first articulated approach to case management developed in the US in the 1960's, which focused primarily on assessing clients' needs, referring clients to appropriate services and coordinating and monitoring treatment. Under this approach to service delivery case managers 'brokered' a range of services such as psychiatric and medical care, housing and educational services (Rohde, 1997). In contrast to later approaches, the broker model required case managers to connect people with mental illness to other services, without any direct provision of services (Mueser, Bond, Drake, & Resnick, 1998).

As the range of mental health services rapidly expanded in the US during the 1960's and 1970's services became highly fragmented, no longer facilitating continuity of care (Rohde, 1997). In response the National Institute for Mental Health devised a framework that

required individual services to centralize treatment, developing case management into a 'clinical model' (Rohde, 1997). In contrast to the broker model that preceded it, the clinical model was developed in recognition that case managers should and could provide direct services to service users (Mueser, Bond, Drake, & Resnick, 1998). Under the clinical model staff provided direct assistance in areas such as crisis intervention, housing, supportive psychotherapy and medication management (Rohde, 1997). Clinical case management has been described as consisting of 4 broad areas: 1) initial phase (engagement, assessment, planning), 2) environmental interventions (for instance linkage with community resources, consultation with families/carers, collaboration with physicians and hospitals), 3) client interventions (for instance training in independent living skills, psychoeducation), and 4) client-environmental interventions (such as crisis intervention and monitoring) (Kanter, 1989).

'ACT', 'ICM' and 'Strengths based' models of case management

Assertive community treatment (or ACT) evolved out of the work of Stein and Test in the 1970's, as a specialist service to meet the needs of people with serious and enduring mental illness (Mueser, Bond, Drake, & Resnick, 1998). The focus of this approach is to provide ongoing care and rehabilitation of people in community settings by a mobile, multidisciplinary team of mental health workers. Essential characteristics of ACT have been identified as low case loads, a multidisciplinary team (with shared case loads), small numbers of part time staff, 24 hour availability, team autonomy and part time psychiatrist consultation (Mueser, Bond, Drake, & Resnick, 1998; Stein & Santos, 1998). Similar characteristics have been noted by other authors, with additional features including community based services (i.e. services not typically provided in offices) and services provided directly by team (not brokered out) (Stein & Test, 1985; Stein & Test, 1980).

Intensive case management (ICM) has been less well defined than other models. However its primary function has been described within context of linking and coordinating services for mental health consumers (Schaele, McGrew, Bond, & Epstein, 2002). This model, as discussed by some authors shares many key features with ACT including low client to case manager ratios, and services provided in natural environments (as opposed to offices), as

well as practical assistance with day to day activities (Mueser, Bond, Drake, & Resnick, 1998). Perceived differences between ACT and ICM include the emphasis in ACT on multidisciplinary teams that share case loads and meet frequently, whereas the emphasis on teamwork in ICM appears to be of less importance. ICM models have also been found to have a greater tolerance for closing case files, when compared to ACT approaches (Schaedle, McGrew, Bond, & Epstein, 2002).

The strengths based model was developed in Kansas, USA in the 1980's. By definition its focus is on enriching and building clients strengths and assisting clients to gain the required skills and resources to live successfully in the community, with the explicit purpose of improving their quality of life (Stanard, 1999). Development of this model was guided by concerns that earlier models remained too heavily focused on client and environmental limitations and deficits to the exclusion of client's personal strengths and goals for their life (Mueser, Bond, Drake, & Resnick, 1998). Rapp (1994) outlined the key components of strengths based case management as: 1) focus on clients strengths, as opposed to pathology, 2) focus on importance of client-case manager relationship, 3) work guided by self determination of client, 4) community viewed as avenue for resources, rather than obstacle, 5) aggressive outreach as preferred intervention approach, and 6) belief that individuals with severe mental illness can learn and grow.

Of all the models, at least at a definition level the strengths based approach to case management appears most closely related to concepts consistent with the recovery based literature with its focus on individuals' strengths and personal goals with the underlying purpose of improving people's quality of life.

3.2 EFFECTIVENESS STUDIES OF CASE MANAGEMENT REVISITED

As raised earlier, the author of this thesis and colleagues (Marshall, Crowe, Oades, Deane, & Kavanagh, 2007) have previously reviewed research on case management drawing on consumer perspectives. This review is considered important as it identifies gaps in the literature, relevant to rationale for research undertaken as part of this thesis. Findings from

this paper are therefore briefly summarised in this section. For elaboration around relevant findings, readers are referred directly to article (see Appendix A).

This review presents an argument that consumers' perspectives should hold substantial weight in the evaluation of case management practices and outcomes. This does not imply that previous case management evaluations are lacking in value. Rather, it is suggested that consumers' views should be upheld equally alongside other stakeholders, when undertaking evaluation of case management activities.

Examining past practices and looking towards the future

Historically, case management evaluation has traditionally been approached within the paradigm of 'outcome research', with a focus on medical domains-including symptoms, hospital admissions and functional status (Hambridge & Rosen, 1994; Issakidis, Sanderson, Teesson, Johnston, & Buhrich, 1999; Marshall, Gray, Lockwood, & Green, 2004; Ziguras & Stuart, 2000). For example, a randomised controlled trial undertaken in Australia investigating the effectiveness of case management activities focused on level of functioning or disability, number of hospital admissions and bed days (Issakidis, Sanderson, Teesson, Johnston, & Buhrich, 1999). In comparison a meta-analysis investigating the effectiveness of case management over the past 20 years focused on improvement in symptoms, number of hospital admissions, length of hospital stay, proportion of clients hospitalised, contacts with mental health services, contacts with other services, dropout rates from mental health services, level of social functioning, improvement in housing situation, clients' satisfaction, family members' satisfaction, family burden of care and cost of services (Ziguras & Stuart, 2000).

Illness and disability-focused outcomes are likely to retain relevance within a recovery framework. For example it has been suggested that assisting people to gain mastery over their illness and symptoms and preventing hospitalisations can provide hope for the future and facilitate movement towards personal goals (Mueser et al., 2002). Fisher (1994) has suggested that although total remission of symptoms is not a requirement for recovery, that people often talk about managing their symptoms as being one aspect which can be important when actively working towards recovery (see section 2.2.1 for further

discussion). Current research indicates that management of symptoms can assist recovery, but is not essential for recovery to occur. What is clear is that that recovery-oriented approaches adopt a more holistic perspective, expanding their focus to incorporate development of positive mental health (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Examples include personal goal striving, identification of meaningful roles, hope, empowerment and self-esteem (Lakeman, 2004; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Closer consideration of illness-focused outcomes across evaluations of case management is required, to provide enhanced meaning from a recovery framework. For example, it may be important to establish whether people perceive that they have gained control over symptoms, rather than focusing entirely or even primarily on the degree of reduction. Likewise considering hospitalisations, there is likely to be an important difference from a recovery orientation between voluntary and involuntary hospital admissions (Anthony, Rogers, & Farkas, 2003). However, even when individuals are ‘scheduled’ to hospital against their will, opportunities can be provided to offer choice and control to the person, promoting self responsibility (Roberts & Wolfson, 2004). Hence within the context of supporting recovery, it may become important to ascertain from a consumers’ perspective whether they are afforded opportunities to retain some control over their lives during any hospital admissions. Other subtleties that may become increasingly important are establishing whether individuals have an understanding of recovery and consider themselves to be in the process of recovery, despite possible admissions to hospital. This becomes possible as understandings of recovery move away from a purely medical definition. These suggestions raise significant challenges for research design and measurement.

Assessments around ‘positive mental health’ outcomes have been limited in existing evaluations. Quality of life has been investigated in a number of studies (Gorey et al., 1998; Ziguras & Stuart, 2000). Other evaluations have at best included a measure of client satisfaction (Bond et al., 1990; Holloway & Carson, 1998; Lafave, de Souza, & Gerber, 1996). However, the validity of such measures is questionable when consumer involvement

in development is lacking (Campbell, 1997; Lovell, 1995) and they focus on the extent that current practices are endorsed, failing to assess dissatisfaction (Stallard, 1996).

Review of the literature: case management, consumer perspectives and recovery

A literature review of case management evaluation research was undertaken as follows: Searches of Ovid Medline(R) (1966-2006), Psycinfo (1967-2006) and Cinahl (1982-2006) databases were conducted using combinations of: assertive community treatment, case management, assertive outreach, strengths model, rehabilitation model, ICM and intensive case management, client perspectives, participant perspectives, service users, consumer priorities, and client attitudes. Additional searches used terms from identified papers. Reference lists were checked for other relevant articles. The search focused on papers that explicitly aimed to capture consumer perspectives. Evaluations that only incorporated satisfaction ratings or similar methodologies were not included in the primary analyses, because of the limited extent that they can offer a consumer perspective. Studies were assessed using consumer involvement criteria summarised in Table 2. This table is taken directly from the article by Marshall and colleagues (2007).

The search identified the thirteen studies listed in Table 2 (Allam et al., 2004; Chinman, Allende, Bailey, Maust, & Davidson, 1999; Cullen, Waite, Oliver, Carson, & Holloway, 1997; Geanellos et al., 2001; Kisthardt, 1993; Krupa et al., 2005; Leiphart & Barnes, 2005; McGrew, Wilson, & Bond, 1996, 2002; O'Brien, 2001; Prince, Demidenko, & Gerber, 2000; Redko, Durbin, Wasylenki, & Krupa, 2004; Watts & Priebe, 2002). Studies are ordered chronologically by year and then according to the total number of consumer criteria, indicated by ticks, that were met.

Nine studies focused on evaluations of ACT, which is not surprising given the popularity of this model (Mueser et al., 2002). Considering the focus of the Strengths Model in particular it was somewhat surprising that consumers' perspectives have not been more readily investigated in existing evaluations. However, it is worth keeping in mind that this particular model is one of the more recent, developed in the 1980's (Stanard, 1999).

Note. This table is taken directly from article by Marshall et al., (2007)

^a Methodology informed by a recovery framework (e.g. whole-of-life perspective, hope, meaning, etc.)

^b Active involvement of consumers in the research process (at any level), or active involvement at multiple levels (e.g. study design, methodology, data collection, analysis).

^c Qualitative methodologies, allowing exploration of case management processes considered helpful or unhelpful by consumers.

^d Opportunity for consumer comments on unhelpful aspects of the case management, or a question about general experiences.

^e Opportunity for consumers to comment about potential improvements to case management.

^f Exploration of case management from multiple perspectives (e.g. consumers, clinicians, carers).

^g McGrew and colleagues (1996) reported on helpful factors, but a companion paper (McGrew, Wilson, & Bond, 2002) reported unhelpful factors. Therefore it was coded as offering ‘opportunity to identify unhelpful factors.’ McGrew and colleagues (2002) was also coded as obtaining ‘multiple perspectives’, as professionals’ opinions were surveyed in a companion paper (McGrew, Bond, Dietzen, McKasson, & Miller, 1995).

^h McGrew et al (2002) received a checkmark for multiple perspectives, since a companion paper (McGrew, Bond, Dietzen, McKasson, & Miller, 1995) included staff perspectives.

1. In one article researchers asked consumers about their experiences of services regarding recovery

Chinman and associates (1999) interviewed three clients and their clinicians as part of an ACT program to identify program features that appeared to help or hinder recovery. Researchers also reviewed case records from treatment sessions. Whilst results need to be replicated in larger research studies, this paper illustrates how consideration of multiple perspectives can enhance understanding of consumer/case-manager interactions, and better facilitate recovery. No other studies identified during this review asked consumers about their experiences of case management practices within the context of supporting, or hindering their recovery.

2. Active consumer participation was poorly represented in the research activities

Two studies involved consumers extensively throughout the research process (Allam et al., 2004; Krupa et al., 2005), and another involved consumers only in data collection (Redko, Durbin, Wasylenki, & Krupa, 2004). This low level of consumer involvement in the studies identified during this review is certainly reflective of other authors suggestions that consumer participation is only starting to occur in research activities (Faulkner & Thomas, 2002). Allam et al., (2004) involved consumers and carers extensively in all aspects of research when evaluating an Assertive Outreach service in Lincolnshire, UK. Twenty service users and 10 carers were interviewed about their experiences. This paper discusses how consumers and carers were involved in the research, but does not report on interview findings. Regardless, this study may be of interest to researchers seeking to undertake participatory research as a descriptive example. None of the reviewed studies provided direct evidence on whether consumer involvement impacts on findings. This needs to be more systematically assessed as part of future research.

3. Qualitative methodologies facilitated deeper understanding

All studies included in Table 2 had some form of qualitative assessment, providing a rich and detailed information source. Some studies focused on examining not only helpful ways of working, as identified by consumer participants, but also aspects of concern or dissatisfaction. For instance Krupa and colleagues (2005) undertook focus group meetings

with 52 consumers. Aspects of “helpful” relationships were described, including staff that collaborated in goal setting, encouraged clients to participate in the community and helped clients to identify areas for growth. In contrast areas of dissatisfaction mentioned by participants included aspects such as a low emphasis on work, education and training and excessive focus on weakness, as opposed to strengths.

Opportunities to identify the wide range of observations specific to identification of ‘helpful’, as well as ‘less helpful’ practices across case management settings are unlikely to have emerged without the opportunity for responses from open-ended questioning. This focus is particularly important, with a view to improving services. Qualitative methodologies such as focus groups or interviews also offer greater scope for people with mental illness to emphasize issues of perceived importance for their individual recovery (Carrick, Mitchell, & Lloyd, 2001). Recovery-related issues were raised as part of this review, even though questions were not specifically focused on recovery. For instance, the quality of the working relationship, an issue raised by participants in Redko et al (2004), is viewed as a central factor in facilitating recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Tooth, Kalyanasundaram, & Glover, 1997; Torgalsboen, 2001). Characteristics of ‘helpful’ relationships and positive aspects of service delivery identified by consumers in Krupa et al. (2005) map onto features that can support people’s recovery processes, for example autonomy support, meaningful activities and a focus on the person, as opposed to the illness (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Sullivan, 1994; Tooth, Kalyanasundaram, & Glover, 1997).

4. ‘Process information can aid improved practices

Opportunities to learn about processes contributing to change were evident in some qualitative studies identified in this review e.g. (Chinman, Allende, Bailey, Maust, & Davidson, 1999; Krupa et al., 2005; O’Brien, 2001). For example, in O’Brien (2001), consumer participants emphasised the importance of therapeutic relationships in case management, together with having choice, feeling understood, gaining understanding, having someone look out for them and collaborative relationships. Therapeutic relationships were also highlighted as important in McGrew et al., (1996) but questions

within this study did not clarify which characteristics of relationships were helpful, thereby limiting ability to inform service improvements. Evidence on case management effectiveness is steadily growing, however limited research identifies active ingredients or processes. As a result services are limited in regards to driving improved practices (Patton, 2002). Qualitative methodologies offer unique opportunities to sample processes that consumers see as important to success (Anthony, Rogers, & Farkas, 2003; Buck & Alexander, 2006; Wykes, 2003). See section 2.2.3 for further discussion around the relevance of qualitative methodologies for improvement focused evaluation activities.

3.3 CONCLUSIONS

Consumers rarely have been asked about their experiences of case management within the context of supporting their recovery processes. Likewise, consumers have traditionally not been directly involved in research activities within case management contexts. This is of concern with the growing emphasis on recovery-based services and importance of collaborating with service users in mental health policy (Australian Health Ministers, 1997, 2003), as well as in view of mounting research outlining potential benefits of involving consumers in research activities (see sections 2.3.2, 2.4 and 2.6.3 for further discussion). Possible benefits of including qualitative methodologies have also been highlighted, particularly within the context of studying processes which are central to service improvement and identifying processes which are supportive of people's recovery processes within case management settings.

The next chapter briefly describes the Collaborative Recovery Model. The Collaborative Recovery Model has been used to train mental health staff in evidence based practices and constructs consistent with the recovery movement. An understanding of this model provides the context for the remainder of this thesis, with its focus on exploring consumers' perspectives of the Collaborative Recovery Model, received in case management settings.

CHAPTER 4:

**TRAINING MENTAL HEALTH STAFF IN THE
COLLABORATIVE RECOVERY MODEL**

“Encouraging people to have a vision of what they would like their life to be, not just what the regimented life is and um coaxing them out of their cocoon and helping them ah live their dream. If you get someone to um achieve their dreams you are going to help them tenfold more than just giving them a pill” (Consumer AIMhi HSS project, 2006)

The above interview segment was taken from a conversation between a person with mental illness and a consumer researcher, and involves a discussion as to how, in this person’s view a case manager might work more effectively with people with mental illness. Clearly for this individual a helpful therapeutic relationship involves much more than assistance with medication; it also involves assistance with visualising and moving towards a more personally meaningful life.

The experiences of people who have ‘recovered’ or who are ‘recovering’ from mental illness provides insight suggesting that people with mental illness can live a meaningful life in the community, despite the presence of mental illness. Whilst recovery has often been described as an individualised journey, the Collaborative Recovery Model is based on the assumption that collaborative relationships can help support the recovery process. Importantly, there is mounting evidence in the literature to suggest that other people, including mental health professionals, can either support or hinder the individual’s recovery journey (Borg & Kristiansen, 2004; Davidson, 2003; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Ralph & Corrigan, 2005; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). For example, Davidson (2003) reported that people in recovery typically describe the importance of having someone believing in them, or standing by them, when they have lost hope, or become subsumed by their illness. Similarly, Ralph and colleagues, recognise that one of the common themes emerging from personal accounts of recovery is ‘being supported by others,’ and continue on to state that “despite appearances, at times, recovery is not a solitary, but an inevitably social, process”(2005, p. 151).

This chapter briefly describes the Collaborative Recovery Model. An emphasis is placed on highlighting key areas covered during staff training in this model. Existing literature supporting the importance of key aspects of the Collaborative Recovery Model from

consumers' and staff members' perspectives will be reviewed. Some understanding of the Collaborative Recovery Model is necessary to provide the context for this thesis, with its focus on understanding consumers' experiences of receiving this model of care within case management contexts.

4.1 BACKGROUND TO THE COLLABORATIVE RECOVERY MODEL

The Collaborative Recovery Model was originally developed as a staff training model bringing together evidence-based practices and constructs consistent with the recovery movement. The purpose of this model was to assist people with chronic and recurring mental disorders to work towards recovery in community mental health contexts. A definition of recovery, consistent with this thesis is outlined elsewhere (see section 1.1) and involves “the establishment of a fulfilling and meaningful life and a positive sense of identity founded on hopefulness and self determination” (Andresen, Oades, & Caputi, 2003, p. 588).

The Collaborative Recovery Model and associated training program for staff is an example of an early attempt to move a recovery vision for mental health services, into specific principles and practices occurring at the ground level between consumers and staff. Despite the increasing emphasis on recovery as a guiding vision for mental health services, few models of care have attempted to operationalise the principles of recovery into practice (Torrey & Wyzik, 2000; Onken et al., 2006). Development of the Collaborative Recovery Model and training program draws on existing evidence from the recovery literature, in particular concepts such as facilitating hope, supporting autonomy, and subjective goal ownership (Oades et al., 2005). For example Collaborative Recovery Model training specifically champions the individuality of the lived experience and ownership of the recovery process by the consumer, whilst recognising that other people (including mental health staff) can support individual's recovery processes. This is emphasised strongly during staff training and flows through the various practical aspects of the model. A key way in which this is operationalised within the Collaborative Recovery Model is through a focus on authentic, approach oriented goals, collaboratively agreed upon by the consumer and mental health staff. It is known that active goal setting focuses recovery and provides

individuals with a sense of what is important and meaningful to strive towards in the future (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). The Collaborative Goal Technology (CGT) was developed specifically with this purpose in mind. Using this tool staff are encouraged to assist consumers to identify a personal recovery vision, as well as autonomous goals to support them in moving towards a meaningful and fulfilling life (Oades et al., 2005).

Another key way in which recovery is operationalised within the CRM is through the emphasis on recovery as a collaborative process, which can be supported by others. Whilst recovery can be described as an individual process, this process does not occur in isolation from others. Indeed, support and assistance from other individuals is a key factor in facilitating recovery (e.g. Onken et al., 2007; Davidson, 2003). The emphasis on building a collaborative therapeutic relationship is a key principle emphasised during staff training and flows through all practical components of the model including needs assessment, goal setting and homework components. Further discussion in relation to how aspects of the Collaborative Recovery Model and related staff training link to the recovery literature are outlined below.

The Collaborative Recovery Model consists of two guiding principles: 1) recovery as an individual process and 2) collaboration and autonomy support. It also has four practical components 1) change enhancement 2) collaborative needs identification 3) collaborative goal setting and striving and 4) collaborative task striving and monitoring. Guiding principles and practical components of the Collaborative Recovery Model are briefly outlined below. Emphasis is given to the main topic areas delivered within the two day workshop and six monthly booster sessions, as part of the clinician-training program. For further rationale in relation to key aspects of the model and associated training program for mental health staff readers are referred elsewhere (Oades et al., 2005). In addition a one page table taken directly from the Oades et al., paper (2005), summarising each module of the Collaborative Recovery Model training program and relevant knowledge domains, protocol, skills/attitudes and competencies is included in Appendix B.

4.1.1 Guiding principles of the Collaborative Recovery Model

1. Recovery as an individual process

The Collaborative Recovery Model training program emphasises the individual nature and the need for ownership, of the recovery experience of the person living with mental illness. During training case managers are introduced to the concept of psychological recovery. This is understood within the context of a range of possible perspectives including medical, rehabilitation and empowerment models of recovery (Andresen, Oades, & Caputi, 2003). Case managers are also introduced to the four key processes of psychological recovery (i.e. hope, meaning, self identity and responsibility) identified in a recent review (Andresen, Oades, & Caputi, 2003). Group discussion is generated around these concepts and a task is undertaken where case managers are asked to consider the recovery orientation of their services, staff and clients (Oades, Lambert, Deane, & Crowe, 2003b).

2. Collaboration and autonomy support

Collaborative Recovery Model training emphasises the importance of an effective working alliance between case managers and consumers. It also recognises that although recovery is the journey of the person with mental illness, other people, including mental health professionals, can support this process. During training case managers are introduced to Bordin's (1979) conceptualisation of the working alliance, which consists of three components 1) agreement of goals 2) agreement about the appropriateness and usefulness of treatment support tasks and 3) the development of relational bonds (Horvath & Greenberg, 1994).

There is also an emphasis on identifying and resolving ruptures in the therapeutic alliance. Consistent with the work of Safran and colleagues (Safran, Crocker, McMain, & Murray, 1990; , 1996) the interactional nature of ruptures is emphasised. It is postulated that staff must therefore be alert to the interactional dynamics of the therapeutic relationship, including their own attitudes, feelings and behaviours. Also emphasised during training is the notion of autonomy support (Sheldon, Williams, & Joiner, 2003), which is contrasted with paternalism (Hendrickson-Gracie, Stayley, & Neufeld-Morton, 1996).

4.1.2 Four-skills based components of the Collaborative Recovery Model

1. Enhancing change

The Collaborative Recovery Model draws on the evidence base for motivational interviewing to encourage clinicians to assist consumers to explore competing motivation sources and to identify advantages and disadvantages of specific current behaviours, as well as planned behaviour change (Oades et al., 2005). Motivational interviewing is often associated with the stages of behaviour change literature (Prochaska, DiClemente, & Norcross, 1992).

Collaborative Recovery Model training emphasises the importance of clarifying consumer's motivational readiness to engage in health behaviour change and to address specific behaviours. They practice using a 'decisional balance' to explore change related phenomena by examining the costs and benefits of changing a specific behaviour versus costs and benefits of retaining the behaviour. 'Importance' and 'confidence' are also explored as component factors of motivation (Oades, Lambert, Deane, & Crowe, 2003b). 'Importance' in this context refers to the degree to which a given task is aligned with consumers' personal values, or is seen to lead to life improvement. 'Confidence,' on the other hand is perceived mastery or ability to achieve a specific self efficacy task. Five key principles are emphasised during clinician training to assist clinicians to minimise or overcome resistance including expressing empathy, developing discrepancy, avoiding argumentation and rolling with resistance (Oades, Lambert, Deane, & Crowe, 2003b).

Another factor covered in association with motivational enhancement is the impact of cognitive deficits. People with schizophrenia may experience cognitive deficits in attention, executive functioning, memory and language. These deficits are explored so that workers can become aware of possible ways in which they can work to help people manage these difficulties.

2. Identifying needs

The definition of a need as used by the Collaborative Recovery Model is "the ability to benefit in some way from health and social care" (Phelan et al., 1995). Within the training

model needs are viewed as socially negotiated. This means that needs are not defined from one perspective alone. Rather needs are identified and discussed from a range of perspectives (i.e. consumer, worker and carer). Effectively this represents a shift away from needs being ‘professionally’ defined to being more of a collaborative process (Carroll & Mortimer, 1998).

The Collaborative Recovery Model uses the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) (see Appendix C) as a starting point for collaboratively identifying the needs of individuals with mental illness in case management settings. Case managers are encouraged to collaboratively identify unmet needs through the CANSAS interview and/or through more general discussion with service users. Unmet needs are emphasised as a logical place to start setting goals and generally represent a source of consumer motivation to pursue these goals, in order to meet underlying needs.

3. Collaborative goal striving

Setting personally meaningful goals with people with mental illness promotes hopefulness in relation to recovery (Baumeister & Leary, 1995). Active goal setting also focuses recovery and provides people with a sense of what to strive for in the future (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Making goals explicit, and monitoring progress towards goals has also been found to increase the likelihood of goal attainment (Locke & Latham, 1990). There is a much wider literature on goals, beyond recovery settings, that provides empirical support for the benefits of goal setting and striving in relation to human goal attainment (Austin & Vancouver, 1996).

The Collaborative Recovery Model utilises a new goal striving intervention, the Collaborative Goal Technology (CGT) to assist consumers to progress through their recovery processes. This particular intervention, is designed to be used in collaboration with consumers and case managers to develop and monitor individuals’ goals, within the context of an overall ‘recovery vision.’ This goal striving intervention is an adaptation of the Goal Attainment Scaling (GAS) (Kiresuk, Smith, & Cardillo, 1994) and is described in

detail in Clarke et al., (2006). A copy of the CGT sheet utilised in the AIMhi HSS project is available in Appendix D.

The CGT intervention consists of several procedures, which are emphasised during training with clinicians. These are outlined in detail in Clarke et al., (2006, p. 131) and include “ 1) orienting the person to the concept of recovery and recovery prospects and helping him/her shape his/her personal recovery vision 2) developing time-framed goals with three levels of goal progress 3) prioritising goals in terms of relative importance 4) negotiating goal progress indicators in relation to goal attainment confidence 5) reviewing goal progress systematically: and 6) upon review generating an overall goal attainment index”.

4. Collaborative task setting, striving and monitoring

Homework has been broadly defined as between session activities that are targeted towards achieving therapy goals (Kazantzis & Lampropoulos, 2002). Homework activities provide consumers with an opportunity to transfer the knowledge that they ascertain during treatment sessions to other environments. Completion of tasks can also increase motivation and feelings of self worth for individuals through enhancement of opportunities to be actively engaged in their own treatment (Deane, Glaser, Oades, & Kazantzis, 2005). A number of authors have found that homework has positive effects on therapy outcomes and that active completion of homework is a significant predictor of therapeutic outcomes (Kazantzis, Deane, & Ronan, 2004; Startup & Edmonds, 1994).

Task setting or homework within the Collaborative Recovery Model is explicitly linked to the CGT or goal setting component. Consumers are encouraged to collaboratively set regular tasks with their case managers to assist them to achieve their 3 monthly goals. A copy of the homework sheets utilised in the AIMhi HSS project is available in Appendix E.

Limited evidence supporting importance of Collaborative Recovery Model from consumer and staff perspectives

Currently, within the recovery literature there is a broad evidence base to support principles and components emphasised in the Collaborative Recovery Model such as encouraging

responsibility (Andresen, Oades, & Caputi, 2003; Davidson, O'Connell, Tondora, & Lawless, 2005), self-determination and choice (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002), working towards goals (Andresen, Oades, & Caputi, 2003; Baumeister & Leary, 1995) and effect of homework on outcomes (Kazantzis, Deane, & Ronan, 2000). However few studies have examined how important these case management activities are from consumers' or staff perspectives.

For example, whilst homework is recommended for use with people with severe mental illness (Kelly, Deane, Kazantzis, Crowe, & Oades, 2006) only one small study was identified (Dunn, Morrison, & Bentall, 2002) where 10 consumers with a history of psychosis were asked about their experiences of homework based activities. However, the previous study focused on exploring reasons for 'homework compliance', rather than more general evaluation regarding experiences and valuing of these activities. There is some research indicating that mental health workers in Australia (Deane, Glaser, Oades, & Kazantzis, 2005) and New Zealand (Kazantzis & Deane, 1999) consider homework as less important for delusions and hallucinations, when compared to other problems such as anxiety and depression. Kelly et al (2007) examined the attitudes of 122 case managers in Australia towards the use of homework for people with serious mental illness, such as schizophrenia. They found that workers tended to hold positive attitudes towards use of homework in general. They also found that whilst there was a difference in case managers' importance ratings for moderate psychiatric disability (e.g. anxiety and depression) when compared to serious mental illness (e.g. schizophrenia, bipolar disorder), this difference was relatively small. Clearly further research is needed to explore consumer and staff perceptions of homework activities, for people with serious mental illnesses.

For practical components of needs based assessment and motivational enhancement, even less is known in terms of perceived importance from a consumer or staff perspective. Research indicates that consumers and professionals may not always agree on the identification of problems and areas of need, (Campbell, 1996; Crane-Ross, Roth, & Lauber, 2000; Lynch & Kruzich, 1986) hence treatment goals for therapy. Such findings, as well as the more general emphasis placed on collaborative practices in the recovery

literature (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002) suggest that consumers and mental health staff would value collaborative need based assessments, although this is not known for certain. Furthermore, there is evidence that motivational interviewing is effective in assisting people to clarify both benefits and barriers to individual goals (Corrigan, McCracken, & Holmes, 2001). Little is known however of the perceived importance from a consumer or staff perspective regarding motivational enhancement.

When compared with the views of mental health professionals there is more known at present about consumers' perspectives highlighting the importance of collaborative practices (Chinman et al., 1999; O'Brien, 2001; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002), responsibility for recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002) and goal striving activities, (Kisthardt, 1993; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002), specifically when working with mental health staff. However, consumers general acceptance of such principles and individual's perceptions regarding the delivery and application of such principles with staff trained in the Collaborative Recovery Model, poses a different question entirely.

A search of the literature revealed that mental health staff have rarely been asked directly about their perceptions of recovery-based practices such as supporting responsibility, collaboration and goal striving when working with mental health consumers. More generally several instances were identified (Angell & Colleen, 2007; Buck & Alexander, 2006) where staff had been afforded opportunities to discuss their experiences when working with mental health consumers. In one study staff discussed their perceptions of 'quality care' when working with psychiatric clients (Shroder & Ahlstrom, 2004). In another mental health staff discussed their perceptions of the therapeutic relationship in case management contexts (Angell & Colleen, 2007). Ways of working emphasised within the Collaborative Recovery Model, including collaborative relationships, autonomy support, encouraging responsibility and goal striving activities, among others were discussed as important within these studies when working with mental health clients.

Despite limited evidence in this area, with the emphasis on recovery, collaboration and development of individual treatment within mental health policy in Australia (Australian Health Ministers, 2003; National Mental Health Strategy, 1996) it was anticipated that staff would likely value key parts of the Collaborative Recovery Model. However, this link is not proven and there is a clear need to further examine consumers' and case managers' perceptions around the relevance and importance of all principles and components of the Collaborative Recovery Model when working with mental health staff within case management contexts. This is a key focus of this thesis.

4.2 THE AUSTRALIAN INTEGRATED MENTAL HEALTH INITIATIVE-HIGH SUPPORT STREAM PROJECT (AIMHI HSS)

As part of an National Health and Medical Research Council partnership grant (219327) entitled the Australian Integrated Mental Health Initiative-High Support Stream Project (AIMhi HSS project) mental health clinicians in four government and five non-government mental health services in metropolitan, regional and rural areas of New South Wales, Queensland and Victoria, Australia received training in, and were encouraged to work with mental health consumers within the Collaborative Recovery Model (described in the proceeding section). This thesis draws on the experiences of a number of consumers and case managers participating in the AIMhi HSS project.

The Collaborative Recovery Model training program incorporates a variety of interventions and practices that case managers may already be using, but provides these very systematically. Training is provided over two days, with follow up booster sessions at six and twelve months. Trainees are provided with a training workbook (Oades, Lambert, Deane, & Crowe, 2003b) and reading guide (Oades, Lambert, Deane, & Crowe, 2003a), with prescribed readings for each module. The training program requires case managers to understand the guiding principles of the model as well as to display competency in the four specific skill components, in relation to specific knowledge and skills, as well as certain attitudes towards a recovery orientation (Crowe, Deane, Oades, Caputi, & Morland, 2006). During training case managers are required to engage in role-play practice of practical components and ensure demonstrated skills competence (Oades et al., 2005). For further details in relation to Collaborative Recovery Model training program refer to Appendix B.

Study design for AIMhi HSS project

As part of the AIMhi HSS project, case managers were recruited and assigned by participating services to either ‘active,’ Collaborative Recovery Model training or ‘delayed’ training conditions. In the ‘active’ condition case managers received training in the Collaborative Recovery Model as detailed above and were encouraged to commence working in these ways straight away with clients from their existing case load. In the ‘delayed’ condition case managers were encouraged to continue working as usual until they received training in the Collaborative Recovery Model 12 months later. The research that follows draws on the experiences of consumers and case managers working in both ‘active’ and ‘delayed’ conditions as part of the AIMhi HSS project, although primarily focuses on consumers in the active condition.

Sampling of consumer participants for AIMhi HSS project

Eligible consumers were randomly selected from caseloads and included where informed consent was provided. The following criteria were used to determine consumer eligibility: (1) Aged 18 or over; (2) diagnosis of a psychotic disorder of at least six months duration (Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Depressive Psychosis), (3) exclusion of consumers with dementia, severe mental retardation or severe brain injury; (4) inclusion of consumers with comorbid substance misuse or personality disorders; (5) “high support needs” (≥ 5 total needs) on the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), (6) consumer is expected to be treated/case-managed by clinician for at least 12 months. All consumers participating in this thesis met the eligibility criteria outlined above. Further specific sampling criteria, consistent with the various studies within this thesis are detailed in the methodology sections of the relevant chapters that follow.

As part of their involvement in the AIMhi HSS project, consumers and case managers were required to complete a range of routine assessment tools and outcome measures at three monthly intervals in both the ‘active’ and ‘delayed’ conditions, as well as baseline measures on commencement in the project. A limited number of these measures were relevant to this thesis including direct ratings of completion of the Collaborative Goal Technology worksheets and homework assignment forms. Background information

collected at baseline (such as sex, age) for consumers and case managers, and diagnosis for consumers was also accessed when describing the samples for the various studies as part of this thesis. Service characteristic information was collected using the Dartmouth Assertive Community Treatment Scale (DACTS) (Teague, Bond, & Drake, 1998). Data in relation to culture/ethnicity were not collected from consumer or staff participants as part of the AIMhi HSS study. Hence for this research it was not possible to explore issues such as whether ethnicity/cultural background impacted on individuals' perceptions of the program. Clearly this is an area that requires examination in future studies to explore the relevance of the program for different cultural/ethnic groups.

4.3 CONCLUSIONS

The Collaborative Recovery Model and associated training program for mental health staff has been presented as a model of care that attempts to operationalise the principles of recovery into practice. There is clearly a need to further examine consumers and providers perceptions regarding the relevance and importance of Collaborative Recovery Model principles and components when working with mental health staff in case management contexts.

The AIMhi HSS project has also been outlined as a research endeavour evaluating the effectiveness of the Collaborative Recovery Model in various states of Australia. All participants taking part in this thesis met criteria for, and were taking part in the AIMhi HSS project. The various aspects of the Collaborative Recovery Model were also described including two guiding principles 1) recovery as an individual process 2) collaboration and autonomy support, and four skills based components 1) enhancing change 2) collaborative needs identification 3) collaborative goal setting and striving and 4) collaborative task striving and monitoring.

The next chapter provides the rationale for, and briefly outlines the three studies comprising this thesis. This thesis primarily focuses on capturing consumers' experiences of the interactions that occur in case management settings, within the context of evaluating the Collaborative Recovery Model. This thesis is also undertaken with a focus on the ongoing

improvement and evolution of the Collaborative Recovery Model and its delivery and use in services, in collaboration with mental health consumers.

CHAPTER 5:

**THESIS RATIONALE AND OUTLINE OF THE
THREE STUDIES**

“We cannot assume to know how consumers feel about the services they receive or, even more so, about the things that they perceive would be helpful” (Buck & Alexander, 2006, p. 479)

This thesis draws on the perspectives of mental health consumers to contribute to the evaluation and ongoing improvement and delivery of the Collaborative Recovery Model in mental health services. This thesis also seeks to contribute to a greater understanding of how professionals can assist consumers’ recovery processes in case management, as well as other community mental health contexts.

It is recognised upfront that transfer of training problems may limit consumers’ exposure to Collaborative Recovery Model principles and components. Research indicates that it is often extremely challenging to ensure that new mental health innovations are taken up, and implemented in services either at all or comprehensively (Deane, Crowe, King, Kavanagh, & Oades, 2006; Kavanagh et al., 1993). However, even with the prior expectation of a likely gap between clinician training and routine practice it is still considered crucial to gain an understanding of consumers’ experiences of what is actually received, when working with their case managers, as well as how they feel about the experienced therapeutic relationship and ways of working. Indeed, this thesis is designed to investigate what consumers’ experiences of working within case management contexts have been, regardless of whether their staff have been working consistently with the Collaborative Recovery Model training protocol, or not. Consumers’ views have rarely been sought within the context of evaluating case management activities highlighting the importance of this process.

This chapter begins with an outline of relevant research gaps, which this thesis aims to address. This chapter also outlines the aims of this thesis, including broad research questions, which provide a guiding structure for subsequent studies comprising this thesis. For specific research questions/hypotheses relevant to each of the three studies-readers are referred to the chapters that follow. A brief overview of the three separate, but inter-related studies detailed in the remaining chapters of this thesis is also provided.

5.1 SUMMARY OF RESEARCH GAPS

a) Few known studies, if any, have attempted to examine consumers' perceptions of recovery oriented service provision as received in mental health services

This research gap needs to be addressed if mental health services are to be improved to support recovery. The Collaborative Recovery Model and associated training program is an example of an early attempt to move a recovery vision for mental health services, into specific principles and practices occurring at the ground level between consumers and staff in service settings. This thesis begins to address this gap by drawing on the experiences of mental health consumers during an evaluation of the Collaborative Recovery Model within case management settings. A key aim is to facilitate understanding of consumers perceptions of activities and practices, within the context of supporting or hindering their recovery.

b) To date, consumers have infrequently been involved as co-researchers in the evaluation of case management activities, in particular with reference to supporting recovery

This thesis begins to address this gap by involving consumers as actively as possible throughout the research process. Consumers are involved, for example to varying degrees in the design of each of the three studies, in the data collection phase, as well as in the interpretation and discussion of findings.

5.2 RESEARCH AIMS

The broad aims of this thesis are to examine:

a) consumers' perceptions regarding the effectiveness of the Collaborative Recovery Model in assisting their recovery, as experienced in case management settings¹

¹ The views of mental health staff who have received training in the Collaborative Recovery Model are also investigated, although the focus of this thesis is first and foremost on exploring consumers' perceptions and experiences.

- b) consumers' perceptions in relation to the degree with which they engaged in recovery-focused support practices consistent with the Collaborative Recovery Model when working with their case managers
- c) consumers' perceptions in relation to the ongoing improvement of the Collaborative Recovery Model and its use and delivery in mental health services ²

This thesis includes three key studies combining quantitative and qualitative methodologies (a quantitative self-report questionnaire, semi structured interviews and focus group meetings). These methodologies are usefully combined to meet the research aims, however each meet a specific purpose as outlined below.

The quantitative self-report questionnaire developed and administered as part of study one provides an avenue whereby the broader population of consumers and staff participating in the AIMhi HSS can offer input, at least at some level, about the Collaborative Recovery Model. Further this questionnaire allows for broad comparisons to be made between consumers and staff engaging in recovery-based practice with staff trained in the Collaborative Recovery Model, when compared to consumers and staff receiving services as usual (staff not trained in the Collaborative Recovery Model).

Semi-structured interviews are viewed as the most appropriate method for obtaining in-depth information from consumers as a way of understanding their experiences of actual processes that were viewed as helpful and or hindering to their recovery, when working with Collaborative Recovery Model trained staff. Focus groups, in contrast are viewed as the most appropriate method to bring together groups of consumers, whilst discussing key findings from earlier studies. The primary focus of this study is on improving the Collaborative Recovery Model and its use and delivery in mental health services. That is, there is a strong 'action' focus, taking into account findings from earlier studies, with an attempt to answer the question-where to from here?

² This is likely to include possible changes and recommendations specific to the Collaborative Recovery Model as a conceptual model, as well as feedback regarding how the model can be more effectively offered and delivered to consumers within case management contexts.

5.3 THREE STUDIES: EVALUATING AND IMPROVING THE COLLABORATIVE RECOVERY MODEL

The research design for this thesis consisted of three key studies:

Study one) Brief self-report questionnaire completed by consumers and case managers engaging in recovery-based practice received with staff trained in the Collaborative Recovery Model (active condition), when compared to consumers and case managers receiving services as usual (delayed condition)

Study two) Semi-structured interviews undertaken with consumers receiving services from Collaborative Recovery Model trained case managers

Study three) Face-to-face focus group meetings undertaken with consumers receiving services from Collaborative Recovery Model trained case managers

Consumer researchers were involved in this research and their involvement was considered integral to its success. Consumer participation in the research process was maximised at as many levels as possible, however, some constraints existed in terms of available resources.

The three studies, including levels of consumer researcher involvement are highlighted briefly here; more detailed information is available in the respective three chapters, which follow.

Study One: Self-report questionnaire sought to gain consumers' and case managers' perceptions regarding engagement in and perceived importance of recovery-based practice received with staff trained in the Collaborative Recovery Model. These findings were compared to consumers' and case managers' perceptions around receiving services as usual (non Collaborative Recovery Model trained staff). Consumers' and case managers' perceptions in relation to 'overall helpfulness' of service contact in assisting individual's recovery processes were also examined.

Consumer researchers were involved in the review of the self-report questionnaire during its development, and to some extent in data collection.

Study Two: Semi-structured interviews explored in detail consumers' perceptions regarding the Collaborative Recovery Model and its use in relation to supporting their personal

recovery journey. This included a focus on examining processes that consumers' perceived as helpful within the context of supporting their recovery, as well as any perceived barriers or unhelpful processes which they may have experienced. This study also focused on exploring consumers' perceptions of aspects of the Collaborative Recovery Model, or case management practices generally, which they believe could be improved.

Consumer researchers were involved in reviewing the interview guide (which outlined key areas to be explored during interviews) and undertook all interviews with consumer participants.

Study Three: Focus groups of consumers met generate feedback to guide improvement of the Collaborative Recovery Model and its use and delivery in services. Focus group participants were presented with key findings from studies one and two, with a focus on highlighting any areas of concern/unhelpful experiences raised by their peers. Group members were also encouraged to offer their direct experiences of working with Collaborative Recovery Model trained staff. The combination of key findings from earlier studies and group members own experiences were discussed amongst the group, with the intention of generating feedback to guide improvement of the Collaborative Recovery Model and its use and delivery in services. Focus groups also provided an opportunity to further validate and offer some interpretation and confirmation around key findings as part of studies one and two.

Consumer researchers reviewed the structure and content for focus groups and co-facilitated focus group meetings.

5.3.1 Research questions

In order to achieve the overall aims, the following broad research questions were used to guide the investigation presented in the following chapters:

Research question 1: What are consumers' experiences of the Collaborative Recovery Model as received in case management contexts? This includes an investigation of both positive as well as any negative experiences.

This research question was addressed during studies one, two and three. A key intention of study one (self-report questionnaire) was to gain an overall snapshot of consumers³, perceived importance ratings for each of the guiding principles and practical components of the Collaborative Recovery Model. Study two (semi structured interviews) was undertaken in contrast, with a view to understanding in detail consumers' experiences of the actual processes that occurred when working with staff trained in the Collaborative Recovery Model. Interview questions were designed in an attempt to draw out and capture any negative, as well as positive experiences that consumers may have had when working within this model. Furthermore, purposeful sampling for interviews included people who found the delivery and use of the Collaborative Recovery Model in services 'helpful', as well as 'less helpful.'

Study three (focus groups) focused primarily on generating information to improve the delivery and use of the Collaborative Recovery Model in services. Focus group participants reflected on unhelpful experiences/concerns/recommendations generated by their peers (as part of studies one and two), along with their own experiences of working with Collaborative Recovery Model trained staff.

Research question 2: From consumers' perspectives to what degree did they engage in recovery focused practices consistent with the Collaborative Recovery Model when working with their case managers?

This research question was addressed as part of studies one and two. Study one (self-report questionnaire) obtained a broad snapshot of consumers' perceptions around the degree with which they had been working consistently with key parts of the Collaborative Recovery Model. Study two (semi structured interviews) in contrast, allowed for more detailed exploration around consumers' perceptions of what had actually been experienced when working with Collaborative Recovery Model trained staff. Importantly within this methodological framework it was possible to combine a discussion of what actually occurred, from consumers' perspectives, with how they felt about these perceived

³ Staff perceptions were also sought as part of study one, however the primary focus of this thesis was on examining consumers' experiences

experiences. Consumers' experiences of receiving and engaging in Collaborative Recovery Model components such as collaborative goal technology and homework sheets was also examined in more detail in study two (as opposed to more general examination in relation to engagement in goal and homework activities as part of study one).

Research question 3: From consumers' perspectives how can the Collaborative Recovery Model and delivery and use of this model in services be improved, to better support the recovery of people with mental illness?

More generally from consumers' perspectives how can professionals work more effectively to support the recovery processes of people with mental illness?

These research questions were addressed as part of studies two and three. Study two (semi structured interviews) had specific interview guidelines designed to engage interviewees around discussing aspects of the Collaborative Recovery Model, which they thought could be improved. Interviewees were also asked more general questions about how they believed recovery could be better supported within case management settings. Study three brought together groups of consumers with a primary focus on generation of information to guide improvement of the Collaborative Recovery Model and its use in services. This was undertaken by asking group participants to reflect on unhelpful experiences, concerns and recommendations generated by their peers (as part of studies one and two), along with their own experiences of working with Collaborative Recovery Model trained staff. Study three also focused on enhancing general understanding as to how mental health staff could work, so as to better support individuals' recovery journeys.

5.4 CONCLUSIONS

This thesis focuses on capturing consumers' experiences of the actual interactions that occur between consumers and staff in case management settings, within the context of evaluating and improving the Collaborative Recovery Model and its use and delivery in mental health services. Consumer researchers will be employed to work closely with the primary researcher throughout various stages of this research. The three studies comprising this thesis have been briefly outlined, including a self-report questionnaire, semi structured interviews and face-to-face focus group meetings.

The next chapter focuses on study one, involving a self-report questionnaire collected from consumers and mental health staff engaging in recovery-based practice received with staff trained in the Collaborative Recovery Model, when compared to consumers and staff receiving services as usual. This chapter details the background to the study, including research questions and methodologies and in addition chapter results and related discussion.

CHAPTER 6:
STUDY 1: SELF-REPORT QUESTIONNAIRE
CONSUMER AND STAFF PERCEPTIONS OF
RECEIVING RECOVERY-FOCUSED
SERVICES CONSISTENT WITH THE
COLLABORATIVE RECOVERY MODEL

Consumers and case managers have rarely been asked about their experiences of case management practices at all, and certainly not within the context of supporting consumers' recovery processes. This is apparent both in terms of consumers' and staff perceptions of the support activities that they engage in within case management settings, as well as how they feel about these service contact experiences.

This study utilises a self-report questionnaire to examine consumers' and case managers' perceptions around the degree to which various recovery-focused practices consistent with the Collaborative Recovery Model are being received/experienced in mental health services. It also explores how much value consumers and mental health staff attribute to key parts of the Collaborative Recovery Model. Findings from the self report questionnaire administered to consumer participants reported in this chapter have been accepted for publication in the *Journal of Evaluation in Clinical Practice*. See Appendix F for a copy of this paper (Marshall, Crowe, & Oades, in press).

This chapter will begin by briefly outlining the background to this study, including aims and specific hypotheses for investigation. This will be followed by methodology, including description of questionnaire development, data collection, description of participants and data analysis procedures. Results and discussion will follow.

6.1. INTRODUCTION

A self-report questionnaire was selected for this study as it was considered desirable to obtain feedback from the larger population of consumers and case managers participating in the AIMhi HSS project, evaluating use of the Collaborative Recovery Model in various mental health services in Australia. This included consumers and case managers who were receiving services as usual in case management settings (delayed condition-non Collaborative Recovery Model trained workers) in comparison to consumers and case managers who were in theory, actively working within the Collaborative Recovery Model (active condition-Collaborative Recovery Model trained workers). It was of particular interest to explore potential differences between delayed and active conditions in terms of frequency with which various aspects of the Collaborative Recovery Model were perceived

to be received/delivered, as well as comparing overall ratings of case manager 'helpfulness', in assisting recovery. Investigation of consumers' and case managers' perceptions regarding the relevance and importance of Collaborative Recovery Model principles and components was also of interest, in view of limited research in this area (see section 4.1.2 for further discussion).

This study is contrasted with qualitative methodologies utilised for studies two and three which consistent with the varying research aims, sought to obtain more detailed information from a limited number of consumers in relation to their experiences of receiving services from Collaborative Recovery Model trained staff. Further discussion around suitability of particular methodologies dependent on the aims of the researcher are discussed elsewhere (see section 2.2.3).

Whilst the focus of this research project is on evaluating consumers' experiences of the Collaborative Recovery Model as received in services, the opportunity was also taken during this study to survey case managers' experiences. The rationale for seeking the perspectives of both consumers and case managers is discussed elsewhere (see section 2.3.4). To recap, collaboration with consumers is considered critical to any evaluation and in particular when undertaking 'recovery research.' However, there are other stakeholders views which could usefully be included (e.g. views of case managers and family members). Limitations in terms of resources meant that family perspectives were not sought as part of this evaluation, and case managers views were only sought to a limited extent (i.e. the self report questionnaire used in this study).

From the outset it was considered likely that at least some consumers and case managers in the delayed condition would already be working in ways consistent with the Collaborative Recovery Model. It was also anticipated that even for consumers and case managers in the active condition, that there would likely be an inconsistent match between the conceptual model and what was implemented in practice for some participants. Other authors have noted the extreme difficulty regarding ensuring that new mental health interventions are implemented in services (Deane, Crowe, King, Kavanagh, & Oades, 2006; Kavanagh et al., 1993).

Inclusion of an item assessing case managers' overall level of helpfulness in assisting recovery was of specific interest as some research undertaken in Australia and the United States has reported that consumers have found health professionals and mental health staff to be more hindering, than supportive of their recovery journeys (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). However, no investigations of this nature have been found specific to case management settings. Furthermore, the Collaborative Recovery Model and associated training program was developed, within the context of providing a framework, which could potentially support individual recovery processes.

6.1.1 Research questions and hypotheses

The self-report questionnaire examined case managers' and consumers' perceptions regarding their engagement in recovery-based practice received with Collaborative Recovery Model trained staff, when compared to non Collaborative Recovery Model trained staff. This study also explored consumers' and staff valuing of Collaborative Recovery Model principles and components.

Specific hypotheses/research questions for investigation are outlined below. Consumers' perceptions of key aspects of the Collaborative Recovery Model are presented first (consistent with the primary focus of this research), followed by case managers' perceptions.

Consumer Evaluation of the Collaborative Recovery Model (CEO-CRM) questionnaire

Research question 1: Are particular parts of the Collaborative Recovery Model more important to consumers than others?

Research question 2: Does the relative importance for key parts of the Collaborative Recovery Model differ for consumers working with Collaborative Recovery Model trained case managers, when compared to consumers engaging in usual client support practices?

Hypothesis 1: Consumer self-ratings of frequency of personal engagement in Collaborative Recovery Model principles and components will be higher for consumers working with Collaborative Recovery Model trained case managers, when compared to usual client support practices

Hypothesis 2: Consumer self-ratings of case managers' overall helpfulness in assisting recovery will be higher for consumers working with Collaborative Recovery Model trained case managers, when compared to usual client support practices

Staff Evaluation of the Collaborative Recovery Model (SEO-CRM) questionnaire

Research question 1: Are particular parts of the Collaborative Recovery Model more important to staff than others?

Research question 2: Does the relative importance of key parts of the Collaborative Recovery Model differ for case managers who have attended Collaborative Recovery Model training, when compared to those who have not attended training?

Hypothesis 1: Case manager self-ratings of frequency with which they engage in Collaborative Recovery Model principles and components will be higher for Collaborative Recovery Model trained case managers, when compared to usual support practices

Hypothesis 2: Case manager self-ratings of overall helpfulness in assisting their client's recovery will be higher for Collaborative Recovery Model trained case managers, when compared to usual client support practices

6.2. METHODOLOGY

6.2.1 Questionnaire development

No existing psychometric measures were identified that sought to evaluate consumers' perceptions of case management delivery within a recovery framework. Furthermore whilst existing measures are available that attempt to 'measure recovery,' this is clearly different from asking consumers and staff directly about the degree to which they feel that recovery is being supported within the context of the therapeutic relationship. Therefore a questionnaire was developed by the research team (Marshall, Oades & Crowe, 2005). The questionnaire sought to identify key parts of the Collaborative Recovery Model and perceptions in relation to implementation of the model in services. Questionnaire versions were termed the Consumer Evaluation of the Collaborative Recovery Model (or CEO-

CRM) and Staff Evaluation of the Collaborative Recovery Model (SEO-CRM) (see Appendix G. for copies of CEO-CRM and SEO-CRM versions).

Fourteen questionnaire items were generated, that attempted to tap into key guiding principles and components of the Collaborative Recovery Model (responsibility, collaboration, autonomy, motivation, needs, goals, homework). Questionnaire versions (CEO-CRM and SEO-CRM), asked participants to 1) rate the frequency with which they were receiving (or delivering in relation to staff) each of the guiding components and principles of the Collaborative Recovery Model over the previous three month period (scale ranged from 0='never' to 4='always', 7-items), 2) rate the 'importance' they placed on each of the components and guiding principles of the Collaborative Recovery Model in relation to assisting individuals' recovery processes (scale ranged from 0='not important' to 4='extremely important', 7-items) and 3) provide a rating of case managers' 'overall helpfulness' in relation to assisting individual's recovery process over the previous three month period (scale ranged from -3='extremely unhelpful' to 3='extremely helpful', one item). A three month time period was selected since it was known from analysis of AIMhi HSS data that there was a delay between training and staff implementation of protocols in practice (Uppal, Oades, Crowe, & Deane, in press). Further, the goal striving component was required to be completed at three-month intervals, hence a shorter time recall period would have been inappropriate based on the training protocol.

The introduction to the CEO-CRM and SEO-CRM provided the following definition of recovery to aid clarification of usage of this term relevant to this study: 'Psychological recovery can be defined as a process whereby individuals' acquire hope and self determination to lead a meaningful life and achieve a positive sense of self, whether or not mental illness is still present' (Andresen, Oades, & Caputi, 2003).

Questionnaire items were designed to be as simple as possible in order to enhance understanding among participants with varying educational backgrounds. Case manager (SEO-CRM) and consumer questionnaire versions (CEO-CRM) were created by changing wording slightly, to make items relevant to each group, whilst attempting to mirror each

item as closely as possible. Depending on the organisation that the participant was from, certain terms were also changed, to facilitate understanding among participants. For example the term 'case manager' was substituted with the term 'support worker' in some non-government services since this term was commonly used.

Consumer feedback about questionnaire

Five consumers from the Illawarra/Shoalhaven region in New South Wales, Australia, agreed to provide feedback regarding wording and comprehension of the questionnaire. Feedback was investigated via a brief questionnaire comprised of open-ended questions. These five people were members of the consumer reference group formed by the researcher specifically to provide opportunities for consumer feedback into the research. All had been involved in previous research and/or worked as consumer consultants in the mental health field and all were familiar with the Collaborative Recovery Model. Members of the consumer reference group were advised about the main purpose for developing the questionnaire. Open-ended questionnaire items asked specifically about the layout/design, wording of individual items, introductory paragraphs/directions for participants. Individuals were also encouraged to make general comments regarding improvements, as well as to indicate any concerns with the questionnaire.

Three people said that the questionnaire was acceptable and did not make any suggestions for improvement. Two people made minor recommendations regarding changes to the scaling and spacing/design. Recommendations guided further refinements to the questionnaire.

Psychometric testing

Reliability of consumer (CEO-CRM) and case manager questionnaire (SEO-CRM) versions were tested utilising the results from 82 consumer and 112 staff questionnaires respectively (10 consumer questionnaires were excluded from the psychometric analysis due to missing data and 14 staff questionnaires). Cronbach's alpha for CEO-CRM importance items was acceptable at $\alpha = 0.78$ with item-total correlations ranging between 0.41 and 0.70. Similarly Cronbach's alpha for frequency items was acceptable at $\alpha = 0.80$,

with item-total correlations ranging between 0.44 and 0.68. Item-total correlations for both frequency and importance indicated that questionnaire items were internally consistent.

Cronbach's alpha for SEO-CRM importance items was also acceptable at $\alpha = 0.77$ with item total correlations ranging between 0.38 and 0.61. Cronbach's alpha for frequency items was $\alpha = 0.68$ with item total correlations ranging between 0.13 and 0.55. Examination of item-total correlations for frequency revealed that deletion of the 'autonomy' item would enhance reliability marginally, increasing Cronbach's alpha to $\alpha = 0.70$. Future use of the SEO-CRM could consider deletion of this item ("I respected my client's right not to take my advice"). However, revision or rewording of this item may be more appropriate since supporting client's autonomy is one important aspect of the Collaborative Recovery Model and considering Cronbach's alpha does not increase substantially if omitted.

Whilst preliminary reliability and face validity of the CEO-CRM and SEO-CRM measures was demonstrated, further piloting and psychometric testing of these measures is necessary and findings are therefore interpreted with caution.

6.2.2 Procedure

Approval was received from the relevant human research ethics committees in various regions. Key ethical considerations for this study and how they were addressed are included in Appendix H. In the active condition case managers and consumers were required to have been providing services based on the Collaborative Recovery Model for at least six months at the time of questionnaire completion. This time period was selected as the analysis of AIMhi HSS data suggested an average delay of 5.6 months for staff to implement protocols following completion of Collaborative Recovery Model training (Uppal et al., in press). In the delayed condition the questionnaire was collected from consumers and case managers at any time, prior to Collaborative Recovery Model training.

A total of 218 questionnaires were collected from consumers and case managers in delayed and active Collaborative Recovery Model training conditions between the period of January

2005 and July 2006. Breakdown of questionnaires collected is outlined in Table 3 by version (consumer or staff) and condition (delayed or active).

Table 3

Breakdown of questionnaires collected by version and condition

Consumer (CEO-CRM version)	N and %	Staff (SEO-CRM version)	N and %
Total number:	92 (42%)	Total number:	126 (58%)
By condition		By condition	
Delayed:	47 (51%)	Delayed:	60 (48%)
Active:	45 (49%)	Active:	66 (52%)

Note. N=218 questionnaires in total collected from consumers and staff

Staff questionnaire version-SEO-CRM

In the delayed condition questionnaires were collected from staff along with other pre-training measures, prior to commencing training in the Collaborative Recovery Model. In the active condition questionnaires were collected from staff during training booster sessions, at least 6 months post initial Collaborative Recovery Model training.

Consumer questionnaire version-CEO-CRM

Research assistants working on the project (including a consumer research assistant in some sites) distributed and collected the consumer version of the questionnaire. Assistance in completing the questionnaire was provided where needed. It was considered a priority to avoid involving case managers and other service staff from the relevant organisations in questionnaire collection, as it was thought that this might affect the validity of information (consumers may be more likely to report positively about their experiences of working with case managers if direct service staff were involved in data collection). There is some research to support suggestions of acquiescent and/or ingratiation responding when surveys/questionnaires are collected by service staff, with the possibility of more reliable data when collected by peers (Clark, Scott, Boydell, & Goering, 1999; Gill, Pratt, & Librera, 1998; McGrew, Wilson, & Bond, 2002; Morrell-Bellai & Boydell, 1994; Rose, Wykes, Leese, Bindman, & Fleischmann, 2003). Whilst ideally consumer researchers would have been involved extensively in the collection of all consumer questionnaires, this was not possible due to limited financial resources.

6.2.3 Participants

Participants for this study were consumers and case managers taking part in the larger AIMhi HSS project evaluating the use of the Collaborative Recovery Model in services. Eligibility requirements for this project are reported elsewhere (see section 4.2). Mental health services participating in the AIMhi HSS project were cluster randomised by service to either the active, or one year delayed Collaborative Recovery Model training condition. In total four mental health services were randomised to the active condition and three services were randomised to the delayed condition. As part of this study questionnaires were collected from as many consumers as possible participating in the AIMhi HSS project (Crowe, Deane, Oades, Caputi, & Morland, 2006), within the limitations of time and resources.

Of a potential sample of approximately N=190 consumers taking part in the AIMhi HSS project, a convenience sample of N=92 (48%) took part in this study. Whilst there was an attempt to obtain questionnaires from as many consumers as possible, there were some practical barriers that presented this from occurring. For example collection of consumer questionnaires by the researcher was prevented at some services due to geographical distance. Where geographical difficulties presented, on site researchers at various services were typically asked to assist in the collection of questionnaires. Despite the researcher actively following up requested data, actual response rates in terms of data returned varied from service to service.

Out of a potential sample size of N= 127 case managers, a convenience sample of N= 97 case managers (76%) participated in this study. Once again there was an attempt to obtain questionnaires from as many case managers as possible. Practical barriers were less evident for collection of case manager questionnaires since they were collected by research staff directly prior to staff training in the Collaborative Recovery Model. However in reality, the questionnaire was voluntary and some staff chose not to complete it. Further some service sites commenced Collaborative Recovery Model training prior to the development of the SEO-CRM questionnaire. Therefore some opportunities for data collection were missed due to practicalities regarding timing. Table 4 highlights the total number of potential

consumers and case managers available to participate in this study and the actual number of participants who submitted questionnaires.

Table 4

Potential questionnaire participants and actual participation rates

	Potential participants (N)	Actual participation rate N and %
Consumers	190	92 (48%)
Case managers	127	97 (76%)

N=189 consumers and case managers participated in study one

6.2.4 Descriptive information

Descriptive information reported in this section was collected as part of the AIMhi HSS project. Descriptive data was not available for all participants. Attempts were made to collect missing data, however, this was not always possible for a range of reasons. For instance when staff and/or consumers exited relevant services, or failed to provide missing data when requested. Furthermore 24 case managers and 2 consumers remained anonymous, and did not provide personally identifying information on the questionnaires, beyond the service they were associated with. These questionnaires could not be matched with participant demographic information. Descriptive information provided here is therefore only an indirect indicator of the overall sample of study participants.

Consumer participants

Of the 92 consumer participants 47 (51%) were male, 30 (33%) were female and this information was missing for 15 (16%) participants. The mean age of consumer participants was 42.5 years with a SD of 10.2 years (data was available for N=56 participants, 61% of sample). Consumers in delayed and active conditions did not differ significantly on demographic variables of sex (Chi square=2.9, df=1, p=.09) or age ($F=.41$, $p=.53$). Diagnostic information was collected from case managers. The majority of participants in this study met the diagnostic criteria for schizophrenia (68%) consistent with sampling for the AIMhi HSS project with the remaining participants meeting a diagnosis for schizoaffective disorder (8%), bipolar disorder (6%), depressive psychosis (8%) or multiple

diagnoses (10%). Multiple diagnoses referred to participants meeting diagnostic criteria for two or more diagnosis listed above.

Consumers were attending three different public mental health services and four non-government organisations in three eastern states of Australia, (New South Wales, Queensland and Victoria). This included both metropolitan, regional, as well as rural locations. Service characteristic information regarding caseload and service intensity and frequency was collected using the Dartmouth Assertive Community Treatment Scale (DACTS) (Teague, Bond, & Drake, 1998) and is presented in Table 5. Services were typically defined by a low caseload and high service intensity and frequency reflecting the large number of participants attending community based non-government organisations (58%). Average caseload, service intensity and frequency information were compared for staff working with consumer participants in delayed and active conditions. Consumers in the delayed condition were found to be working with case managers with significantly smaller caseloads when compared to case managers in the active condition ($Z = -1.9$, $p = .05$). However it needs to be kept in mind that DACTS provides average caseload data for a team, not for individuals so some caution should be exercised in relation to this finding. Service intensity and frequency did not differ between delayed and active conditions.

Table 5

Caseload, service intensity and frequency for consumer participants

Caseload	N and % of sample, reported by delayed & active condition
50 clients per case manager or more	Delayed: N=4 (9.5%) Active: N=4 (8.9%)
21-34 clients per case manager	Delayed: N=0 (0%) Active: N=12 (26.7%)
11-20 clients per case manager	Delayed: N=5 (11.9%) Active: N=2 (4.4%)
10 clients per case manager or less	Delayed: N=33 (78.6%) Active: N=27 (60%)
Service intensity	
15 mins week or less per client	Delayed: N=1 (2.4%) Active: N=1 (2.2%)
15-49 mins per week per client	Delayed: N=4 (9.5%) Active: N=9 (20%)
2 hours per week or more per client	Delayed: N=37 (88.1%) Active: N=35 (77.8%)
Service frequency	
Average of less than 1 contact per week or less per client	Delayed: N=1 (2.4%) Active: N=3 (6.7%)
1-2 contacts per week	Delayed: N=15 (35.7%) Active: N=15 (33.3%)
2-3 contacts per week	Delayed: N=4 (9.5%) Active: N=10 (22.2%)
3-4 contacts per week	Delayed: N=14 (33.3%) Active: N=2 (4.4%)
Average of 4 or more contacts per week	Delayed: N=8 (19%) Active: N=15 (33.3%)

Note. As measured by the Dartmouth Assertive Community Treatment Scale (DACTS)

Case manager participants

A total of 97 different case managers completed the staff version of the questionnaire. Demographic information reported here does not equal the total number of case manager questionnaires reported elsewhere (126 questionnaires). This is evident as some staff completed the questionnaire in relation to more than one client in their caseload. This was considered acceptable, as questionnaire items were answered in relation to a case manager's perceptions of working with a specific individual. Demographic information was entered once only for staff who completed multiple versions of the questionnaire.

Of the case managers participating in this study 44 (45.4%) were female and 27 (27.8%) were male and this information was missing for 26 (26.8%) case managers. Mean age of case managers was 38 years, $SD=10.5$ (data was available for $N=55$ case managers, 57% of sample). Case managers in delayed and active conditions did not differ on demographic variables of sex (Chi square=.38, $df=1$, $p=.54$) or age ($F=.105$, $p=.75$).

Case managers were employed at one of two different public mental health services or five different non-government organisations. Service characteristic information is presented in Table 6. Average caseload, service intensity and frequency information were compared for staff working with consumer participants in delayed and active conditions. Staff in the delayed condition had significantly higher service intensity (spent more time with consumers) in an average week, when compared to staff in the active condition ($Z= -3.6$, $p=.00$). Remaining variables of caseload and service frequency did not differ between delayed and active conditions for case manager participants.

Table 6

Caseload, service intensity and frequency for case manager participants

Caseload	N and % of sample, reported by delayed & active condition
21-34 clients per case manager	Delayed: N=1 (1.7%) Active: N=9 (13.6%)
11-20 clients per case manager	Delayed: N=9 (15.3%) Active: N=6 (9.1%)
10 clients per case manager or less	Delayed: N=49 (83.1%) Active: N=51 (77.3%)
Service intensity	
15-49 mins per week per client	Delayed: N=1 (1.7%) Active: N=9 (13.6%)
85-119 mins per week per client	Delayed: N=0 (0%) Active: N=7 (10.6%)
2 hours per week or more per client	Delayed: N=58 (98.3%) Active: N=50 (75.8%)
Service frequency	
Average of less than 1 contact per week or less per client	Delayed: N=1 (1.7%) Active: N=2 (3.0%)
1-2 contacts per week	Delayed: N=8 (13.6%) Active: N=13 (19.7%)
2-3 contacts per week	Delayed: N=11 (18.6%) Active: N=20 (30.3%)
3-4 contacts per week	Delayed: N=13 (22%) Active: N=0 (0%)
Average of 4 or more contacts per week	Delayed: N=26 (44.1%) Active: N=31 (47%)

Note. As measured by the Dartmouth Assertive Community Treatment Scale (DACTS)

6.2.5 Statistical Analyses

Data from the 218 questionnaires was entered into a database for analysis using the Statistical Package for the Social Sciences. Normality of data was checked using Kolmogorov-Smirnov statistic. Tests were significant suggesting the data was skewed in the positive direction. Therefore only non-parametric analyses were undertaken on this data.

Consistent with hypotheses one and two for consumer and staff versions, Mann-Whitney U test was run, in order to compare ratings of frequency, overall helpfulness and importance between delayed and active conditions. The Mann-Whitney U test examines the hypotheses that two independent samples come from populations having the same distribution and is the non-parametric equivalent to the independent groups t-test (Coakes & Steed, 2001).

Descriptive statistics were run for consumer and staff versions in order to examine importance ratings for the entire sample, consistent with research question three (see Table 7 and 9 respectively). Percentage of staff and consumers rating Collaborative Recovery Model principles and practices as ‘unimportant’ (considered to be a score of ‘0’ or ‘1’) are also reported in the respective tables. Frideman’s test was run separately for consumer and staff participants to explore potential differences between importance ratings for key parts of the Collaborative Recovery Model across delayed and active conditions.

6.3. RESULTS

6.3.1 Consumer questionnaire version-CEO-CRM

Research question 1: Are particular parts of the Collaborative Recovery Model more important to consumers than others?

Research question 2: Does the relative importance for key parts of the Collaborative Recovery Model differ for consumers working with Collaborative Recovery Model trained case managers, when compared to consumers engaging in usual client support practices? On average consumers tended to rate key parts of the Collaborative Recovery Model as important ways of working within the context of assisting their recovery in case management settings. However, a limited number of consumer participants rated key parts

of the model as relatively unimportant in assisting their recovery. See Table 7 for mean importance, SD, number and percentage of consumers rating each aspect as ‘unimportant’ (determined by a score of ‘0’ or ‘1’ on the rating scale). A considerably higher number of consumers rated homework as ‘unimportant’, when compared to other key parts (N=9, 10.7%). However, this percentage was still relatively low, when compared to the overall sample. All consumers rating homework as ‘unimportant’ were in the delayed condition.

Table 7

Consumers’ importance ratings for key parts of the Collaborative Recovery Model

Questionnaire item	Mean importance ^a	SD	N and percentage of consumers rating area as ‘unimportant’ ^b
Responsibility “My case manager encourages me to take responsibility for my own recovery process”	3.41	.86	N=3 (3.4%)
Collaboration “My case manager involves me in decisions about my recovery process”	3.46	.78	N=2 (2.4%)
Autonomy “My case manager respects my right not to take his/her advice”	3.14	.92	N=3 (3.5%)
Motivational enhancement “My case manager helps to motivate me”	3.45	.79	N=3 (3.5%)
Needs assessment “My case manager understands my range of needs”	3.36	.82	N=4 (4.7%)
Goal striving “My case manager encourages me to set goals that are meaningful for me”	3.38	.86	N=4 (4.7%)
Homework “My case manager encourages me to set homework tasks to achieve my own goals”	3.07	1.19	N=9 (10.7%)

^a Importance scale ranged from 0=‘not important’ to 4=‘extremely important’

^b Ratings indicating lack of importance for particular items determined by a score of 0 or 1 on the rating scale

Friedman's test was run to establish whether homework importance was rated significantly below other key parts of the Collaborative Recovery Model for consumer participants in the delayed condition. Friedman test was significant (Chi square=25.1, df=6, $p < .00$) indicating that differences were apparent. Wilcoxon Signed Ranks test indicated which parts of the Collaborative Recovery Model consumers comparatively viewed as significantly more important. Homework, as anticipated was found to be contributing to the majority of the variance. Homework was rated significantly below all other areas of the Collaborative Recovery Model in terms of perceived importance for consumers in the delayed condition, with the exception of the autonomy item ("my case manager respects my right not to take his/her advice" $Z = -1.83$, $p = .07$). In comparison Friedman's test was non significant for consumers in the active condition (Chi square=7.63, df=6, $p = .27$). That is, consumers working with Collaborative Recovery Model trained staff appeared to value all aspects of the model to a similar degree.

Hypothesis 1: Consumer self-ratings of frequency of personal engagement in Collaborative Recovery Model principles and components will be higher for consumers working with Collaborative Recovery Model trained case managers, when compared to usual client support practices

Consistent with expectations consumers in the active condition reported that their case managers encouraged them to take responsibility for their recovery ($Z = -1.91$, $p = .03$), collaborated with them ($Z = -2.16$, $p = .02$) and encouraged them to complete homework activities to assist them to achieve their goals ($Z = -3.13$, $p = .00$) significantly more often than consumers in the delayed condition. In addition findings approached significance in the expected direction for the practical component of goal striving ($Z = -1.39$, $p = .08$). No significant differences were found for frequency ratings between delayed and active conditions for remaining parts of the Collaborative Recovery Model including autonomy support, motivational enhancement and needs assessment (See Table 8).

Table 8

Consumers' frequency ratings for key parts of the Collaborative Recovery Model by delayed and active condition

Questionnaire item	Mean frequency delayed ^a condition	SD	Mean frequency active ^b condition	SD	Z score ^c
Responsibility <i>"My case manager encourages me to take responsibility for my own recovery process"</i>	3.13	1.22	3.67	.56	-1.91*
Collaboration <i>"My case manager involves me in decisions about my recovery process"</i>	3.13	1.02	3.58	.66	-2.16*
Autonomy <i>"My case manager respects my right not to take his/her advice"</i>	2.87	1.17	2.89	1.22	-.20
Motivational enhancement <i>"My case manager helps to motivate me"</i>	3.39	.95	3.41	.73	-.49
Needs assessment <i>"My case manager understands my range of needs"</i>	3.22	1.02	3.42	.72	-.61
Goal striving <i>"My case manager encourages me to set goals that are meaningful for me"</i>	3.11	1.02	3.44	.72	-1.39
Homework <i>"My case manager encourages me to set homework tasks to achieve my own goals"</i>	2.34	1.41	3.24	.93	-3.13***

^a Total N=45. N varied for individual items as not all participants completed all items

^b Total N=47. N varied for individual items as not all participants completed all items

^c Where findings were significant in the expected direction the p value was halved

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

Hypothesis 2: Consumer self-ratings of case managers' overall helpfulness in assisting recovery will be higher for consumers working with Collaborative Recovery Model trained case managers, when compared to usual client support practices

Inconsistent with expectations consumer ratings of case managers 'overall helpfulness' in assisting recovery (over the previous three month period) were not found to be significantly different between delayed ($M=2.24$, $SD=1.30$) and active ($M=2.49$, $SD=0.86$) conditions ($Z=-.79$, $p=.43$). Mean scores on the rating scale (scale ranged from -3='extremely unhelpful' to 3='extremely helpful', one item) suggest that consumers tended to rate their case managers as very helpful in assisting their recovery, regardless of whether they had been working with Collaborative Recovery Model trained staff, or not.

Frequency counts were also examined for the 'overall helpfulness' item. This allowed examination as to whether consumers in delayed or active conditions (working with Collaborative Recovery Model trained workers or usual support practices), provided ratings indicating that their case managers had been 'unhelpful' in assisting their recovery, over the previous 3 months. Unhelpfulness in assisting recovery was determined by any negative rating, including ratings of '-3', '-2' and '-1'. Three people (7%) in the delayed condition rated their workers as 'unhelpful' in assisting their recovery over the previous three monthly period, compared with no consumers in the active condition. Whilst the initial hypothesis was not supported, it was encouraging to find all consumers working with Collaborative Recovery Model trained workers rated their case managers as 'helpful' in supporting their recovery.

6.3.2 Case manager questionnaire version–SEO-CRM

Research question 1: Are particular parts of the Collaborative Recovery Model more important to staff than others?

Research question 2: Does the relative importance of key parts of the Collaborative Recovery Model differ for case managers who have attended Collaborative Recovery Model training, when compared to those who have not attended training?

On average case managers tended to rate all Collaborative Recovery Model principles and components as important ways of working, within the context of assisting their clients' recovery. See Table 9 for mean importance, SD, and percentage of staff rating each aspect as 'unimportant' (determined by a score of '0' or '1' on the rating scale).

Consistent with findings for consumer participants, homework was the area most frequently rated as unimportant. Although relatively speaking the percentage of case managers providing this rating (N=6, 5.2%) was still low within the context of the larger sample (N=115). Only one case manager (0.9%) rated each of the following items including-responsibility for recovery, motivational enhancement, needs assessment and goal striving as relatively unimportant in assisting their client's recovery. Two case managers (1.8%) rated autonomy support as relatively unimportant in assisting their client's recovery.

Table 9

Case managers' importance ratings for key parts of the Collaborative Recovery Model

Questionnaire item	Mean importance ^a	SD	N and percentage of case managers rating area as 'unimportant' ^b
Responsibility <i>"Encouraging my client to take responsibility for his/her own recovery process"</i>	3.72	.61	N=1 (0.9%)
Collaboration <i>"Involving my client in decisions about his/her recovery process"</i>	3.79	.45	N=0 (0%)
Autonomy <i>"Respecting my client's right not to take my advice"</i>	3.46	.72	N=2 (1.8%)
Motivational enhancement <i>"Helping to motivate my client"</i>	3.60	.63	N= 1 (0.9%)
Needs assessment <i>"Understanding my client's range of needs"</i>	3.70	.51	N= 1 (0.9%)
Goal striving <i>"Encouraging my client to set goals which are meaningful for him/her"</i>	3.70	.56	N=1 (0.9%)
Homework <i>"Encouraging my client to set homework tasks to achieve his/her own goals"</i>	3.18	.82	N= 6 (5.2%)

^a Importance scale ranged from 0='not important' to 4='extremely important'

^b Ratings indicating lack of importance for particular items were determined by a score of 0 or 1 on the rating scale

Friedman's test was run to establish whether case managers comparatively viewed any Collaborative Recovery Model principles and components as significantly more important. Friedman's test was significant (Chi square=66.37, df=6, $p<.00$) for staff in the delayed condition indicating that differences existed. Wilcoxon Signed Ranks test was run to observe which key parts were viewed as significantly more important by case managers, when compared to other parts of the model.

Similar to findings for consumer participants the homework component was identified as contributing to the majority of variance. Homework was rated significantly below all other Collaborative Recovery Model principles and components, in terms of perceived importance by case managers in the delayed condition. In addition goal striving ($Z=-2.50$, $p=.01$), autonomy support ($Z=-2.68$, $p=.01$) and motivational enhancement ($Z=-1.98$, $p=.05$) were rated significantly below collaboration in terms of perceived importance.

Friedman's statistic was also significant (Chi square=48.75, df=6, $p<.00$) for staff in the active condition, indicating that differences also existed in relation to perceived importance between key parts of the model for case managers in the active condition. Wilcoxon Signed Ranks test revealed that similarly for case managers in the delayed condition, staff in the active condition rated the homework component significantly below all other parts of the model. The exception to this in terms of perceived importance was the autonomy item ("respecting my client's right not to take my advice" $Z=-.85$, $p=.40$). In addition autonomy support was rated significantly below all other parts of the Collaborative Recovery Model in terms of perceived importance, with the exception of the homework component.

Hypothesis 1: Case manager self-ratings of frequency with which they engage in Collaborative Recovery Model principles and components will be higher for Collaborative Recovery Model trained case managers, when compared to usual support practices

This study did not find that case manager ratings with which they were engaging in key parts of the Collaborative Recovery Model were for higher for Collaborative Recovery Model trained case managers. Indeed significant differences were found between the

delayed and active condition in the unexpected direction for three parts of the model including encouraging responsibility for recovery ($z=-2.03$, $p=.04$), needs assessment ($z=-2.28$, $p=.02$) and motivational enhancement ($z=-2.28$, $p=.02$)-see Table 10.

Table 10

Case managers' frequency ratings for key parts of the Collaborative Recovery Model by delayed and active condition

Questionnaire item	Mean frequency delayed ^a condition	SD	Mean frequency active ^b condition	SD	Z score
Responsibility <i>"I encouraged my client to take responsibility for his/her own recovery process"</i>	3.53	.72	3.32	.69	-2.03*
Collaboration <i>"I involved my client in decisions about his/her own recovery process"</i>	3.69	.68	3.60	.63	-1.27
Autonomy <i>"I respected my client's right not to take my advice"</i>	3.57	.59	3.48	.61	-.80
Needs assessment <i>"I understood my client's range of needs"</i>	3.15	.71	2.92	.51	-2.28*
Motivational enhancement <i>"I helped motivate my client"</i>	3.40	.79	3.08	.86	-2.30*
Goal striving <i>"I encouraged my client to set goals which were meaningful for him/her"</i>	3.47	.91	3.61	.68	-.39
Homework <i>"I encouraged my client to set homework tasks to achieve his/her own goals"</i>	2.52	1.20	2.82	1.12	-1.39

^a Total N=60. N varied for individual items as not all participants completed all items

^b Total N=66. N varied for individual items as not all participants completed all items

* $p<.05$

Hypothesis 2: Case manager self-ratings of overall helpfulness in assisting their client's recovery will be higher for Collaborative Recovery Model trained case managers, when compared to usual client support practices

Inconsistent with expectations case manager ratings of 'overall helpfulness' in relation to assisting their client's recovery were non-significant between delayed ($M=1.71$, $SD=.92$) and active ($M=1.80$, $SD=1.10$) conditions ($Z=-.70$, $p=.48$). Mean scores on the rating scale (scale ranged from -3='extremely unhelpful' to 3='extremely helpful', one item) suggest that case managers tended to rate sessions as 'helpful' in assisting their client's recovery, regardless of whether they had received training/were being encouraged to work consistently with the Collaborative Recovery Model, or not.

Frequency counts were observed to obtain a clearer picture of case managers' ratings at the negative end of the rating scale. 'Unhelpfulness' in assisting recovery was determined by any negative rating, including ratings of '-3', '-2' and '-1'. One case manager in the delayed condition (1.7%) and 2 case managers (3%) in the active condition provided a rating in the 'unhelpful' range with respect to assisting their client's recovery.

6.4. DISCUSSION

6.4.1 Consumer questionnaire version-CEO-CRM

Consumers identified some significant changes to recovery focused service provision

Preliminary findings suggest that consumers working with Collaborative Recovery Model trained workers were able to identify some significant changes to service delivery in relation to the frequency with which they were encouraged to take responsibility for recovery, degree with which they collaborated with staff and completed homework activities. This is particularly noteworthy considering consumers in the delayed condition were working with case managers with significantly smaller caseloads on average, when compared to case managers in the active condition. Despite this difference in average caseload, findings were significant in the expected direction. These findings are also noteworthy in view of the difficulties around ensuring that new mental health interventions

are implemented in services (Deane, Crowe, King, Kavanagh, & Oades, 2006; Kavanagh et al., 1993).

Other research exploring consumers' experiences of what is actually being received within case management settings from a recovery framework is limited (Marshall, Crowe, Oades, Deane, & Kavanagh, 2007) making comparisons with this study difficult. However, there are some anecdotal reports that some mental health services may be doing little more than bringing recovery into the mission statements and descriptions of programs (Gawith & Abrams, 2006; Glover, 2005; Groom, Hickie, & Davenport, 2003; Onken, Dumont, Ridgway, Dornan, & Ralph, 2006). A report undertaken as part of a National review into the state of mental health services in Australia suggested that professionals remained illness focused, with an emphasis on 'containing' consumers, as opposed to promoting improved quality of life and recovery (Groom, Hickie, & Davenport, 2003). Such suggestions highlight the importance of research that attempts to clarify from consumer and staff perspectives what is actually occurring within the context of receiving 'recovery' focused services.

Differences to do with frequency of homework completion were particularly apparent between delayed and active conditions within this study. This could be explained in that without specific training case managers are less likely to use homework systematically (Kazantzis & Deane, 1999; Kelly, Deane, Kazantzis, Crowe, & Oades, 2006). In a recent survey of 122 case managers in public and non-government mental health organisations in Australia it was found that only 15% of workers used a systematic approach to homework administration (Kelly, Deane, Kazantzis, Crowe, & Oades, 2006). This is comparable to a New Zealand study which found that only 25% of psychologists surveyed completed homework systematically (Kazantzis & Deane, 1999). It is possible that Collaborative Recovery Model training for mental health staff may have led to more frequent homework administration procedures.

It is also possible that training may have positively impacted on staff attitudes towards homework, thus leading to an increase in frequency of homework activities for staff and consumers in the active condition. Findings from a recent study suggest that case managers

who held positive attitudes towards homework activities were more likely to report higher levels of homework completion and also better response from clients (Kelly, Deane, Kazantzis, & Crowe, 2007) lending some support to this possibility. Alternatively staff who had undertaken training may have better socialised consumers to practices of homework setting, accounting for the differences in frequency of homework completion between delayed and active conditions.

It is possible that goal setting, in comparison to homework activities may already be a more routine part of case management activities, making it harder to identify differences between conditions, as observed in this study. Another possible explanation is that goal setting, as emphasised within the training protocol is to be completed much less frequently (emphasis around completion at 3-monthly intervals), when compared to the homework component (emphasis around weekly completion). Hence, the likelihood of detecting changes in frequency around completion of this component is reduced.

Consumers reported that case managers were generally supportive of their recovery process, regardless of whether they were working with Collaborative Recovery Model trained staff. Consumers working with case managers who had attended training did not rate their workers as more helpful in supporting recovery. However, frequency ratings with which consumers worked consistently with the model were skewed in the positive direction, for participants in delayed and active conditions. This could suggest a ceiling effect operating, or that ‘overall helpfulness’ may be perceived as independent from the frequency of specific activities.

Alternatively it is possible that consumers in the delayed condition may have overrated their experiences in a positive manner, based on their inability to conceptualise alternate, more helpful ways of working. Furthermore it is possible that consumers may have responded in a ingratiating manner to the questionnaire in an attempt to appease the staff with whom they were working. However, attempts were made to minimise the likelihood of ingratiating responding by reinforcing that data would remain confidential and by involving outside researchers (rather than case managers) in data collection. Clearly asking

consumers to rate ‘overall helpfulness’ does not specifically address whether consumers perceived working within the Collaborative Recovery Model to be more helpful in assisting their recovery (when compared to receiving services as normal in case management contexts).

The current finding that consumers viewed case managers as generally supportive of their recovery process is inconsistent with findings of some researchers (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). For example, Tooth et al (2003) as part of their Australian study reported that two thirds of the 57 consumers they interviewed stated that ‘health professionals’ had a negative impact on their recovery. However, the nature of services and staff discussed within this study is unclear (e.g. crisis and hospital based services, public mental health services etc).

Onken et al (2002) in their United States based study involving 115 consumers found reports of more ‘hindering’ content regarding formal mental health services and staff employed within it, than in any other domain. This included consumers’ feedback on a range of services including, but not limited to crisis oriented and emergency services. Differences in this study may be explained in that crisis and emergency services are by their very nature more illness focused and less likely to be focused towards recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). The Attitudes of Health Professionals Project (AHPP) undertaken in Australia indicated that consumers’ satisfaction with public and private psychiatric hospitals was lowest, when compared with various others aspects of mental health service delivery (Mental Health Council of Australia, 2000).

Consumers tended to value key parts of the Collaborative Recovery Model

In general consumers in this study tended to place value on key aspects of the model when working with their case managers within the context of supporting their recovery. This was true for consumers in both delayed and active conditions, that is irrespective of whether consumers were working with staff who had received Collaborative Recovery Model training, or not.

These findings are important since only limited evidence exists at present from a consumer perspective to support the importance of key parts of the Collaborative Recovery Model, when working with mental health staff (see section 4.1.2, p.78). This is particularly evident for practical components of homework, needs assessment and motivational enhancement.

It is important to note that consumers in the active condition may have held positive views regarding key parts of the Collaborative Recovery Model prior to commencing services with staff trained in the model. Indeed the finding that consumers perceived importance for the various aspects of the Collaborative Recovery Model did not differ significantly between delayed and active conditions (with the exception of the homework component) suggests that this may have been the case.

This is perhaps not surprising in keeping with research in the recovery area. For example consumers have discussed the importance of goal striving when working towards their recovery (Andresen, Oades, & Caputi, 2003; Baumeister & Leary, 1995; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). It is also known that motivational interviewing is an effective strategy to assist people to clarify both benefits and barriers to individual goals (Corrigan, McCracken, & Holmes, 2001). Other factors such as encouraging responsibility, collaboration and autonomy have been emphasised as important in supporting individuals recovery (Onken et al., 2002). Findings from this study add further support to existing literature from a consumer perspective highlighting the importance of encouraging responsibility, autonomy support, collaborative practices and assisting consumers to work towards their goals, when working with mental health staff (Chinman, Allende, Bailey, Maust, & Davidson, 1999; Kisthardt, 1993; O'Brien, 2001; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Consumers in the delayed condition rated homework importance significantly below other key parts of the Collaborative Recovery Model (excluding autonomy support)

It is possible that this finding is an accurate reflection of consumers perceived importance for homework activities. That is, there may be a proportion of consumers who view homework activities as relatively unimportant in assisting their recovery. However

differences in terms of homework importance ratings for consumers in delayed and active conditions, may provide some explanation for these findings (all consumers rating homework as unimportant (N=9, 10.7%) were in the delayed condition).

It is possible that some consumers in the delayed condition (receiving services as usual) might have perceived homework more negatively if they equated this with previous negative experiences, either with respect to mental health service delivery, or experiences at school. For example, the term homework traditionally implies another person prescribing homework, with no or little input required from the actual person required to complete the task. Alternatively, consumers in the active condition may have been more actively involved in the homework setting process. Hence it may be that these consumers more clearly articulated the link between homework tasks and achieving their goals (consistent with the staff training protocol) potentially increasing their valuing regarding these activities. This possibility is tentative and requires further investigation through direct questioning of mental health consumers.

6.4.2 Staff questionnaire version: SEO-CRM

Differences in frequency ratings between delayed and active conditions

Preliminary findings suggest that case managers who attended Collaborative Recovery Model training and were encouraged to work consistently with this intervention did not rate the frequency with which they were delivering key parts of the Collaborative Recovery Model higher, when compared to workers in the delayed condition. Indeed, significant differences were found in the unexpected direction for some key parts of the Collaborative Recovery Model including encouraging responsibility, needs assessment and enhancing motivation.

This is potentially an accurate account of the degree with which case managers worked consistently with the Collaborative Recovery Model. It may indicate that Collaborative Recovery Model training had little impact on changes to service delivery and ways of working, as perceived by staff participants in this study. However, consumers' findings are contrary to those reported here with some changes in services identified across the areas of

responsibility for recovery, homework and collaborative practices. Furthermore existing research evaluating the effectiveness of Collaborative Recovery Model training found a positive training effect for 248 mental health workers in areas of attitudes and hopefulness-including belief in effectiveness of all Collaborative Recovery Model principles and practices (Crowe, Deane, Oades, Caputi, & Morland, 2006). It is possible however that positive training effects and attitudes towards key principles and components reported in this study, may not have transferred into practice at the level of service delivery. The difficulty of ensuring that new interventions are implemented within mental health services has been raised (Deane, Crowe, King, Kavanagh, & Oades, 2006).

Alternatively it is possible that observed differences in service intensity between delayed and active conditions (i.e. staff in the delayed condition on average spent more time with consumers over a weekly period, when compared to staff in the active condition) might go some way towards accounting for these findings. Another possibility is that some case managers in the delayed condition may have over-inflated the degree with which they reportedly worked consistently with the Collaborative Recovery Model. For example, staff participants would have had some awareness of the context for the project (with an emphasis on supporting consumer's recovery processes) prior to commencing formal training. Some staff are also likely to have been aware of emphasis on recovery-based practices more generally within National policy documents (Australian Health Ministers, 2003). Therefore, staff may have viewed it as desirable to portray the perception that they had been working consistently with recovery-based practice to a greater degree, than was actually the case. These findings may also be explained in terms of Collaborative Recovery Model trained staff being more aware than non Collaborative Recovery Model trained staff about poor performance in these areas.

Inability to identify significant differences in terms of frequency of engagement with Collaborative Recovery Model guiding principles and components may also reflect deeper underlying issues to do with questionnaire development. Further psychometric testing is necessary in order provide clarification in this area. One possible future direction is the inclusion of a social desirability scale as a covariate for staff and consumers. This may assist in assessing the validity of reporting on the SEO-CRM and CEO-CRM.

Case managers reported working in ways that supported consumers' recovery processes, regardless of whether they had attended Collaborative Recovery Model training

As was found for consumer participants, staff tended to report that they were helpful in supporting their client's recovery, regardless of whether they were in delayed or active conditions. This finding is not unexpected considering frequency data were skewed in the positive direction, indicating that workers in both delayed and active conditions tended to be perceived as working consistently with the Collaborative Recovery Model.

Comparisons with existing research were difficult as no research was located which similarly queried workers perceptions in relation to effectiveness of service delivery within the context of supporting their clients' recovery. One study undertaken with a sample of 248 Australian mental health workers from non-government and public mental health services explored staff attitudes to recovery using the Recovery Attitudes Questionnaire (RAQ) (Crowe, Deane, Oades, Caputi, & Morland, 2006). Findings from this study indicated that staff tended to hold relatively positive attitudes towards recovery. Clearly this research question differs however from asking staff about their perceptions as to whether they actually worked in ways that supported their client's recovery processes.

Case managers tended to value key aspects of the Collaborative Recovery Model

Findings from this study indicated that case managers tended to value key parts of the Collaborative Recovery Model as important when supporting consumers' recovery processes, regardless of whether they had received training in the model. This finding was in keeping with consumers' experiences and was not unexpected considering key parts emphasised within the model have been highlighted as important within the recovery literature and broader evidence based practice (Andresen, Oades, & Caputi, 2003; Gehrs & Goering, 1994; Kazantzis, Deane, & Ronan, 2000; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Rollnick, Mason, & Butler, 1999; Sheldon & Elliot, 1998).

That is, there were reasons to believe a-priori that at least some case managers in the delayed condition would rate various aspects of the Collaborative Recovery Model as important. Similarly, it is considered that case managers in the active condition may have held positive views regarding various aspects of the Collaborative Recovery Model prior to

attending training. For example case managers most likely would already have been familiar with literature and policy in the area of recovery from working in the field, potentially positively influencing their ratings. Some services are also likely to have had existing policy requiring staff to work in ways consistent with aspects of the Collaborative Recovery Model. For example, National policy in Australia requires staff to develop individual treatment, or recovery plans in collaboration with service users (National Mental Health Strategy, 1996). Some support for this suggestion is evident considering the lack of perceived differences for importance ratings among staff who had attended Collaborative Recovery Model training, versus those who had not attended training.

A limited number of case managers rated key parts of the Collaborative Recovery Model as relatively unimportant, within the context of supporting their client's recovery. Similarly to findings for consumer participants, staff most commonly rated the homework component as unimportant. Six case managers (5.2%) rated homework as relatively unimportant in assisting their client's recovery. Of these six people, a total of four had received training in the Collaborative Recovery Model (were in the active condition). Despite the relatively low overall percentage (3.5%) the finding that four case managers rated homework as relatively unimportant is somewhat surprising. In particular considering staff attended training, emphasising the evidence base and benefits of engaging in this activity within the context of supporting consumers to move towards their goals.

It may be that some workers in this study held negative attitudes towards the use of homework with people with serious mental illness, which were not positively impacted by attendance at training. Alternatively it is possible that these workers may have been providing services to consumers who were extremely disabled by their illness at the time of questionnaire completion and therefore considered unlikely to benefit from homework activities.

Limited research exists at present examining staff perceptions of homework activities when working with clients with serious mental illness such as schizophrenia. However, one study undertaken in Australia (Kelly, Deane, Kazantzis, & Crowe, 2007) examined case managers' attitudes towards the use of homework for people with serious mental illness.

Case managers in this study reportedly held positive attitudes towards the use of homework when working with mental health clients. Furthermore relatively small differences in importance ratings for homework activities were found for people with moderate psychiatric disability (e.g. anxiety and depression) when compared to people with serious mental illness (e.g. schizophrenia, bipolar disorder). These findings in part support those reported here in that case managers were, in general, found to emphasise the importance of homework activities when working with people with serious mental illness.

Study limitations

A limitation of this study is that it utilises a questionnaire that requires further psychometric testing in order to more comprehensively establish its reliability and validity. For example examination of test-retest reliability and convergent/discriminant validity is warranted. Further work comparing the questionnaire used here and other measures of recovery oriented practice, would be of benefit. Results are therefore reported as preliminary and interpreted with caution. Limitations in terms of the design characteristics are also evident as it was also not possible to match either case manager or consumer data in the delayed and active conditions (due to a very limited number of participants having matched data, despite efforts to obtain this information). It is possible that findings of differences between the two samples could be attributable to pre-existing differences in the samples, rather than differences in relation to delivery of training.

Consideration should also be given to the possible impact of sample attrition and missing data for consumer and staff participants, that is the findings may not be representative of the larger group of individuals participating in the AIMhi HSS study (48% of consumers and 79% of case managers from the AIMhi HSS study participated). Another limitation of this study design is that consumers and case managers were only afforded an opportunity to provide limited feedback about the services they received by way of structured, close-ended questionnaire items. This methodology obviously limits consumers' ability to comment in detail about the services they received. Furthermore no opportunity is provided to discuss any difficulties or concerns, or to identify ideas for improved service delivery. However, this study is part of a larger design incorporating qualitative methodologies (see studies two

and three which follow), which go some way to addressing these limitations regarding consumer participants.

A further limitation of this study is that the CEO-CRM and SEO-CRM provide only an indirect indicator of consumers and staff exposure to Collaborative Recovery Model relevant practices. For example within the context of this study consumers were not asked specifically about whether they completed practical components such as Collaborative Goal Technology (Clarke, Oades, Crowe, & Deane, 2006) and homework based sheets (Oades, Lambert, Deane, & Crowe, 2003b) specific to the Collaborative Recovery Model training protocol. Rather, they were more generally asked about their engagement in goal striving and homework based activities. It is also possible that consumers and staff may have responded in a socially desirable or acquiescent manner when completing questionnaires, despite attempts to reduce this likelihood through design aspects of the study (see section 6.2.2).

6.5 CONCLUSIONS

Whilst findings are preliminary, this study is significant as it is an early attempt to examine the extent to which various recovery-focused practices are being engaged in within case management settings from the perspective of mental health consumers and staff. It also examines consumers' and case managers' valuing of the Collaborative Recovery Model as one avenue to delivering recovery-oriented services. Clearly this is an important direction for future research if the emphasis on recovery oriented mental health services is to be realised.

Preliminary findings indicate that consumers were able to identify some changes to service delivery in terms of the frequency with which they were encouraged to take responsibility for recovery, degree with which they collaborated with workers and the extent to which they completed homework activities to assist them to achieve their goals, when working with Collaborative Recovery Model trained mental health staff within service settings. Consumers tended to place importance on key parts of the Collaborative Recovery Model, regardless of whether they were working with staff trained in the model, or not. Consumers

also reported that case managers were generally supportive of their recovery processes, irrespective of whether their workers had received Collaborative Recovery Model training.

As was found for consumer participants, staff tended to place importance on key aspects of the Collaborative Recovery Model whether or not they had attended training. Similarly they reported that they were generally supportive of their client's recovery processes, regardless of whether they had attended training. In contrast to findings for consumer participants, case managers did not report that they engaged in activities consistent with the model more frequently when they had received Collaborative Recovery Model training, compared to staff that had not attended training.

The next chapter focuses on exploring mental health consumers' evaluations of the Collaborative Recovery Model received in case management settings by way of in-depth interviews. Participants were purposively sampled from non-government organisations and public mental health services in New South Wales and Queensland, Australia. Consumer researchers undertook all interviews. The background and aims of the study are described first, followed directly by description of the methodology, analysis (using Leximancer software analysis program), results and relevant discussion.

CHAPTER 7
STUDY 2: INTERVIEWS

**THE HELPFUL AND THE HINDERING:
CONSUMERS' EXPERIENCES OF THE
COLLABORATIVE RECOVERY MODEL AS
RECEIVED IN SERVICES**

“You had to look inside and say what do I need in my life or what do I, what do I have to work on and that was one of the positive points of the whole project that I was being insightful to what I needed to do to help myself.” (participant 13)

The study outlined in this chapter utilised semi-structured interviews with consumers who have been working with Collaborative Recovery Model trained mental health staff. Interviews were used to explore in detail consumers’ perceptions regarding their experiences of the model as received in case management settings. This chapter commences with a description of the context, background and aims for this study, development of interview guidelines, sampling procedures, description of participants and background to Leximancer data analysis software (used in analysis of interview data). This is followed directly by findings and discussion arising from this study.

7.1 INTRODUCTION

Qualitative methodologies are particularly appropriate in understanding the value and meaning people ascribe to their experiences, from their own personal and cultural perspectives. In addition qualitative methodologies have been noted as particularly beneficial for obtaining process information, or understanding how something happens (Patton, 2002) and are important for informing improved services delivery (Burns et al., 1999). For example, within the context of this study, it was considered important not only to understand whether people had been encouraged to take personal responsibility for their recovery, (within the context of their therapeutic relationship with their clinician) but also how this was perceived to have occurred or not occurred. Furthermore to understand how responsibility for recovery could be more actively encouraged by staff within the therapeutic relationship.

7.2 STUDY AIMS

The key aim for undertaking semi-structured interviews was to obtain detailed information from consumers about their experiences of working within the Collaborative Recovery Model as received when working with their case managers in mental health settings. This

information was collected from consumers with the aim of informing the ongoing improvement of the Collaborative Recovery Model and its use and delivery in services. Specifically this study aimed to address the following questions:

1. What are consumers' experiences of the Collaborative Recovery Model as received in services?
2. From consumer's perspectives, what do they actually receive when working within the Collaborative Recovery Model with their case manager/s?
3. From consumers' perspectives how can the Collaborative Recovery Model and delivery and use of this approach in services be improved, to better support the recovery of people with mental illness?

7.3 METHODOLOGY

7.3.1. Development of interview guidelines

The semi-structured interview guide was developed in collaboration with the primary researcher, supervisors and a number of consumer researchers. A copy of the interview guidelines is available in Appendix I. A decision to retain a reasonable degree of structure within the interview process was considered necessary for the purpose of achieving the aims of this study. For instance specific information was desired in relation to evaluating the various key parts of the Collaborative Recovery Model. Secondly this study involved four different consumer researchers undertaking interviews, in various mental health settings. There are benefits to having structured interview guides, particularly when there are multiple people undertaking interviews. For example, structured interview guides protect against possible variations in skills and interviewing techniques, and make participants' responses easier to elicit, clarify and compare (Patton, 2002; Ralph & Corrigan, 2005). Indeed, an inherent risk when various researchers are working inductively with qualitative data and little or no structure to the research process, is that they will end up with data overload and lack of comparability among cases (Miles & Huberman, 1994).

However, whilst a decision was made to ensure a considerable degree of structure was maintained, it was also considered important that there was sufficient flexibility provided to allow for consumers to identify important aspects of their experience that may fall outside

pre-determined areas queried in the interview schedule. This was because the broader aims of this research were to enhance understanding as to how recovery is both supported, and inadvertently hindered in case management settings. Further, the Collaborative Recovery Model is perceived to be in a process of ongoing evolution and improvement, rather than a final and fixed state. It was therefore considered possible that consumers may identify important ways of working which were not currently emphasised as part of the training protocol.

Stages of development of the interview guide

Development of interview guidelines occurred over a number of stages, involving discussion among the various consumer and researcher groups and ongoing refinement based on feedback provided. A flow chart depicting stages of development for the interview guidelines is displayed in Figure 1. Nine consumers were contacted and invited to attend one of two focus group meetings to assist in refining interview guidelines. Consumers were paid for their time according to University guidelines for casual employees. Feedback provided during groups was incorporated into interview guidelines. Two consumer researchers, recruited to carry out interviews undertook a final review of the guidelines, prior to commencement of interviews. A summary of recommendations in relation to interview guidelines arising from meetings with consumers is available in Appendix J.

Interviewees were encouraged to start with broad, less directive questioning and non-specific probes. They were encouraged to proceed with more specific probes, when questions were too general for a particular participant to elicit a response. Interview guidelines were deliberately structured in order to extract both positive and negative experiences that individuals may have had when working within the model. Interviewers were also encouraged to personalise guidelines-for instance through rewording questions in the way that they felt most comfortable, whilst retaining inherent meaning.

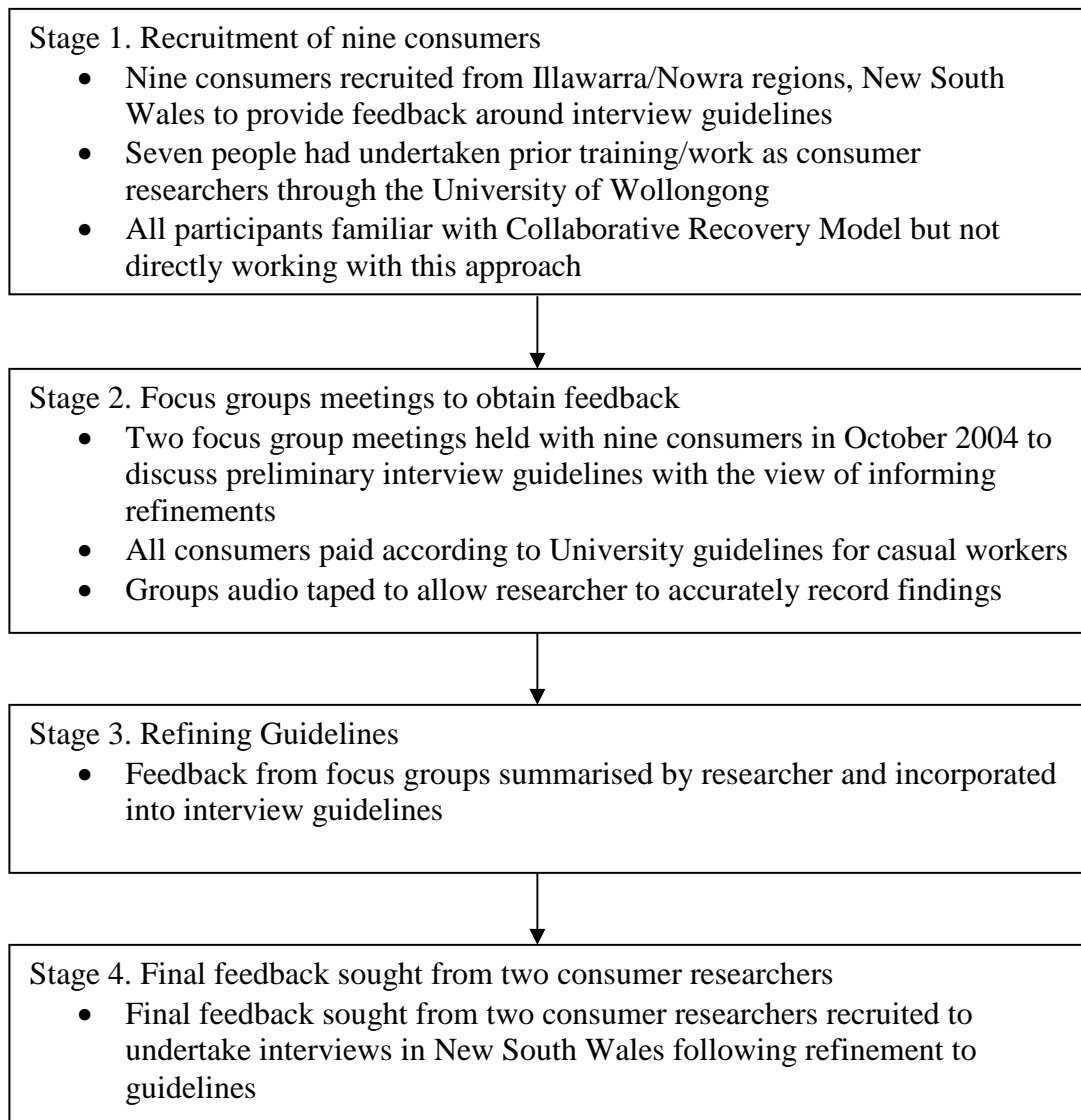


Figure 1. Flow chart depicting consumer consultation during interview guide development

Summary of interview guidelines

See Appendix I for copy of interview guidelines. Summary of key aspects covered by these guidelines include:

- 1) Build rapport and briefly introduce their own role as a consumer researcher (the purpose of this was to create an atmosphere where interviewees might feel more comfortable talking about and sharing their own experiences)
- 2) Anchor interviewee's experiences of working within the AIMhi HSS project (for instance by asking the interviewee to identify the case manager/s with whom they've worked on the project and recall the time when they started working on the project)
- 3) Introduce interview aims
- 4) Ask interviewee for personal definition of recovery/process of recovery
- 5) Interviewee to describe their relationship with their case manager and discuss how they feel about that relationship (key aspects to cover include collaboration, personal responsibility, risk taking, autonomy/decision making & providing hope)
- 6) Interviewee to discuss practical components of motivation and needs assessment-where relevant discuss experience of completing Camberwell Assessment of Need Short Appraisal Schedule (needs assessment as part of Collaborative Recovery Model) (see Appendix C)
- 7) Interviewee to discuss personal goal setting and where relevant experience of using Collaborative Goal Technology (goal setting technology consistent with Collaborative Recovery Model protocol) (see Appendix D)
- 8) Interviewee to discuss homework and where relevant completion of homework sheets (specific to the Collaborative Recovery Model protocol) (see Appendix E)
- 9) Interviewee asked general questions focused on drawing out unhelpful and helpful experiences, of using the Collaborative Recovery Model in case management settings

7.3.2 Consumer researcher training and support procedures

Consumer researcher training

Training in interviewing strategies for consumer researchers was considered desirable to ensure adequate skill development in this area, as well as to ensure consistency across the various researchers working in various mental health sites. Other authors have emphasised

the importance of providing adequate training to consumers when engaging them in research activities such as undertaking interviews or facilitating focus groups (Linhorst & Eckert, 2002; Morrell-Bellai & Boydell, 1994).

Two researchers were initially recruited to undertake interviews with consumers in participating organisations in New South Wales. Both researchers had previous experience working as part of a research team through the University of Wollongong, in interviewing other consumers and had undertaken extensive training as part of this process (Malins, Morland, & Oades, 2002). Training therefore focused on refreshing existing knowledge and practicing skill set, consistent with interview guidelines specific to this study. As part of the preparation the two consumer researchers met with the primary researcher and reviewed interview guidelines and engaged in role-plays of the interview process. Both consumers attended the two day Collaborative Recovery Model training, and were familiar with the protocol (Oades et al., 2005).

Another two consumers were recruited several months later to undertake interviews in Queensland. Both consumers were recommended by the participating organisations, had experience working in a consumer advocacy role and familiarity with the interviewing techniques. Both attended the two day Collaborative Recovery Model training to ensure they were familiar with the protocol. As part of the training each researcher was provided with guidelines for interviewing procedures, developed as part of consumer researcher training for a previous research project (Malins, Morland, & Oades, 2002). A training audio was developed which provided an example of an interview (based on an actual interview undertaken in New South Wales). A conference call was also organised involving the primary researcher and the two consumer researchers recruited in Queensland to clarify procedures and training materials. One consumer researcher from New South Wales was also available to answer questions during this conference call, based on their direct experience of undertaking interviews in this geographical region.

Consumer researcher support and feedback procedures

Feedback was provided by the primary researcher to each of the consumer researchers following completion and review of each interview undertaken. Other researchers have emphasised the importance of providing positive feedback and encouragement when working with consumer researchers (Morrell-Bellai & Boydell, 1994). Consumer researchers indicated that this process was helpful, particularly during the early stages, as they were becoming comfortable with the interview guidelines and interviewing process.

Support procedures were also established for the consumer researchers (Morrell-Bellai & Boydell, 1994). Provision of adequate support and opportunity to debrief was also raised as an important issue during focus group meetings with consumers in the planning phase for this study. For the majority of interviews undertaken in New South Wales, the primary researcher was available at the place of interviewing to allow for the consumer researcher to debrief in person following the interview. Alternatively, in several instances a support phone call was arranged prior to the interview and directly following the interview, to allow for the interviewee to debrief and discuss any issues, personal or otherwise, that may have arisen during the course of the interview. Similar telephone support procedures were put in place for the two consumer researchers working in Queensland. In addition all consumer researchers were encouraged to provide additional support directly to each other through exchange of telephone numbers and email addresses. The primary researcher sent regular group emails between all researchers updating on interview progress, also encouraging communication between the researchers.

7.3.3 Sampling

This study employed purposive sampling, aimed at attaining maximum variation sampling. Purposive sampling is typically adopted within qualitative studies and focuses in depth on relatively small samples. The logic and power of purposive sampling strategies are that they select information rich cases for in depth study (Patton, 2002).

Maximum variation sampling is a type of purposive sampling selected for this study.

Maximum variation sampling “aims at capturing and describing the central themes that cut

across a great deal of variation” (Patton, 2002, p. 234-5), hence ensuring that people selected represent the greatest differences in the phenomenon being studied. This type of sampling applies the logic that any common patterns, which are found to emerge from great variation are of value and particular interest, in capturing the key experiences and shared dimensions of a setting or specific phenomenon (Patton, 2002).

Key sampling domains

There was a particular interest in recruiting interview participants with diverse variations in the following domain: consumers who found the Collaborative Recovery Model, or certain key parts of it, either extremely helpful or unhelpful (including people who may have dropped out of the project). This sampling domain was selected, since one of the key aims of this research was to evaluate and drive the improvement of the Collaborative Recovery Model and its use in services. Therefore it was considered particularly desirable to attempt to recruit people to interview who had either found their involvement in the project particularly helpful in assisting their recovery, or alternatively unhelpful. Identification of people, who had experienced their involvement in the project as ‘unhelpful,’ was proposed to be indicative of two key scenarios. Firstly such selection criteria could potentially result in the selection of consumers whose workers had been delivering the Collaborative Recovery Model inconsistently, or inadequately in keeping with the training protocol. Secondly, it was thought that this selection criterion could potentially result in the selection of consumers who had deeper underlying concerns to do with the Collaborative Recovery Model, or certain aspects of it, as a model of care.

In the initial stages of sampling for this study a key requirement was that consumers had been working with their clinician for at least six months within the Collaborative Recovery Model. This timeframe was initially proposed to ensure that participants had adequate time to experience the practical model components such as goal setting and homework activities. Analysis of data from the AIMhi HSS project indicated that for staff there was an average delay of 5.6 months between clinicians attending initial training and actually implementing any aspect of this training protocol in practice with consumers (Uppal et al., in press).

Individual clinicians and research assistants working within the various organisations nominated people they believed met these selection criteria. In addition a consumer friendly information flyer was created for reference when describing the study to consumers. This flyer emphasised that researchers were interested in finding out both what participants liked about the project, as well as what they disliked.

Identifying interview participants with ‘less helpful’ experiences

As interviews progressed it became clear that the majority of people being nominated, were identified as having ‘positive experiences’ when working with Collaborative Recovery Model trained staff. This was of concern within the context of key sampling criteria. It was also suspected that it was unlikely that all participants had had positive experiences. Therefore later stages of recruitment focused specifically on attempting to recruit people to interview who had had less positive experiences with respect to their involvement in the project. This included seeking people who may have had a negative experience with only a certain aspect of the project, such as the homework or goal setting component, as well as seeking people who expressed more general dissatisfaction when working with mental health staff trained in the particular model of care.

A number of additional processes were established in an attempt to recruit persons meeting this criterion. Firstly, research assistants at participating organisations were contacted by the primary researcher and the list of participating consumers from each site was reviewed (with a particular focus on participants who had dropped out of the project from as early as three months). This was considered important as it was expected that people who had been particularly dissatisfied with their experience of the project, would potentially have been most likely to drop out in the early stages. Where clear alternative reasons for dropping out were identified, for instance it was found that the client was ineligible, where clients had expressed dissatisfaction with the assessment process (completion of measures), or for clients who had left the service, no further follow up was undertaken. However, where reasons for dropping-out were unclear the client’s clinician was contacted wherever possible and further enquiries were made as to whether they were aware of the particular consumer’s experience of working within the project. This typically involved staff speaking

directly to consumers they had been working with to clarify more about their experiences and to ascertain whether they were suitable and willing to be interviewed.

In addition to this extensive process an advertisement was placed in the Collaborative Recovery Model Newsletter, which was posted to all consumers participating in the project in November 2006. This advertisement emphasised that in order to evaluate the model that researchers were seeking to talk to people whose experiences with the intervention had been less positive.

Additional sampling criteria

In addition to key sampling domains described above there was an attempt to balance gender and ensure a range of ages, including representation of people across the range of ages participating in the AIMhi HSS project (at baseline mean reported age for AIMhi HSS project participants was 39.85 years, with a SD 12.15 years). There was also an attempt to interview people from a range of participating organisations in the overall AIMhi HSS project, with a representation of people from both government and non-government organisations. In addition this study aimed to capture individuals across the range of diagnoses participating in the AIMhi HSS project, including individuals with diagnoses of schizophrenia, bipolar affective disorder, schizoaffective disorder and depressive psychosis. However, the majority of individuals participating in the AIMhi HSS project were diagnosed with schizophrenia.

7.3.4 Recruitment of participants

See Figure 2 for an overview of the recruitment process for interview participants. Key ethical considerations for this study and how they were addressed are included in Appendix K, with the relevant information and consent sheet. There were a number of reasons for approaching potential participants indirectly through their clinicians. It was expected that clinicians would be able to inform the researcher of people who they thought may be unsuitable to participate (for instance if a person was considered too unwell mentally to participate at a particular time). It was also thought that clinicians might have clearer insight into experienced negativity in relation to the Collaborative Recovery Model. Thirdly, participation in the interviews was voluntary and it was thought that participants

might feel more comfortable indicating their lack of interest to someone they were familiar with and who was not directly involved in conducting the research.

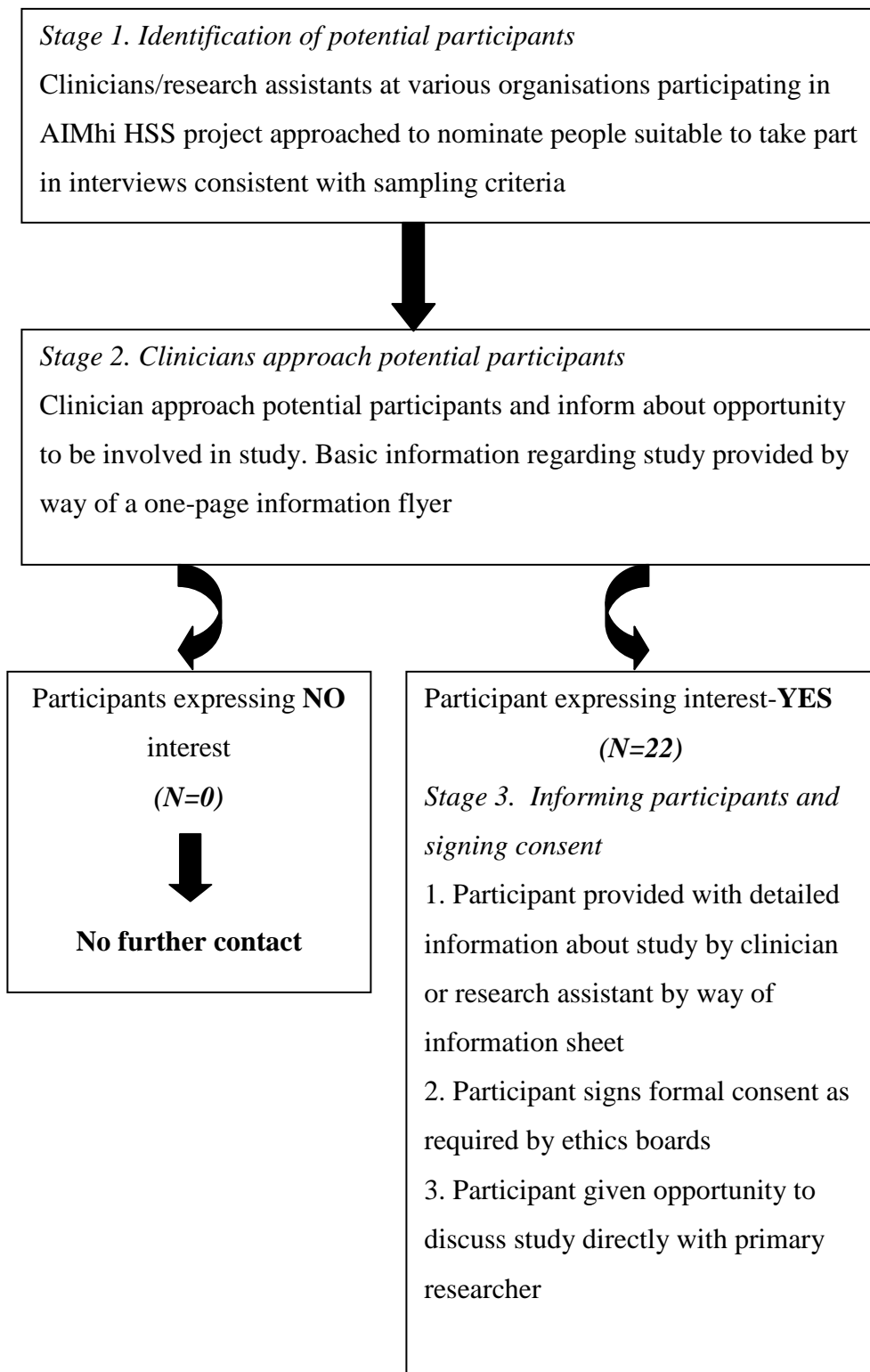


Figure 2. Overview of recruitment process for interview participants

7.3.5 Description of interview participants

All consumers taking part in the interviews were part of the AIMhi HSS project. Criteria for eligibility in this study are reported elsewhere (see section 4.2). From the sample of 22 interview participants, 12 (55%) were female and 10 (45%) were male. Participants had a mean age of 39.27 years with a SD of 8.71 years, closely comparable to the larger sample of consumers taking part in the AIMhi HSS project ($M=39.85$ and $SD=12.15$, at baseline). Diagnostic information for the 22 participants was collected from clinicians and is available in Table 11. Consistent with the larger population of consumers taking part in the AIMhi HSS project, the vast majority met the diagnostic criteria for schizophrenia. One participant met the criteria for both schizophrenia and schizoaffective disorder. Another participant met the diagnostic criteria for both schizophrenia and depressive psychosis.

Table 11

Diagnoses for consumer participants in interview study

Diagnosis	N and %
Schizophrenia	12 (54.5%)
Schizoaffective	1 (4.5%)
Bipolar	4 (18.2%)
Depressive	3 (13.6%)
Psychosis	
Multiple	2 (9.1%)
diagnoses	

Note. 22 consumers participated in interviews

Of the 22 interview participants, three reported that they had worked with more than one clinician as part of their involvement in the AIMhi HSS project. Of these people, one reported working with two clinicians, with the remaining two people reporting that they each worked with three different clinicians during their involvement in the project.

Data on number of hospitalisations over the past three years was available for 20 of the 22 participants, as reported by their clinicians. Number of hospitalisations for consumer participants ranged from 0-13 admissions over the previous three year period, with a mean

number of 2.9 per participant. A total of eight people reported no hospitalisations in the previous three years.

Consistent with key sampling criteria (see section 7.3.3) four consumers were nominated by staff as they were understood to have criticisms regarding their experiences of working within the Collaborative Recovery Model. Of these, two people were understood to have criticisms of certain key aspects, such as the homework activities or goal setting. The remaining two were recommended, as they were understood to be more generally critical of their experiences of working within the model.

An exhaustive review of all participants whom had dropped-out of the AIMhi HSS project (see section 7.3.3) as well as existing participants did not reveal any other people who met the ‘unhelpful’ sampling criteria at any other participating organisation. It needs to be kept in mind however that this is not necessarily an indication that there were no other people who had been unhappy with their experiences of the Collaborative Recovery Model as received in services. For example, a considerable number of participants on the ‘drop out’ list had left the mental health organisation they had previously been working with and were therefore unable to be contacted in order to enquire as to their experiences. It is also entirely possible that some people were unhappy with their experiences of the model and/or delivery of this model by staff, yet were not comfortable sharing these experiences as part of this study. A total of five people were recommended for involvement in this study based on their particularly positive experiences of the Collaborative Recovery Model as received in services when working with mental health staff.

Mental health service characteristics

The 22 interview participants were attending a non-government organisation, or one of two public mental health services in metropolitan, regional and rural areas of New South Wales and Queensland. Of these three services, all had multiple sites operating within the larger service. Participants were recruited from as many of the individual sites as possible (this included all four participating sites within one public mental health service, three out of four participating sites within the other public mental health service and four out of five participating sites within the non government organisation).

Service characteristic information was collected using the Dartmouth Assertive Community Treatment Scale (DACTS) (Teague, Bond, & Drake, 1998) for each participating service/organisation. Across the various organisations average caseloads for staff ranged from 10 consumers or less up to 50 consumers or more per staff (average caseload between 21-34 clients). Number of service contacts ranged from an average of 1-2 contacts per consumer per week, up to 4 or more contacts per week for some staff (average service contacts between 3-4 per week). The duration of these contacts ranged from between 15-49 mins per consumer per week, up to 2 hours or more per week per client (average duration of contact with clients was between 85-119 mins per week).

7.3.6 Interview procedure

A total of 22 interviews were undertaken between 19th April 2005 and 14th November 2006. Recommended length for interviews were in the range of 30 to 70 minutes, based on interview guidelines. The longest interview was approximately 1 hour, 30 minutes and the shortest interview was approximately 25 minutes. One consumer, who was one of the first people to be interviewed, was approached and agreed to be interviewed for a second time. This was seen as advantageous as there were additional areas of interest, which were not covered in the initial interview, which the primary researcher and consumer researcher desired to follow up.

Interviews were audio taped to allow for accurate transcription of individuals' experiences. Every attempt was made to interview consumers at a time and place convenient to them, where they felt most comfortable. This was discussed with interviewees on an individual basis. However, no people were interviewed in their home, this was a specific requirement of the ethics approval. In most cases people expressed a desire to be interviewed at the local mental health service that they were attending. In the Illawarra region four people chose to be interviewed in a room at the University of Wollongong.

Following participation in the interview, all interviewees were posted a \$10 money order and letter signed by the primary researcher thanking them for their contributions to the evaluation. They were also asked to indicate by way of a reply paid envelope if they wished to receive an overview of research findings down the track, and to specify whether they

were interested in being involved in study three (face-to-face focus groups) if the opportunity arose.

7.3.7 Leximancer text analysis and concept mapping

The primary researcher transcribed audiotapes from the 22 consumer interviews verbatim. Leximancer text analysis software v. 2.25 (www.leximancer.com) was employed to analyse interview transcripts and to visually display the extracted information plotted in terms of concept maps. Leximancer is a computer assisted text analysis program which performs content analysis of text using a machine-learning technique based on computational linguistics (Smith & Humphreys, 2006). Concepts in Leximancer are defined as collections of terms that provide evidence for the use of a concept in the text. They are found by taking an initial set of a few words or phrases (called seeds) commonly found in a text and using a machine learning program to find the optimal set of words related to those seeds (Smith, 2005). The operational method employed by Leximancer is performed in 6 key stages. For a detailed description of these stages the reader is referred to Appendix J.

One of Leximancer's main features is that it is capable of inferring the concept classes contained in texts, discovering and extracting a thesaurus of terms for each concept. This relieves the user of the laborious task of formulating their own coding scheme required when analysing qualitative data by hand (Smith & Humphreys, 2006). Once thesaurus learning has taken place concepts are coded within the text based on this learned information. Information regarding the relationships between concepts (i.e. the co-occurrence of concepts) is then used to generate a concept map that provides a birds-eye view of the data, displaying main features (concepts) and how they interrelate. Concepts are automatically grouped into themes to facilitate easier interpretation of results (Smith, 2005; Smith & Humphreys, 2006).

Leximancer is also designed to provide clear and transparent conceptual analysis of text. For example, any direct intersection between concepts can be explored at the document level by drilling down through the concept map results into underlying sections of text where concepts and words are found, using the Leximancer interactive browser. This allows the user to inspect the validity or nature of induced abstract relationships following

inspection of the concept space. The thesaurus of terms generated for each concept can also be directly examined facilitating an understanding of the usage and meaning of concepts identified in the text (Smith, 2005).

In brief using Leximancer words are essentially mapped to a much smaller set of concepts and relationships between concepts identified. Another key feature of Leximancer is that it allows users with knowledge of a particular domain to influence or customise concept definitions, hence focusing on particular concepts that they are interested in exploring (Smith, 2005). Using the customisation option the user can name their own concept/s of interest, selecting seed words and terms that are appropriate for learning the particular concept/s. Leximancer then takes these seed words and terms specified by the user and builds a thesaurus of words that are closely related by proximity to the concept generating a semantic profile. Concepts can then be explored with regards to their placement on the concept map and relationship with other key concepts identified in the text.

Conceptual and relational analysis

Leximancer software performs conceptual and relational analyses allowing the user to identify concepts in textual documents as well as how they relate. In conceptual analysis texts are examined for the presence and frequency of concepts. This is the most common form of content analysis. Relational analysis in contrast, measures how identified concepts relate to each other in the text. Two key types of relational analysis are performed by Leximancer, proximity analysis and cognitive mapping. Proximity analysis measures the co-occurrence of concepts found in the text. Cognitive mapping attempts to compress the information from co-occurrence matrix into a two dimensional visual form, displaying the main relationships between concepts (Smith, 2005).

Leximancer concept mapping

Cognitive mapping involves a visual display of the main concepts contained within a text and how they are related. Through the process of mapping Leximancer essentially attempts to compress the information generated from the relational analysis (relative co-occurrence frequencies) into two dimensions (Smith, 2005). Firstly links are created based on the direct

co-occurrence of concepts (the more times a concepts co-occurs directly with another the stronger the relationship). Secondly indirect relationships between concepts are established. This occurs when information about what is semantically related to a concept is connected to other concepts and their co-occurring words (Smith, Grech, & Horberry, 2002).

In summary concepts that appear in similar contexts (i.e. they co-occur with other concepts in a similar fashion) appear in close proximity, or cluster together on the conceptual space. Concepts that are directly related but not necessarily strongly semantically linked may appear far apart on the map. For instance the words eye and eyes may have no direct link in a text document (never appear together) but they may appear adjacent on a map (within the same thematic group) due to the similar contexts in which they appear. Likewise, in an analysis of political speeches, parties that discuss similar issues will appear closer together on the map than parties which have different agendas, due to semantic similarity (Smith, 2005).

For a strict interpretation of cluster maps the user is required to run clustering several times with the relative positioning of concepts being inspected on each occasion (rotations and reflections are permitted variations). Changes in gross map structure provide indication that some revision of Leximancer parameters is required prior to interpretation. Alternatively if relative positioning of concepts remains similar between maps this provides indication that the map is a stable representation of relationships between concepts and inspection and interpretation of findings is warranted (Smith, 2005).

Labelling of themes is facilitated by consideration of placement and relationships between concepts on the concept map and by drilling down and examining chunks of text where one concept co-occurs with another. This allows the user to interrogate the text and interpret it in view of his or her reading. Each theme is traditionally characterised by the most strongly connected concept in the thematic region (identifiable on the map as the concept with the largest circle).

Validation and application of Leximancer

Preliminary validation of Leximancer analysis software has been undertaken using a set of evaluation criteria for content analysis, appropriate for knowledge discovery tasks. This includes criteria such as face validity, stability (sampling of members), reproducibility (including structural validity, sampling of representatives, and predictive validity), correlative validity and functional validity (Smith & Humphreys, 2006). Existing published research is available, which has effectively and efficiently used Leximancer for the analysis of textual information (e.g. De la Varre, Ellaway, & Dewhurst, 2005; Martin & Rice, 2007; Scott & Smith, 2005).

Leximancer has been used widely in fields ranging from communication psychology, government, clinical psychology, literature and media analysis (Smith, Grech, & Horberry, 2002). Leximancer has also been used in health care settings. For example, for analysis of professional-patient interaction in clinical settings, hospital enquiry transcripts, video-cued recall examining doctor-nurse relationships and handover communication in intensive care cases. In addition Leximancer has also been used for speech pathology analysis of interviews of people with schizophrenia, as well as more generally by the Australian Council of Healthcare Standards (personal communication Andrew Smith, developer of Leximancer software, October 2006).

Advantages of Leximancer

Leximancer has demonstrated a number of advantages for textual analysis:

1. This analysis software removes the need for multiple coders as text segments are always coded in the same way, when parameter settings are the same (Smith & Humphreys, 2006; Watson, Smith, & Watter, 2005).
2. Provides visualisation techniques including cognitive mapping and bar charts that facilitate enhanced understanding for the user. This is particularly beneficial for complex information spaces and can generate new hypotheses for further investigation (Smith, Grech, & Horberry, 2002).

3. Allows for more rapid and frequent analysis and re-analysis of text. This makes it possible to analyse large quantities of text that would be impractical or even impossible to code and analyse by hand (Smith & Humphreys, 2006).
4. Provides the user with the option to undertake analyses with varying degrees of customisation from fully automatic analysis, to highly customised analyses using concepts specified in advance by the user (Smith, Grech, & Horberry, 2002).

Advantages of Leximancer for analysis of interview data as part of this study

Leximancer was viewed as particularly advantageous for analysis of interview data for the following reasons:

1. Option for concept mapping. Concept mapping is considered beneficial in aiding interpretation for the researcher as well as facilitating understanding and communication of findings to the reader.
2. Possibility to undertake analyses with varying degrees of user customisation relevant to this study in a timely and cost effective manner. This was particularly important for analysis three.

Analysis one:

Relevant research question: From consumer's perspectives, what do they actually receive when working with Collaborative Recovery Model trained case manager/s in mental health services?

This analysis focuses on obtaining a brief overview of participants' degree of exposure to Collaborative Recovery Model principles and components. This is undertaken in part by running a simple keyword search in Leximancer to locate information relevant to key parts of the Collaborative Recovery Model. Direct indicators of Collaborative Goal Technology and homework completion for interview participants were also observed. This initial analysis remains less focused on evaluative content, primarily explored in later analyses. There was a prior expectation that there would be a gap between the conceptual model (consistent with the staff training protocol) and consumer's experiences of the Collaborative Recovery Model as received in case management settings.

Analysis two:

Relevant research question: What are consumers' experiences of the Collaborative Recovery Model as received in services? This involves a particular focus on any *helpful* aspects of experience.

This analysis focuses on an overview of key concepts and thematic groupings discussed by consumers during evaluation of the Collaborative Recovery Model. Using Leximancer it is possible to run this analysis whilst remaining grounded in the data with minimal user influence (beyond some editing and merging of concepts). Concept mapping is viewed as advantageous to provide a bird's eye two-dimensional view of central concepts and relationships between concepts, facilitating ease of interpretation and communication of findings to the reader. In particular this analysis focuses on exploring in detail process information offered by consumers with respect to helpful relationships with staff and helpful aspects of experience regarding goal striving and homework components (key practical components of the model).

Analysis three:

Relevant research questions: What are consumers' experiences of the Collaborative Recovery Model as received in services? This involves a particular focus on any *unhelpful* aspects of experience.

From consumers' perspectives how can the Collaborative Recovery Model and delivery and use of this model in services be improved, to better support the recovery of people with mental illness?

This analysis focuses on exploring in detail any aspects of experience that consumers identified as unhelpful as well as any suggestions for improved practices. Leximancer was viewed as advantageous in this context since the user can seed in their own terms of interest, (such as 'unhelpful' and 'improve') that may occur only rarely in textual documents and are therefore unlikely to emerge as concepts were this option not available. In essence this level of customisation was considered desirable in order to locate information relevant to this area of interest, since overwhelmingly interviewee's spoke positively about their experiences of the Collaborative Recovery Model and its use in

services. In contrast less favourable aspects of experience and ideas around improvement were discussed much less often during interviews.

7. 4 ANALYSIS ONE: CONSUMERS' EXPOSURE TO KEY ASPECTS OF THE COLLABORATIVE RECOVERY MODEL

7.4.1 Method

Relevant data during this analysis was located in one of two ways. Firstly directly observable indicators for the return of goal and homework setting (from the AIMhi HSS project) were located and summarised across interview participants. Secondly Leximancer settings were customised to undertake simple key word searches for key parts of the Collaborative Recovery Model specified in advance by the user, e.g. responsibility, needs assessment, goals, homework and recovery vision (Leximancer has a setting which essentially allows the researcher to disable 'thesaurus learning-' whilst undertaking a simple key word search). For example, the concepts 'needs' and 'CANSAS' were entered manually by the researcher and thesaurus learning was disabled. This allowed Leximancer to search and locate all instances where participants had discussed needs assessments or more specifically the CANSAS consistent with the staff training protocol. The degree to which interviewees had engaged in this process with their workers was then summarised by the researcher. Steps undertaken in Leximancer specific to this analysis are available in Appendix M.

7.4.2 Findings and discussion

Exposure to Collaborative Recovery Model practical components

Not surprisingly summary statistics (available from AIMhi HSS project) for the return of more directly observable indicators of goal and homework setting indicated that for the 22 people participating in these interviews some participants had limited or no exposure to key components of goals or homework.

Goal striving and setting a recovery vision

Six out of 22 (27%) people interviewed had no documented evidence of a completed CGT (goal) sheet and 9 out of 22 (41%) of people had no written evidence of a recovery vision

(recorded on CGT sheets). These findings are comparable to the broader population of participants taking part in the AIMhi HSS project, which found that only 37% of participants completed at least some (defined as at least one) goal or homework sheets. Furthermore less than half the consumers participating in the project were making regular use of goal and homework components (Deane, Crowe, King, Kavanagh, & Oades, 2006).

Interestingly, findings from interviews indicated that some consumers who had not completed goal sheets/discussed recovery visions with their case managers had however, given consideration to these ways of working independently, in their own time. These findings are informative in terms of highlighting apparent valuing of these activities by consumers, independent of work being undertaken within case management settings. Discussion in some instances also highlighted the potential benefits around working on, or discussing these aspects with case managers, rather than in isolation. One participant said that she had typed some goals out on her computer and had been working towards these on her own, which she described as “satisfying”, however had since ceased this activity. Her discussions around goals striving clearly indicated that she clearly viewed this process as valuable and worthwhile, “without goals you don't have any direction in life, as I know that from personal experience, from how I am right now, so I would say that it is definitely important to set goals” (participant 7).

Another three people said that they had given consideration to their ‘recovery vision,’ despite having not discussed this with their worker. Of these one person said that her vision was “scrambled” in her head, identifying that documentation of her recovery vision may assist her to make it more concrete. She said:

Cause it's the act of writing and the act of seeing something on paper can make things seem more concrete than just muddled ideas in your head. It can help to get rid of the uncertainty that's part of it, whereas in my head the recovery vision is uncertain.
(participant 7)

Another participant said that they had an idea of what their vision would be however had not formalised it, or worked consistently towards it.

In contrast another consumer stated that she had a clear idea of her vision or dream for the future, which she had been thinking about for a period of years, but was yet to actualise this in practice. She indicated that she had not discussed this vision with her case manager, however thought this would be a good idea in assisting to turn her vision into a reality. When discussing the perceived benefits of discussing her vision with her worker she said, “I have been thinking of doing this for two years and what I do with things is I stew over them and (case manager) comes along and takes the stew away and says right, what do you think we can do?” (participant 9).

Homework

Two out of the 22 interview participants had no direct evidence of a completed homework sheet. Several participants also indicated that they had been setting and working on homework or exercises to improve their lives, prior to commencing this work with their case managers, thus emphasising the perceived value placed on these activities for these persons.

Needs assessment

Nine out of the 22 participants stated that they did not complete, nor have any memory of completing a needs assessment or discussing their needs with their worker (interviewees were visually prompted during interviews by viewing of the CANSAS). Limited recall around completion of this component is hardly surprising considering within the Collaborative Recovery Model training protocol for staff there is only an expectation that a needs assessment is completed once with consumers, prior to assisting a person to establish their goals. However, it is worthy to note that where feedback was provided in relation to needs based assessments, content of discussions offered by consumers were positive.

Three participants discussed the benefits of completing the CANSAS in terms of identifying areas of need which consumers and staff may otherwise have overlooked. For example, “just basic things like needs often get overlooked you know in the whole scheme of things, you know you are so busy trying to you know, get a career or whatever” (participant 5). Another participant highlighted that completion of these assessments was of

assistance when prioritising what they wanted to focus on with staff. For one person, completion of the CANSAS was viewed as particularly beneficial as they had difficulty verbalising their needs. This participant stated, “I am very quiet and I don’t speak up for myself a lot and when I get something written down on paper it helps the other person to understand what my needs are” (participant 19). One person suggested that it might be helpful if the CANSAS was completed more often, perhaps every six months as an indicator of progress. Further evaluation around this component was not possible in view of limited feedback.

Motivational enhancement

Motivational enhancement, another practical component of the Collaborative Recovery Model was not queried directly during interviews as it was considered difficult to assess (unlikely to be explicit and observable by consumers at practice level). Instead consumers were asked more generally about motivation within the context of their relationship with staff. Relevant findings with respect to motivational enhancement are discussed elsewhere (see section 7.5.2).

Exposure to Collaborative Recovery Model guiding principles

Qualitative evidence regarding exposure to guiding principles of the Collaborative Recovery Model, including emphasis on collaboration, responsibility, autonomy and hope was comparatively positive, when compared to practical components. These aspects are emphasised specifically during staff training in the Collaborative Recovery Model. For example the training program emphasises the individual nature and the need for ownership, of the recovery experience of the person living with mental illness. It also emphasises the importance of an effective working alliance and collaboration between case managers and consumers. For further discussion of the emphasis on the above recovery elements during Collaborative Recovery Model training see section 4.1.

Inspection of instances where participants discussed their relationships with staff revealed a common perception that case managers were working ‘with them’ and involving them in the decision-making process. One participant said of this process “they are bringing their

ideas, I am bringing my ideas...and most of the time, most of the time we are pretty much where we want to be” (participant 11). There was also consensus that this was an important aspect of the relationship, however one participant identified that this may not always be appropriate, depending on level of wellness over time. She said “I think there are people at different levels or stages of recovery, or even just extremely unwell where um they need their support worker to take over the decision making stuff, because they are just too unwell” (participant 22).

Evidence from interviews also indicated that consumers perceived that they were being encouraged to take responsibility for their recovery and their autonomy was being supported, within the context of their relationships with staff. One person clarified the importance of supporting autonomy saying “if someone gives you advice all the time that puts them in a position of power” and when describing her relationship with her case manager said, “she listens and she um asks me why I want to go off my medication, but she won’t actually advise me not to” (participant 7). Having a sense of responsibility or ownership over life direction was also identified as important during interviews. Consumers’ discussions with respect to ownership and self-responsibility and more specifically ways in which these processes were perceived to be supported, are described in more detail in a later chapter (see section 7.5.2).

In summary consumers exposure to the Collaborative Recovery Model, as expected, was limited within practice settings. This appeared to be particularly true within the context of practical components of goal setting-including establishment of recovery visions and needs based assessment, and to a lesser degree in terms of exposure to homework based tasks (motivational enhancement was not directly assessed). Evidence for ways of working consistently with guiding principles of the Collaborative Recovery Model appeared more promising, as discussed by interview participants. These findings are informative in and of themselves in terms of providing some indication of participants’ perceived exposure to key aspects of the Collaborative Recovery Model, within case management settings. These findings are also important in terms of providing a broad context for the analyses that follow, which focus on exploring consumers’ experiences of the Collaborative Recovery

Model as received in services, including process information with respect to helpful, as well as any less helpful experiences.

7.5 ANALYSIS TWO: CONSUMER CONCEPTS OF THEIR EXPERIENCES OF THE COLLABORATIVE RECOVERY MODEL

7.5.1 Method

This analysis was undertaken in order to obtain initial exploratory insights into the data set provided by interview participants. In particular this involved a broad overview of key concepts and thematic groupings discussed by consumers within the context of evaluating their experiences of working within the Collaborative Recovery Model with their case managers. It also involved detailed examination around helpful processes identified by consumers regarding their relationships with staff, and goal striving and homework procedures.

An overview of key steps undertaken when performing this analysis is outlined below. A more detailed technical description of step-by-step processes undertaken in Leximancer during this analysis is available in Appendix M. In addition See Appendix L for a detailed overview of key processes such as text preprocessing, concept editing, thesaurus learning and concept mapping as they apply to Leximancer.

Editing of stop words: During the text-preprocessing phase Leximancer removes frequent words arbitrarily designated as having little meaning. Following examination of the word list removal of some words was overridden (e.g. alone, together) as they were considered potentially meaningful based on pre-existing knowledge of the research domain/literature.

Removal of 'junk' concepts and merging/editing of concepts: During the automatic concept identification phase concepts are automatically generated from the text. Concepts generated by Leximancer during this stage were examined. Some concepts were deleted as they were considered irrelevant and provided little or no insight into the text. Merging of some concepts was also undertaken based on user knowledge of the research domain (e.g. merging of concepts case manager and support worker).

Thesaurus learning: During this stage a machine-learning algorithm is used to locate optimal thesaurus words from the text for each concept. Each block of text is then automatically tagged with the concept names from the analysis.

Generation of conceptual map/testing of map stability: The concept map is a visual display of key concepts, relationships between concepts, as well as thematic groupings. Concept map stability was checked using the reset and learn function. Relative positioning of concepts appeared similar between maps, taking into account allowances for reflection indicating that the map was a stable visual representation of relationships between concepts in the text.

Interpretation of concept map: Initial inspection of the concept map provided insight into key concepts raised by consumers and relationships between these concepts identified within the text. The thesaurus of terms for each concept was examined, assisting in interpretation of concept usage by interviewees. Direct relationships between concepts were also explored at the text level by drilling down through concept map results, into underlying sections of text where concepts and words were located. This process allows for a more thorough inspection of the validity and nature of induced abstract relationships proposed initially from viewing of the concept map. Labelling of the various thematic groupings was undertaken following interpretation of the concept map described above.

7.5.2 Findings and discussion

The concept map (see Figure 3) provides insight into relationships between concepts and key thematic groupings identified in the text (thematic groups are identified by circles and concepts are identified by individual dots on the map). Concepts in Leximancer are defined as collections of terms that provide evidence for the use of a concept in the text. Themes group together related concepts (i.e. concepts that co-occur with other concepts in a similar manner).

Six thematic clusters were identified and are clearly visible in Figure 3. Themes were labelled by the researcher following interpretation of the concept space. Interpretation of findings was facilitated in a number of ways including by examination of concepts thesauri and placement of concepts on the concept map (indicating direct and indirect relationships

between concepts). Further validation of induced relationships between concepts was undertaken by drilling down into underlying sections of text where concepts were located in order to establish meaning and usage by interviewees (using the Leximancer interactive browser). Following the interpretative process thematic groupings were subsequently labelled 1) moving towards a better life, 2) development of positive relationships, 3) case managers can offer support 4) present focus, 5) setting and working towards goals helps and 6) self responsibility.

As observed in Figure 3 there is much overlap between the thematic groupings indicating that whilst concepts formed various clusters, there were also strong relationships between them. A number of concepts are also visible positioned some distance from the central clusters and did not belong strongly to any thematic group (e.g. job, months, risks and comfort zone). These concepts are interpreted with respect to their direct-co-occurrence with other concepts (see section 7.5.2, p. 198). The six key thematic groupings will now be interpreted with respect to concept placement and inter-relationships between concepts. This was undertaken with a view to clarifying consumers' concepts of their experiences of the collaborative recovery model within the textual documents. There was also a focus on exploring process information relevant to consumer's helpful experiences to do with the therapeutic relationship, as well as goal striving and homework procedures.

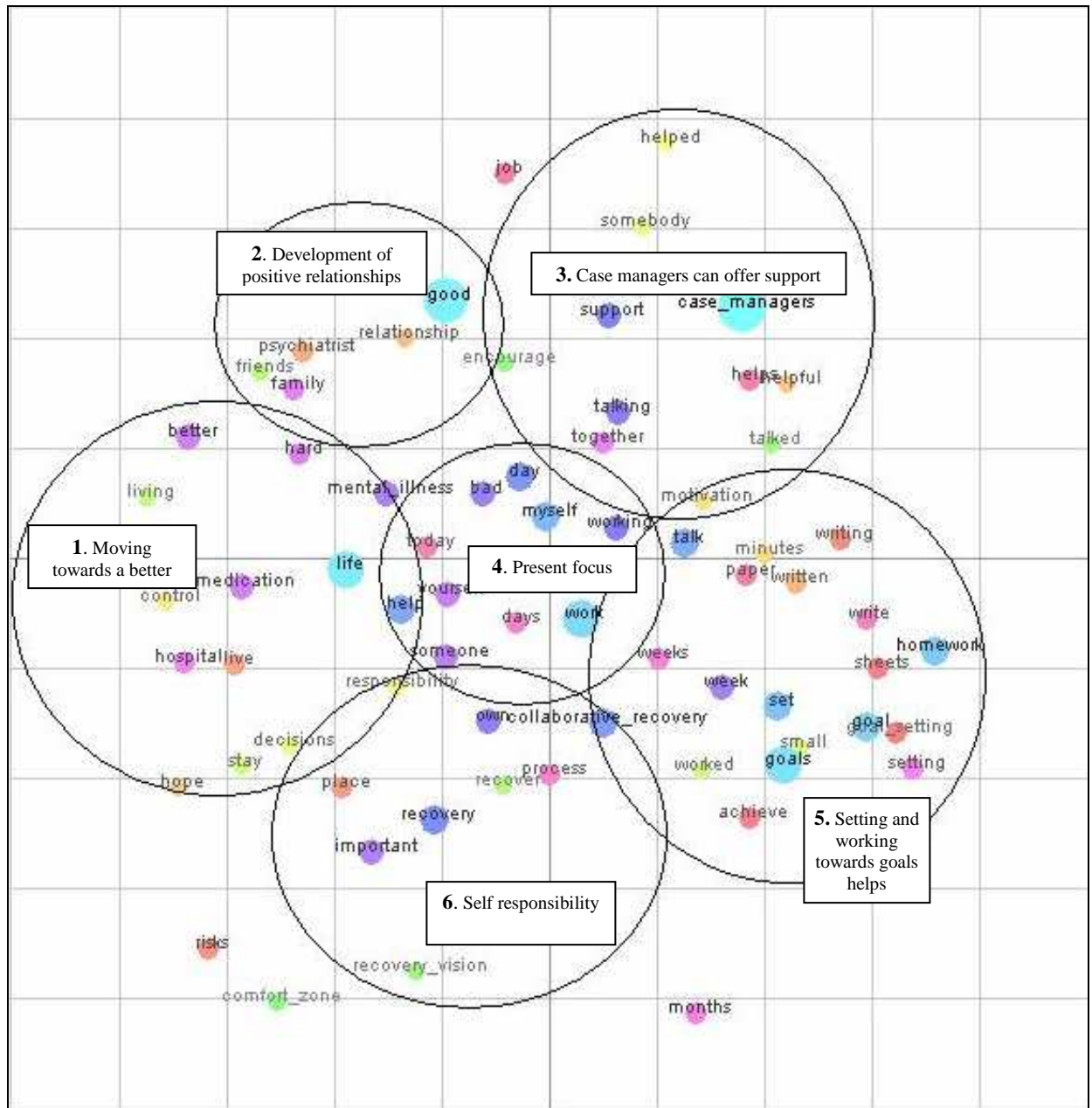


Figure 3. Key themes and concepts raised by consumers during evaluation of their experiences of the Collaborative Recovery Model when working with mental health staff

Theme one: Moving towards a better life

The concept life as referred to by interview participants was primarily used when talking about moving towards, or visualising a ‘better life’ in the future (see Figure 3, theme one). In the words of one individual “my life is pretty good actually, much better than it was three months ago, six months ago, nine months ago, it’s getting better and better” (participant 20). This was echoed in the words of others, for example “life is just so much better, but I have to keep on trying to improve, mentally I have my ups and downs” (participant 8) and “you live your life you don’t live your illness” (participant 10).

Several participants spoke about the lack of direction or disparity between their current situation and what they desired out of life. For example, “I just don’t know what I want out of my life. I wish I could get something out of my life but I just don’t know which way to go” (participant 1). Elsewhere this participant went on to discuss how her worker had set goals for her, indicating that she had not been involved in this process. She identified that the process of becoming involved in setting and working towards goals could potentially provide her with some hope for the future. When discussing goals another participant reflected on the gap between what he desired in life and his current situation, “long term goals to settle down have a family um to raise some kids, but ah presently my financial situation living where I am living, the only girls that ah seem interested are ah prostitute type...and ah, that is not what I seek in life” (participant 3).

Examination of usage of other concepts contained within theme one, such as ‘hard,’ ‘mental illness,’ ‘medication,’ ‘hospital,’ ‘stay,’ ‘hope’ and ‘control’ provided insight into the nature of factors that contributed to a ‘better life’ for participants in this study. One important factor identified by the majority of participants in terms of building a better life was finding ways to manage their illness, either by medication and/or by developing their own coping or management strategies (co-occurrence of concepts ‘mental illness’, ‘medication’, ‘life’ and ‘living’). The emphasis on personal management of one’s illness for participants in this study is also highlighted by the overlap with theme six (self responsibility).

Medication can assist to manage illness and move towards a better life

Six people mentioned medication as being one aspect that assisted their recovery, or helped them to move on with their life. For instance “my medication keeps me on an even keel every day, I will be on that for the rest of my life” (participant 21) and “I had the wrong medication... but now I have found the right medication and stabilised myself” (participant 19). Another person said “a lot of the game...your mental game in trying to get well is in the right medication, ah that’s important” (participant 8). Others stated that they were still trying to find the right medication and viewed that as an important part of their recovery, “my recovery would be good you know if I could get on the right medication cause the medication I am on now just does not seem to be working” (participant 1).

Personal strategies can assist to manage illness and move towards a better life

Twelve consumers alluded to the importance of finding personal management strategies either instead of, or in addition to medication in order to manage symptoms of their illness (co-occurrence of concept ‘mental illness’ with concepts such as ‘hospital,’ ‘life’ and ‘help’). One person spoke of the importance of developing their own personal understanding over time, of how to manage their illness and putting this knowledge into practice. At a personal level this was preferably undertaken without too much reliance on medication and moreover with respect to other personal management strategies. This person elaborates:

You know you get a diagnosis and you start to realise the extent of your problem and maybe some of the things that underpin it and then you start to realise you can actually do some things about that and you know you can do some things to aggravate it less, rather than aggravate it more and so on and so on and everyone is different, every single person has their own formula um so you have got to find yours um and then start putting some things into place. (participant 6)

Similarly another person emphasised the individual nature of learning what works for oneself over time with regards to mental illness stating, “a lot of times you learn from your

experience time and time again that certain things will make things worse, certain things will make things better and certain things help and certain things don't" (participant 17).

Another participant emphasised the importance of personal management strategies in addition to medication with respect to managing their illness "with medication and um symptom management, you know looking after my symptoms myself I can live a relatively normal life" (participant 13). Describing further what was meant by symptom management this person elaborated "you know like if I am getting anxiety attacks I will do something about and ah I will have a couple of valiums and I will put on some chill out music and then I don't have to go to hospital" (participant 13). Such experiences were echoed in the words of other participants with strategies used to manage illness varying widely among participants for example exercise, healthy diet, supporting other people, relaxation and contact with family and friends. Some people spoke more simply about the importance of learning how to handle their 'bad days' or 'down days' in order to remain well, stay out of hospital and prevent relapse. Elsewhere is a discussion of another consumer who spoke extensively about the exercises that he developed in order to "heal" himself (see section 7.5.2, p. 184).

Management of symptoms, either by way of medication and/or by development of other personal coping strategies is an important factor discussed by other consumers with respect to recovery (Deegan, 2005; Fisher, 1994; Mead & Copeland, 2000; Roe, Chopra, & Rudnick, 2004; Spaniol, Wewiorski, Gagne, & Anthony, 2002) and may allow people quality time to spend pursuing their life dreams and goals (Mueser et al., 2002). The emphasis on taking personal responsibility for one's recovery is also an essential philosophy underpinning the Collaborative Recovery Model. Working within this philosophical framework it is possible that case managers may have had some influence regarding consumers' use of personal strategies for management of their illness. The importance of what Deegan (2005) terms 'personal medicine,' defined as self-initiated non-pharmaceutical self-care activities was readily identified by a number of consumers in this study.

Gaining some control over symptoms and staying out of hospital

Use of the concept ‘control’ (see Figure 3, theme one) whilst not always made explicit, appeared to primarily be used within the context of discussing the importance of gaining some control over the symptoms of one’s illness and staying out of hospital, as an important part of the recovery process (observed following examination of usage of this concept with other frequently co-occurring concepts such as ‘hospital’ and ‘mental illness’). For example, one person said “now I am finding I am getting in control but I do have brief times where it gets out of control but not as bad as what it used to be” (participant 19). This perception was echoed in the works of others for example, “when I started getting out of control I would just head for the hospital” (participant 13) and “I have come good in the last two or so years but before that um my life revolved, I was in and out of hospitals, I was um seeing shrinks and ah I was living with my brother at the time and he didn’t understand and basically I have felt I had no control, I had no control at all” (participant 11). Gaining some sense of control and reducing time spent in hospital clearly becomes important with the focus on getting on with, or building a better life (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005).

Several participants identified that for them recovery was partly about staying out of hospital (reflected by close proximity of concepts ‘hospital’ and ‘stay’ in Figure 3, theme one). For example, “one of the things recovery means to me is staying out of hospital” (participant 13). Several other participants described that a positive thing about their lives was that they had been able to stay out of hospital, for example “I really have no big complaints to make, or I am not visiting hospital um much” (participant 20) and “well it can’t get any better, it is going to stay 99% sure as long as I abide with the medication I won’t be in hospital again” (participant 21). Likewise consumers in other studies have identified staying out of hospital as one important aspect of their recovery (Beeforth, Conlan, & Graley, 1994; Krupa et al., 2005; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Other people spoke about the possibility of living a meaningful life even with the disabling impact of their illness (co-occurrence of concept ‘mental illness’ with ‘life’/‘living’). As succinctly put by one person:

Just enjoy every day that you have that, that’s a good day and if you do have any bad days or it gets to the stage where you get sick again don’t hate yourself for getting sick but, cause you know you have done all the right things to keep well and that’s all you can do everyday, and just live everyday and you know, um life is important.
(participant 10)

Another consumer reiterated that mental illness did not have to be a “death sentence” and that it was important for each person to find their own formula to manage their illness in order to get on with their life, stating “ the illness doesn’t necessarily go away and it’s hold doesn’t necessarily lessen” (participant 6). Similarly in the words of another participant it was clear that getting rid of one’s illness was not a precursor to living a meaningful and fulfilling life, “I’m pretty happy with my life considering I am mentally ill and they haven’t got a cure for it, I am still quite happy with my life” (participant 15). These conceptual understandings of recovery are consistent with those emphasised to staff during Collaborative Recovery Model training. That is elimination of symptoms of illness are not a necessary precursor to recovery.

Building a better life is challenging

The use of the concept ‘hard’ (see Figure 3, theme one) appeared to encapsulate the difficulty, at times of attempting to get on with life within the context of living with a mental illness (note close proximity of concepts ‘mental illness’ and ‘hard’ in Figure 3, theme one indicating the relationship between these concepts, supported by textual review). Consumers spoke about various aspects of their life that were disrupted, or became difficult because of their illness. This included five people discussing the difficulty of goal striving during periods of illness with comments such as, “if you have got mental illness it is hard to achieve some things because it is an erratic sort of state that you are always in...so achieving little goals is sometimes hard” (participant 20) and “it can get hard sometimes

(goal striving), it can get hard especially if you are not going, if you are unwell” (participant 19). Whilst the concept goal is not located directly within this theme (rather within theme five) the conceptual relationship between ‘hard’ and ‘mental illness’ was revealing of this aspect for participants.

Two people discussed the difficulty of forming relationships when living with mental illness. For example:

Relationships and mental illness don’t go very well together and I certainly think that is true...friendships are difficult as well and if you make friends with people that also have mental illness, sometimes then they start becoming unwell and then you start getting lots of calls and things and then you have to back off as well, it is a very tricky world with relationships and mental illness I think. (participant 6)

Similarly another person said, “mental illness can be quite severe and change your personality so that you can’t make friends, cause you can’t, um you can’t even vocalise your thoughts” (participant 13).

One woman spoke about the impact of her mental illness, in particular anxiety on her ability to travel to and from work “I do work part time which I’m at this afternoon, days like this afternoon I think why the hell do I bother, this is so hard and I, um, oh the money is good but you know I don’t know that other people have to put up with what I have to, just to be able to walk home from work or whatever and I think oh shit this isn’t worth it” (participant 17). Another person spoke more generally about the difficulty of recovering from mental illness, “it’s been I guess complex and really hard for me ever since ...I had a major psychosis a few years ago and was hospitalised” (participant 5).

Having hope for a better life

Placement of the concept ‘hope’ within theme one (Figure 3) captured the importance of hope within the context of visualising a better life, or more simply being alive (co-occurrence of concept ‘hope’ with concepts ‘better,’ ‘life’ and ‘living’). Indeed a life

without hope was discussed as futile, “hope you can't live without hope” (participant 6). Similarly another person elaborated:

It is hopeless people who are hopeless without hope that commit suicide, so um that is how devastating it can be to be without hope, so I wouldn't say it is important, I would say it is essential to have hope, because without it you just get stuck in that bog and you can't move on. (participant 7)

One person linked the existence of hope to her ability to visualise a pathway towards a better life, “it is good compared to how it has been before to have feelings of hope that my future might be better, or that I can work to make a better future” (participant 7). Other research undertaken with consumers emphasises the importance of having hope for the future in terms of providing motivation for day-to-day life (Borg & Kristiansen, 2004).

A number of participants in this study emphasised the importance of staff members at times ‘holding hope’ for them when they had no hope for their own lives (co-occurrence of concepts ‘hope’ and ‘mental illness’). For example, several people discussed the likelihood of losing hope during times of illness stating “when you are really acutely unwell there is no bloody such thing you know, you are just in the middle of your illness and for me that is depression, so there is no hope” (participant 17) and “hope sort of disappears somewhere when you are not doing too well” (participant 22). At such times it was stressed as particularly important that a significant other was available to offer hope to the person. For example, “the person may not have any hope but um that means that you have to have hope for them and it's just simple you know, they may be too busy just trying to stay alive” (participant 17) and “they are there for the strength, they help, they have got strength and I lean on her strength” (participant 19). Other research has emphasised the importance of professionals, particularly during times of illness as ‘holders of hope’ (Borg & Kristiansen, 2004; Glover, 2002). The role of hope in recovery, and more specifically with reference to case managers role in supporting hope, is emphasised during staff training in the Collaborative Recovery Model.

Case managers were described as supporting hope in various ways including staff's own demeanour and positive attitude and energy towards life, by assisting people to clarify their desired life direction and encouraging them to work towards this, through general encouragement and recognition of achievements, by assisting people to focus on the positives in their life as opposed to the negatives and for one person by raising the possibility of achieving employment in the future. Hope instilling strategies such as recognising achievements and providing encouragement, supporting the person to focus on the positive, assisting in clarifying direction and purpose in life have been mentioned by other authors (Jacobson & Greenley, 2001; Russinova, 1999).

Use of the term 'life' was at times preferred over the term 'recovery'

Examination in relation to use of the concept 'life' (Figure 3, theme one) revealed that some participants seemed to favour the use of the term 'life' over the term 'recovery', highlighting differences in language used by interviewers and interviewees. This became evident when examining instances where the concept 'life' occurred with other concepts including 'goals' and 'own'. For instance four participants talked about the importance of 'taking responsibility for their life' when asked by interviewers about 'responsibility for recovery'. For example, "it's important that you take responsibility for your whole life" (participant 10). An additional four people used the term life, as opposed to the term recovery when asked about their goals or recovery vision. For instance one person talked about their "life goals" (participant 7) and another about their "goals in life" (participant 4). Other participants talked about moving towards their 'life vision' as opposed to their 'recovery vision'. For example, "I feel very strongly on that one, what my vision is in life and it is just to be at peace" (participant 19).

A number of other participants spoke about the importance of goals in terms of providing direction for their lives (see section 7.5.2, p.191 for further discussion). Whilst these participants did not specifically use the terms 'life goals' or 'life vision,' use of language in these contexts raises the possibility that other participants may also favour the term life over the term recovery.

Another study undertaken in Australia with 57 people with schizophrenia likewise found that many consumers in their study appeared uncomfortable with the word recovery, instead making reference to “getting on with their lives” (Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003, p. 76). Differences among language used by consumers and researchers and preferences for the use of the term ‘life’ over the term ‘recovery’ appears consistent with at least some people in this study. Consumers in other studies have spoken about the importance of “getting on with life,” and the perceived role that professionals can play in encouraging this process (Noordsy et al., 2002).

Theme two: Development of positive relationships

Theme two (Figure 3) most strongly reflects consumers’ perceptions of positive relationships when working with mental health staff trained in the Collaborative Recovery Model. To a lesser degree it also captures the importance of relationships with significant others including family, friends and psychiatrists. The concept ‘friends’ was also used within the context of describing the nature of relationships with mental health staff.

The concept ‘good’ within this theme circle reflects broadly consumers’ positive perceptions of and importance placed on relationships with significant others (note the close proximity of concepts ‘good’ and ‘relationships’ within theme two). Whilst the concept ‘case manager’ was not observed directly within this thematic circle, a strong relationship between these concepts was clearly evident from observation of the frequency with which the concept ‘case manager’ co-occurred with the concept ‘good’ and direct examination of text segments where these concepts co-occurred in the text. This relationship is also evident with respect to the close location and overlap between themes two and three in Figure 3.

When discussing their relationships with their case managers consumers reflected positively on the nature of these relationships with comments such as, “my relationship was one hundred percent, it was good” (participant 14), “I found her to be really great” (participant 5) and “I have an excellent relationship with X (case manager)” (participant 22). One consumer highlighted the importance of developing a strong working relationship

as central to other work that occurred between case managers and consumers stating, “I don’t think collaborative recovery would work if you had a case manager that was inept” and elsewhere “I keep saying it but a lot of it depends on the relationship between the case manager and the client” (participant 8). The concepts ‘family’, ‘friends’ and ‘psychiatrist’ were also located within this thematic circle.

Features of helpful therapeutic relationships

Key factors raised by consumers when describing positive working relationships with staff included those who offered encouragement and support, provided assistance with practical problems and difficulties in day to day life, staff who were described as ‘friends,’ or identified as ‘friendly’, staff who ‘heard’ people or listened carefully, importance of respect and trust and encouraging self-responsibility.

Four participants used the concept ‘friends’ when describing the relationships that they shared with particular case managers. Another four people described their relationship with staff as ‘friendly’, emphasising friendliness as one important aspect of the relationship. For example, “I see her as a friend and more than a support worker, I see her as a support worker sometimes but I see her more as a friend” (participant 19) and “we walk together as friends” (participant 9). One participant described her relationship with her worker as being akin to a friendship, at the same time identifying the professional barriers that existed:

It feels like I am walking side by side with somebody...actually it is good because case managers are like friends, but to me you never invade a case managers territory, like um you don’t ask what their family are like, what’s their husband like you know...it may be one sided but um it’s, it’s, that’s the best kind of friendship you can have with a case manager. (participant 10)

Whilst other people did not describe their relationships as specifically analogous to friendships, language indicated that relationships were sometimes viewed along similar lines. For example, one person described his relationship with staff as something like a cross between a father and uncle. Another person elaborated:

She (case manager) has been as close as anyone has ever been...I mean she is a mother, she is a grandmother, she has got the mothering instinct and the desire to protect me...she is the first person I would approach if I wasn't sure about something.
(participant 22)

Other research examining consumers' perspectives reveals that helping relationships are often described as like, or akin to a friendship (Chinman, Allende, Bailey, Maust, & Davidson, 1999; Kisthardt, 1993; Krupa et al., 2005) and peer-like 'friendliness' has been identified as an important feature of helping relationships (Beeforth, Conlan, & Graley, 1994; Borg & Kristiansen, 2004). Description of relationships as like that of a friendship likely reflects the closeness and intimacy of relationships that were formed between some workers and consumers, as perceived positively by consumers in this study. The Collaborative Recovery Model training program strongly emphasises the importance of developing and maintaining a strong working alliance.

Important to consider in view of this finding is that a number of interviewees spoke about the difficulty encountered around forming relationships when living with mental illness (see section 7.5.2, p.168). Whilst not directly stated it is possible that the perception of case management relationships as being described as akin to a friendship by some consumers may, in part, reveal that this aspect of life may be lacking. This is supported by statements such as "she has been my sole consistent person in my whole life" (participant 22). In the words of another person "a lot of people don't have many friends" (participant 20).

Other authors have similarly suggested that given the difficulties that people with mental illness often experience in terms of developing relationships, it is hardly surprising that some consumers view relationships with staff as filling a social void in their lives (Buck & Alexander, 2006; Krupa et al., 2005). One author suggested that development of supportive and trusting relationships with staff may be necessary for some people as a precursor to building other meaningful relationships in the community (Kisthardt, 1993). Other researchers have proposed that it is unsurprising that consumers view relationships with

staff as akin to friendships, when these relationships are based on trust, empowerment and healing (Curtis & Hodge, 1994).

Six participants raised provision of encouragement and support as a valued aspect of the relationship (and elsewhere more extensively with specific reference to goal striving-see section 7.5.2, p. 178). For example, “she will go you are doing well, she is always encouraging me” (participant 14) and “I think people need plenty of encouragement, I think people need to be told they can get better” (participant 7). Other research undertaken with consumers has identified the importance of feeling supported and encouraged within relationships with staff (O'Brien, 2001; Russinova, 1999).

Five people mentioned the benefits of having someone who could assist them with practical problems or difficulties that arose in their everyday life. Assistance with problems and needs of everyday living has been emphasised as one valued aspect within relationships with staff, noted by consumers in other studies (Beeforth, Conlan, & Graley, 1994; Chinman et al., 1999; Leiphart & Barnes, 2005; O'Brien, 2001).

Being heard, or having their case manager listen carefully to what they were saying was raised as particularly important by four participants. One person said of the importance of this process:

I have got on really well with both of them (case managers) because they listen, they have become a sounding board for me...just having them there listening it makes a big difference to hear yourself saying what you are actually talking about.
(participant 15)

One participant when discussing his relationship with his worker stated that his worker did not always appear to listen and respond appropriately to his concerns, discussing that it left him feeling a “little bit bruised,” and less likely to raise other pressing concerns with staff. When discussing his experiences he said, “there were a couple of things I told him that he never listened to, he was sort of um, I repeatedly asked him about it and um it was forgotten

about” (participant 13). Feeling heard or being listened to is one important aspect of the helping relationship mentioned by other consumers (Beeforth, Conlan, & Graley, 1994; Glass & Arnkoff, 2000; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Shroder, Ahlstrom, & Larsson, 2006; Ware, Tugenberg, & Dickey, 2004). In a study undertaken by Redko et al., (2004) the key area of dissatisfaction mentioned by consumers when describing case management services was whether staff listened to, or talked to them adequately.

Several people mentioned the importance of mutual respect and trust within their relationships with staff. Of trust one person said, “it’s like a basic human need that you need to trust someone...you won’t develop any intimate kind of relationships if you don’t trust people” (participant 7) and elsewhere, “without it I wouldn’t be able to open up and say what I really feel and some of my feelings are things that I don’t want to share with just anyone” (participant 7). When discussing the importance of respect another interviewee said, “you have to have a mutual respect...it is respect for one another’s point of view” (participant 8). Other studies have identified trust and respect as important features of helping relationship mentioned by consumers (Borg & Kristiansen, 2004; Chinman, Allende, Bailey, Maust, & Davidson, 1999; Krupa et al., 2005; O’Brien, 2001). See section 7.6.2, p.193 for discussion of encouraging self-responsibility as another important aspect of the therapeutic relationship raised by consumers in this study.

Importance of relationships with family and friends

The concepts ‘friends’ and ‘family’ were also used when discussing the importance of more traditional relationships outside of mental health settings (see Figure 3, theme two). Three people spoke about relationships with family/friends as being an important area of focus for their goal strivings as part of the AIMhi HSS project. For example, “long term goals to settle down, have a family, um to raise some kids (participant 3) and when discussing her goals another said, “meeting new friends and that was really important” (participant 10). Another participant spoke more extensively about a goal that was particularly meaningful in his life, to do with regaining contact with his son:

Seeing my son is a big part of my life and um I couldn't work out a way of um getting to see him, I couldn't work out a way of um getting to see him and ah she (case manager) sort of made it number one priority and that, that pushed me further to try and find a way of getting down to see him and I achieved that. (participant 8)

Other people spoke more generally about the key role of relationships in their lives. For instance "I had a lot of support from my dad, my dad sort of walked me through a lot of the hard times" (participant 13). One participant spoke about a new partner that she had met and the positive impact of that relationship in terms of both her mental and physical health. In contrast another participant spoke about her feelings of loneliness and isolation in the community and her desire to meet a partner and to have a relationship, "I am frightened I am going to be on my own for the rest of my life, that frightens me a lot" (participant 1). When describing a particularly inspirational friendship one person elaborated:

Every now and again you get two guys that get really close to one another and really understand one another, but with him it was total acceptance, total acceptance of my mental illness...it didn't worry (friends name)... he treated me as a person, yeh in a way we loved one another like brothers. (participant 8)

Other research with consumers has emphasised the important role that relationships with family and friends can play with respect to recovery (Cradock, Young, & Forquer, 2002; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003; Topor et al., 2006). However, relationships with family members and friends as discussed by some consumers in this study did not have a positive impact on their lives. Negative aspects raised by consumers with respect to relationships are discussed elsewhere (see section 7.6.2, p. 216).

Relationships with psychiatrists

Two people mentioned relationships with their psychiatrists as one helpful factor that contributed to their recovery. Another person stated that his relationship with his psychiatrist changed for the better, only following the development of positive relationships with his case managers involved in the AIMhi HSS project. The foundation for this change

came when he realised that “what I am saying is important to these people” (participant 15). Elsewhere when describing his relationship with his psychiatrist this person elaborated:

Because I have had that relationship with them (case managers) I am much more myself with my psychiatrist. Like normally I would just go in and sit there and especially when, you know for the first, up until the last couple of years um I wouldn't have much to say or anything like that, I'd, I'd be paranoid out of my head but I wouldn't tell anybody or anything like that, um but now I tell my psychiatrist things because of my experience with AIMhi (HSS project). (participant 15)

However the greater majority of people in this study described unhelpful and often unequal relationships with psychiatrists, in particular with regards to decision making around psychiatric medications (see section 7.6.2, p. 216 for further discussion).

Theme three: Case managers' role in supporting better lives

Theme three (Figure 3) encapsulated the positive role that case managers played within the context of providing consumers with necessary support, encouragement and motivation to achieve their goals and move towards a better life (see location of concepts 'helps', 'helped', 'helpful,' 'encourage,' 'support,' 'case managers,' 'motivation,' 'together,' 'talking,' 'talk' and 'motivation' located within theme three, Figure 3). Importantly consumers valued staff members who supported the goal striving process, working with them rather than doing things for them (evident from location and usage of concepts such as 'together,' 'support' and 'helps' in Figure 3, theme three). This was achieved through the simple process of assisting consumers with goal setting, as well as talking about, reflecting on and encouraging goal progress. Some consumers valued more direct practical assistance from staff when working towards their goals in the community. This involved consumers and staff working alongside each another in order to help consumers take steps towards their goals and building their confidence in the community. The emphasis on personal responsibility and collaboration emphasised here is consistent with the guiding principles of the Collaborative Recovery Model.

Other research undertaken with consumers has emphasised the role of professionals in supporting and engaging the individual's capacity towards recovery, as opposed to doing things for them (Borg & Kristiansen, 2004) and the role of this process in terms of allowing consumers to focus on what is important in their lives (Raponi & Kirsh, 2004).

A number of participants spoke broadly about the role of case managers in assisting people to move on with and improve their lives. For example, "when you have got a, a good case manager and everything it allows you to focus on certain areas of your life that you want, that you want to improve on, or certain areas of your life that you want to achieve" (participant 8). When describing the role that he envisaged was most important for case managers another participant elaborated:

Helping someone achieve one of their dreams, encouraging, encouraging people to have a vision of what they would like their life to be, not just what the regimented life is and um coaxing them out of their cocoon and helping them ah live their dream. If you get someone to um achieve their dream you are going to help them tenfold more than just giving them a pill. (participant 13)

Support and encouragement helps when working towards goals

It was clear from consumer discussions that participants both valued and placed importance on the support of staff within the context of engaging in goal striving as part of the AIMhi HSS project. One person said "goal setting we are doing are part of my recovery, it helps me to be independent and it ah helps that I get some support from my support worker" (participant 19). Another person spoke about how having her case manager support her with the goal striving process made the process more enjoyable.

A number of people discussed how sharing their goals with staff meant that their goals were given greater personal importance or value. For example, "if you are not doing it with somebody else it doesn't give it that, that much importance" (participant 10) and "if we both have a common goal then that sort of becomes stronger if two people are working on the same thing" (participant 7). When discussing goal striving with staff another person

elaborated “well it’s good you feel that somebody cares about it and, and in a lot of cases it is personal, it is between you and your case manager, it is not the sort of thing that you go out and ah tell everybody in the world” (participant 8).

Other participants discussed how talking about and sharing their goals with staff provided them with the motivation and encouragement they needed to continue. For example, “it is good if you can get a bit of assistance with it, because when you do that it gives you more motivation” (participant 10). Another person when discussing the benefits of setting and working towards goals with staff said, “she helps me with the motivating and encouraging me, encouragement, I get a lot of feedback from the support worker cause the support worker has ideas too” (participant 19).

A number of participants also placed importance on staff support with respect to setting, engaging in and reflecting on regular homework activities (when moving towards their goals). Discussion with staff appeared to provide enhanced motivation and commitment when engaging in these activities. One person said “with the goal stuff I get a bit slack and I sit there and she says come on lets do it, I don’t like other people telling me what to do, especially when it’s supposed to be my support but also I need somebody else to give me that, that positive spin on things”(participant 17). This sentiment was echoed in the words of others:

While all this stuff is happening in your life when your worker comes and says well you know here is your goal, did you get it done and you actually reflect back...it said to do it every morning you look back and you go what was I doing every morning, where was I at, where was my head at...so it is good, it is reflective. (participant 20)

Likewise another participant when discussing the benefits of setting homework with staff said, “you talked about that and you think I had better do it, you know it’s a commitment, it helps you commit to something you know” (participant 11). When discussing how mental health staff could most effectively support her recovery one person said simply “by

encouraging me when I do it (homework) by recognising if I have achieved something” (participant 7).

Other studies have found that consumers value the support of staff with respect to the goal striving process (Hendrickson-Gracie, Stayley, & Neufeld-Morton, 1996) and the role is often one of providing encouragement and support (Tunner & Slazer, 2006). The goal striving literature also emphasises the value of receiving support from significant others when working towards goals, leading to enhanced well-being (Little, 1989). A study undertaken with people with mental illness found that people with more satisfactory social support networks were more likely to be focused towards goals and success (Corrigan & Phelan, 2004). Other research has emphasised the importance of provision of verbal praise and encouragement from staff with respect to homework completion (Glaser, Kazantzis, Deane, & Oades, 2000).

Several participants spoke about the work that they had done independently of their work with staff with respect to setting and working towards goals and visualising their recovery vision. Feedback on these processes provided direct and indirect support with respect to the potential value of sharing such processes with significant others. One consumer, who did not engage in goal striving with staff spoke about her valuing of this process and the steps that she had taken towards setting and working on goals independently. However, she also stated that after a short period she lost ‘motivation’ to continue working towards her goals. Whilst she did not directly state that staff support would have been beneficial during this process, reflection on this process indicated this to be the case. She said, “all I know is when I think of them, my head is all jumbled and I don’t know where to start and um like my house is in a big mess and um, it’s like I have lost the focus and I don’t know how to get it back” (participant 7). Another participant indicated that whilst she had not discussed her recovery vision with her worker that she thought that the process of sharing it would be beneficial in assisting her to focus on the practicalities of how to work towards realising her vision in her life.

A number of people spoke about their need for more direct practical support from staff when working towards their goals in the community. For example, one person spoke about her need for practical support from staff to attend a group at her local community centre, with a longer-term goal of attending on her own. She said, “I couldn’t get enough courage to go there by myself but I am hoping one day that I will but first I will have to go with the support worker just for the first day... build up my own courage, my courage so I have a feel of what it is like” (participant 19). Several other people indicated that practical assistance from case managers in the community was important in assisting them to achieve their goals. One person said that without the visits from her case manager and practical support she would not have the motivation to get out of bed in the mornings. Similarly another person said, “I get motivated when (case manager) comes around because you know...you look forward and you go oh well...well what have I got to do?” (participant 20). Consumers in other studies have emphasised the importance of case managers working side-by-side with them to achieve certain goals in the community (Angell & Colleen, 2007).

Theme four: Present focus

Theme four (Figure 3) highlighted consumer discussions around the work that they were doing in their immediate lives, on a daily or weekly basis in order to achieve their goals. This primarily included, but was not limited to homework that they were undertaking as part of their involvement in the AIMhi HSS project. The focus on the ‘here and now’ within this theme is evident by location of concepts such as ‘today’, ‘day’, ‘days’ within theme four, Figure 3. Also dominant within this theme is the emphasis on personal ownership over this process (i.e. the person actively taking small steps to improve their own life). This emphasis on personal ownership is evidenced by the usage of concepts such as ‘myself’ and ‘yourself’ located within theme four. The link between undertaking regular ‘work’ and the goal striving process is further highlighted by the overlap between themes four and five. A smaller sub theme within this broader theme encapsulated the volunteer work or activities that some participants were engaged in, in order to assist other members of the community.

Encouraging self responsibility through homework striving

Enhanced sense of ownership and responsibility that can be gained from engagement in homework activities was emphasised both through the process of setting particular homework tasks, as well as actual task completion. The degree to which participants were involved in the process of selecting their own homework was captured in part by the use of concepts emphasising ownership such as 'own' and 'myself' co-occurring directly with these concepts. For example, participants discussing their 'own homework.' In general feedback appeared to indicate that the greater the level of consumer involvement when engaging in homework setting, the more these process were valued by consumers.

For example, one participant when describing the process of setting homework with staff said "(my case manager) suggests how about we do this for homework and is that ok and I can say yes or no, and I normally say yes but I guess if I wanted to I could say no" (participant 7). Particularly revealing was that this participant identified one instance where she had been involved in selecting her own homework task. When speaking about the positive nature of this experience she said "just the way that I did it myself without anyone helping. Like it was my own initiative and my own thoughts that went into it so I was self motivated the way I did it" (participant 7). This participant went on to discuss how she would like more involvement in designing homework tasks with her worker. Similarly when describing the importance of personal involvement in assigning homework another participant said "you have got to have that, it is building insight of what you need to do to help yourself" (participant 13).

Another participant spoke about how he had total responsibility in selecting his own homework, with no input from his worker. When reflecting on this process he elaborated:

She would just sit there quietly and let me think about what I want to do for the homework so, so that she was actually refraining from having any sort of um direction, setting out the direction for me. (participant 15).

This process was described as “empowering”, with this participant describing how this process had given him the confidence to speak about his illness, and ways in which he was learning to manage it in his own life.

Other research has emphasised the importance of involving consumers in the development of homework tasks as much as possible, for example by offering a number of possible homework tasks and allowing the person to select the one that appeals the most (Glaser, Kazantzis, Deane, & Oades, 2000). Findings from this study suggest that at least for some participants it may be favourable to allow consumers even greater involvement in selection of homework tasks. For example, staff encouraging consumers to come up with their own ideas for homework tasks in line with particular goal strivings. Where necessary staff could provide options for homework tasks and encourage increased consumer involvement in selection of homework activities over time.

Other participants spoke specifically about how ‘homework’ or the process of taking smaller daily steps towards their goals encouraged them to become involved in their recovery process. One participant said of homework:

It gives me more, I was going to say discipline but maybe it is more control, well it gives me something to work towards and by completing it I am showing that I can control certain aspects of my life...it’s good, it’s a positive thing it’s um, it’s important too because you need that kind of self determination to um get better. (participant 7)

Another person described homework in the following way:

In a way that is like a teaching thing and you know thinking what have I got to do today um and when...the longer I looked at it the more it would you know engage my mind to think in that way, to approach the day with well this is my relevant goal and this is the day I am doing it on. (participant 20)

Engagement in day-to day work outside of therapeutic relationship

Whilst the concepts ‘work’ and ‘working’ were most strongly tied to homework activities within the context of the AIMhi HSS project, this was not always the case. Some participants talked about the work they were currently doing, or had previously undertaken independently of staff, in order to improve their lives. For instance one person spoke about the work he had undertaken to develop ‘exercises’, over a period of years to support his healing and to reduce his paranoia, “as I went ahead in trying to heal myself...I became more motivated sort of thing through, through sort of trialing these exercises I, I developed myself” and elsewhere when describing these exercises, “I have got my writing and I have developed my own art form of writing which is combined with music” (participant 15).

Similarly, another person spoke about the journals that he had been writing over a period of many years to assist with his recovery, “I have got a stack of journals a couple of foot high so I have been writing them for quite a lot of years, so it is just one of the ways that I would use to try and get things, to make sense of things” (participant 6). One participant spoke more generally about steps she was taking to actively manage her own mental health, “I have some difficulties but I am working on that, um I am doing the best I can...I end up ah coping with my down days, finding ways to cope with them by myself” (participant 19).

Mental illness and negative impact on life

The concept ‘bad’ (located within theme four, Figure 3) was used by some participants when describing difficult periods of time that they had experienced with respect to their illness. For example, “well I have had a pretty bad week where I have been hearing voices where I want to kill myself and I am just not happy with me life at the moment” (participant 1) and “I have had a pretty bad week this week but um...like I am always flashing back, I don’t know if it’s reality or just a hallucination” (participant 16). That is whilst interviewees generally appeared to speak positively about their experiences of moving towards a better life, there was a recognition among some people that they continued to experience challenging and difficult periods with respect to their illness.

Helping other members of the community

A smaller sub-theme in theme four involved a number of participants speaking about their role in supporting/helping other people (co-occurrence of concepts ‘help’, ‘someone’ and ‘work’). In total 7 out of the 22 people interviewed spoke about their role in helping other people in the community, primarily people with mental illness. Two of these people spoke generally about the value in assisting other people with mental illness through taking part in research activities, such as interviews as part of this study. Remaining participants spoke about their role in supporting others through a wide range of alternative avenues.

For example, one person spoke about her goal of writing an autobiography to help others living with mental illness. Another interviewee spoke about how she had found meaning in assisting other vulnerable members of the community through her volunteer work for meals on wheels (meals on wheels is a community based organisation that operates to provide meals and social support to people in need). One person spoke about her role as facilitator of Internet support groups for depression. Still another person discussed how he valued the contributions that he was able to make through his ministering role as part of his church, encouraging and assisting other people in need.

Consumer quotes provide some insight into the meaningful nature of this activity for participants. For example, one consumer when describing reasons for writing her autobiography stated “well it's, it's sort of, it is religious and about my life and um... help other people who have got similar problems and backgrounds as what I have had” (participant 14). Another participant discussed the personal meaning derived from helping others:

I run um support groups, ah forums on the Internet, I have got six of them and that is what keeps me going because I get up in the morning and I am there, and the best ever way to get out of depression is to help others, it works all the time. So what I will do is I will start answering their posts, and, and sharing with them and everything and then I get distracted because they are in need for me at that moment in time, um, that is what keeps me going. (participant 22)

Other authors have identified the value and meaning consumers often derive from supporting or helping other members of the community (Deegan, 2005; Jacobson & Greenley, 2001). In a study by Deegan (2005), almost half of the 29 participants mentioned that they were working in some way or another to assist others. This was discussed in terms of having a flow on effect, in that it effectively led to them helping themselves. Jacobson et al., (2001) state that many consumers report that a powerful form of connection is supporting others with mental illness. This can occur in many ways, for example through advocacy or through telling their stories. In the goal striving literature self-concordant goals, such as those that include helping others or the community have been linked to more sustained effort over time, more satisfying daily experiences and changes in global well-being (Sheldon & Houser-Marko, 2001).

Theme five: Setting and working towards goals helps

Theme five (Figure 3) highlighted consumer discussions around the perceived value of goal striving, including breaking down goals into smaller homework tasks within the context of moving towards a better life (see location of concepts such as ‘goal,’ ‘goals,’ ‘goal setting’ and ‘homework’ within theme five). Feedback with respect to the perceived value of goal striving and homework was positive in the vast majority of instances. For example, one person said, “I think it is probably an important part of life to set yourself some goals” (participant 12). One person placed particular emphasis on the personal nature of goals and success as being individually determined:

Anyone who is successful in life and there is all different kinds of success, whether it’s like you know being a gold medal Olympic athlete or you know just being a good parent or studying or whatever you want to do, being healthy, um anyone who achieves things in those areas has normally set goals and without goals you don’t have any direction in life. (participant 7)

A limited number of participants raised concerns to do with either homework or goal components. However, this appeared to be more to do with the actual design of CGT and homework sheets utilised as part of the AIMhi HSS project, as well as ways in which these

aspects were offered by staff and less about the actual processes of goal striving per se (see section 7.6.2 p. 182 & 192 for further discussion). Whilst the concept ‘months’ did not appear directly within this theme it was located in close proximity and was used by consumers when talking about their three monthly goal strivings as part of the AIMhi HSS project.

Some consumers showed preference for the term ‘goal’, or alternate terminology when referring to homework

When examining use of concepts ‘goal,’ ‘goals,’ and ‘homework’ within the text it was observed that many participants appeared to be using the term goal, or a derivative of this term (such as mini goals, small goals) interchangeably to refer to both goal and homework based activities. This was primarily evident from temporal cues (e.g. discussion of daily or weekly activities) and by checking interviewer dialogue (e.g. whether interviewee asked about homework). For example, “one of my goals was for this week, this fortnight” (participant 15) and “so that’s my goal and I have to do it today” (participant 20). Other people used the terms ‘exercises’ or ‘tasks’ when referring to homework. For example, “since I started doing the exercises” (participant 15) and “tasks each week” (participant 17). For consistency the term homework will continue to be used in the remainder of this thesis to describe this aspect of the Collaborative Recovery Model. It is recognised however, that there were observed differences to do with language usage when describing this aspect among interviewers and some interviewees in this study.

Benefits of engaging in goal striving and homework

Theme five also provided insight into key factors mentioned by consumers when discussing benefits of engaging in goal striving and homework processes. This included but was not limited to a personal sense of achievement and growth (see concept ‘achieve’), benefits of committing goals and homework to a written format (see concepts ‘paper’ and ‘write/‘written/writing’), goals as providing a sense of direction for life (co-occurrence of concepts ‘goal/goals’ and ‘life/living/live’) and perceived value of breaking down goals into smaller more regular tasks (see concepts ‘small’ and ‘goals’ located in close proximity). The role of homework and goal striving in encouraging self-responsibility

during recovery is discussed elsewhere (see section 7.5.2, p. 182, 186 & 195). Other key areas are discussed briefly below.

Positive feelings of achievement and personal growth

One benefit of goal striving raised by eight participants was the positive feelings of achievement and growth that could arise from completion of longer-term goals, as well as smaller homework tasks. One person discussed how goal striving had positively impacted on his relationship with staff stating, “(the Collaborative Recovery Model) made it a good association with him because he was seeing me grow and I was growing and there was a sense of growth and accomplishment” (participant 13). Another person similarly emphasised the feelings of growth that could arise from engagement in the goal striving process, “these are the things that I have identified that I need to be doing to make me feel good, or to make me feel better or um to help me feel like I am growing as a person” (participant 17). One participant said that she thought that the opportunity to reflect on personal achievements in relation to goal progress could be of particular benefit when feeling depressed and hopeless, “at the stage where you feel helpless and hopeless and lost and you think nothing is working, you actually have this in front of you and can say well I did this or that” (participant 22).

Other people made more general statements about the positive feelings of achievement from completion of goals and homework such as, “I have achieved a lot of my goals, it feels good cause um I know that I can do this” (participant 14) and “it made me feel good when I, when I achieve something” (participant 18). When discussing homework completion one participant said that he felt “proud, achievement, a sense of achievement...it is a small achievement and it gives some satisfaction” (participant 3). Another person said of homework, “nibbling away you get some sort of enjoyment, small scale” (participant 9).

One person said that his case managers belief that he was capable of achieving his goals instilled in him, early on in the goal striving process a strong sense of achievement, “he

thinks that I am capable of meet, meeting my goals and that instils in me a sense of achievement, just his, him thinking that way, that I am capable of doing it” (participant 9).

Committing goals and homework to a written format

Participants discussed a range of benefits around committing goals/homework to a written format in terms of providing clarification, motivation and aiding memory. When describing how documentation of homework tasks provide a much needed source of motivation one person said:

That’s where the AIMhi comes in, that’s where that sort of works quite well, you know so I have got it on paper, I have to get off my bum and do that this week...when it is in writing and in your face you know and you talked about that and you think I had better do it you know, it’s a commitment, it helps you commit. (participant 11)

Other people discussed how writing down their goals provided personal clarification as to what it was that they wanted to work towards. For example, one person stated, “seeing it written down on paper, it helps um to digest what the goals are I would like to get done” and elsewhere “I think the most, most helpful is because you put that, down things on paper” (participant 10). Another person when discussing the benefits of writing a recovery vision within the CGT said, “it’s the act of writing and the act of seeing something on paper can make things seem more concrete than just muddled ideas in your head” (participant 7). One participant emphasised that writing down her goals was helpful in clarifying this process for both herself and her worker, “to see them on paper and for the support worker to see what we need to work on” (participant 19).

Written documentation of homework was also viewed as beneficial in terms of aiding memory and ensuring completion of tasks. For example, one person elaborated, “I am the sort of person that needs something to jog your brain and having paper work and having paper work to do with mental illness, that’s good. It makes you, it stimulates you brain” (participant 10). Similarly another person said “having it on paper it’s easier to look back

and read it and you don't have to remember it at all, you can just like refer to it on paper" (participant 7).

Other people discussed the value of homework in terms of setting out a documented plan around what needs to be done for the week "he puts it on paper yeh and then I can see myself and think oh right I can do that next week, or that one next week" (participant 9) and in the words of another:

The positive side is it offers a discipline to stick to, it offers written down what you have to achieve, when it has to be achieved by, how long it will take, what you have to do and more or less, so it is a written down discipline. (participant 3)

Other authors have suggested that people with schizophrenia in particular may experience cognitive deficits that may make homework completion difficult. Therefore written documentation of homework activity is most likely to be important, serving as a useful visual prompt aiding memory (Deane, Glaser, Oades, & Kazantzis, 2005; Glaser, Kazantzis, Deane, & Oades, 2000).

Breaking goals down into small regular steps

A number of participants spoke specifically about the benefits of breaking down their goals into smaller daily or weekly tasks or activities. Several people discussed that for them this process was not only helpful, but also a process that they had not previously engaged in prior to taking part in the AIMhi HSS project. For example, one person said, "like I have done goals before I went into hospital and um but since, since...doing AIMhi you know it's in detail, yeh I really enjoy it" and elsewhere "having the small goals is excellent and having the big ones." (participant 14)

Another person when discussing how working with staff trained in the Collaborative Recovery Model differed from his previous experiences elaborated:

This was totally different you know like the fact that everything is down on paper and as I said when it comes to your homework you can say yes I will do this, I will do that, yeh it became more structured than sort of ad hoc. (participant 11)

One person when reflecting on goal striving and the downside to this process with respect to mental health services stated, “to me it can be used quite poorly, as in you put down what your goals are and ignore it for three months, I mean that is no different to any other mental health service” (participant 17). Such feedback clearly emphasises the value of assisting consumers to break down goals in smaller, more regular steps that can be completed on a daily or weekly basis.

Other people spoke more generally about the importance of breaking down goals into smaller steps. For example, “little goals can lead to bigger goals and help you get motivated once you start to achieve the little goals” (participant 7). When discussing the benefits of taking small steps towards his goals another person stated:

It was a good reminder to constantly keep on the task where I was heading, those goals, to be constantly reminded and go well alright I have got to do this week, ah I don’t feel like doing it but I have got to do it to get where I am going. (participant 13)

Goal striving and homework provides life direction

A number of participants stressed the importance of goal striving and setting smaller homework tasks in terms of providing a sense of direction for life. For example, one person stated that without goals “you are just drift, drifting through life and things pass you by and you never really get anywhere you’ve sort of wanted to be” (participant 5). Another person when conceptualising the importance of engaging in the goal striving process said that it assisted him to assess, “where I was heading with my life, things I wanted to do with my life, um dreams and wishes” (participant 13).

Insight into the perceived lack of direction that may arise from having no clear goals in life was also reflected in the discussions of several participants. One person said “without goals

you don't have any direction in life as I know that from personal experience, from how I am right now so I would say it is definitely important to set goals"(participant 7). Similarly another person spoke about her lack of direction in life stating, "I just don't know what I want out of my life, I wish I could get something out of my life but I just don't know which way to go" (participant 1). Elsewhere this participant went on to discuss how her worker had set goals for her, indicating that she had not been involved in this process. This same participant identified that the process of becoming involved in setting and working towards goals could potentially provide her with some hope and direction for the future.

A number of participants spoke specifically about how their involvement in the AIMhi HSS project and completion of goals and homework had provided an avenue for visualising and moving towards a better life. In the words of one person "with the AIMhi we worked on little steps you know about recovery, you know, you know what would make life better for you" (participant 20). This viewpoint was echoed among others. For example, when discussing the key benefits of involvement in the AIMhi HSS project another person said, "just to have a direction in life no matter how small it is, it's been good to go forward" (participant 12). Other consumers have identified the importance of goals in terms of providing a sense of direction for life (Kisthardt, 1993).

Some people made particular mention of homework as something that helped them maintain their sense of direction in their day-to-day life. When discussing the benefits of homework one person elaborated:

They really force you to look at your behavior like what are you doing with your day to day life...like if you just sort of live your life day to day you don't really take stock of things but when you actually sort of have something set down, that I am going to walk on these days and when you are actually trying to stick to a plan um yeh it's just very, it can be very challenging. (participant 5)

These views were echoed in the words of other participants. For example, “without the homework I didn’t feel as much sense of direction” (participant 7). Similarly another person when discussing homework stated:

It’s good to get your life together but it’s still hard walking out that front door in the morning and saying I have to do this today for myself but, but um it’s either that or you say I am going to sit in this chair all day and do nothing, so with me I would rather be doing something than nothing and with AIMhi I suppose in a way it keeps you pumped up. (participant 10)

Theme six: Self responsibility

Theme six (Figure 3) highlighted consumer discussions around the importance of being encouraged to take responsibility or ownership over one’s recovery process (see location of concepts ‘own’, ‘responsibility’, ‘recover/y’ and ‘process’). This was achieved in several key ways within the therapeutic relationship, including staff offering options and encouraging people to come to their own decisions. Responsibility was also facilitated through the process of engaging in goal striving and supporting people to take smaller steps towards their goals. For a number of participants an important aspect of their recovery was having their own place or home in the community (see location of concept ‘place’).

Importance of self responsibility

Consumer discussions clearly indicated that they believed that it was important that they had a sense of ownership and involvement in their recovery process or direction of their lives. For example, one person said “it has taken a long time for me to realise how important it is to rehabilitate myself mentally and to physically do it” (participant 14). In the words of another, “I do have to take some responsibility for my own life...it is important that I learn to just yeh, just to take responsibility for my own actions” (participant 5). Similarly another person stated “it is important to be a couple of things, to become involved in your own recovery, and secondly to develop, just how it develops I am not sure, a sense of having something to contribute” (participant 15). One person when discussing

her relationship with her case manager and importance of supporting independence in the community offered:

Fortunately she doesn't act like what, you know would, know as an ACT worker because she doesn't come in and do it. Sometimes I really, there are a few times when I will be so exhausted I can hardly speak and she has been kind enough to actually just cook dinner for me and plop me in front of it, but it is an extremely rare occurrence, like once or twice in eighteen months. (participant 17)

Several participants emphasised that whilst it was important for workers to encourage responsibility that this did not mean that support from staff was removed, or necessarily ceased. For example, when discussing relationships with case managers one interviewee said "they are not so professional that they you know insist that you take every action yourself because when you are mentally ill it doesn't work that way you need support"(participant 20). Similarly in the words of another participant:

Just taking responsibility for yourself as much as you can- I hate it when people say that it all has to come back to you, but it's not that I'm, I really would like to think that I um, you know, get rid of support workers and that kind of stuff but I don't think that is going to happen...you can't do it all on your own sort of thing. (participant 17)

Responsibility has been emphasised widely in the consumer literature as one important aspect of recovery (Marsh, 2000; Mead & Copeland, 2000; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Consumers in one study described recovery as requiring action, or just "doing it". Whilst participants in this study had some concerns for their future they also had hopes and dreams and recognised the importance of taking action, with a view of moving towards a better life (Borg & Davidson, 2008). Responsibility for recovery is identified as a key process in the stage model of recovery, particularly in the preparation, rebuilding and growth stages (Andresen, Oades, & Caputi, 2003). Personal responsibility is also a guiding component of the Collaborative Recovery Model emphasised during staff training. Training recognises that

whilst there is an emphasis on personal responsibility that this does not imply that recovery needs to occur in isolation, instead highlighting the positive role that staff can play in supporting consumers recovery.

Staff supported consumers' responsibility within the therapeutic relationship

Case managers encouraged self-involvement within the relationship in a number of ways. Many participants discussed how their work as part of the AIMhi HSS project and in particular breaking down their three-monthly goals into smaller more regular homework activities supported them to take responsibility for their own lives (see section 7.5.2, p.182 for further discussion of this aspect). This relationship was evident within theme six by studying instances of co-occurrence between the concepts 'own' and 'collaborative recovery'. The strong relationship between ownership and goal striving/completion of homework is also highlighted by the overlap between themes four, five and six in Figure 3.

Some consumers discussed one of the main benefits of involvement in the AIMhi HSS project with regards to encouraging self responsibility. For example, one person stated that the personal highlight of being involved in the project was "the thinking for myself" (participant 9). When discussing the perceived value of the AIMhi HSS project another participant elaborated:

You had to look inside and say what I need in my life or what do I, what do I have to work on and that was one of the positive points of the whole project that I was being insightful to what I needed to do to help myself. (participant 13)

Discussion of his behaviour prior to taking part in the AIMhi HSS project provided further insight into the positive change that had occurred for this person:

Whereas before I would ask someone, I would leave it to the nurses or the doctors and say I don't care, I just don't, I just don't know what to do and it raised the idea in me that I could change my life and how it progresses. (participant 13)

Similarly another person emphasised the value of self-involvement in the recovery process when describing his positive experiences with the AIMhi HSS project. He said, “as I went ahead in trying to heal myself it sort of became obvious that maybe AIMhi would be good for me” (participant 15) and elsewhere:

I have these exercises and I have developed them myself and it is only because, through chance or whatever but also AIMhi um has encouraged me, that I have developed this sort of idea of being involved or having something to contribute. (participant 15)

Case managers more generally encouraged self-involvement by refraining from telling people what to do, instead offering options and letting people arise at their own decisions within their relationship with staff (co-occurrence between concepts ‘decisions’ and ‘responsibility’). One person said of his workers “they don't tell me what to do, they, they always take the back seat, um, um they, they know when to intervene um, they um let me express myself” (participant 15). Similarly another person stated that his case manager was “really, really good at, at basically letting you come to your own kind of conclusions about things. So you don't feel like you are being told and therefore there are no real conflicts” (participant 6).

Other consumers discussed the importance of having staff offer them options whilst allowing them the autonomy to arrive at their own decisions. For example, one person said of staff “she offers me options with a full understanding that maybe I won’t go for them”(participant 22) and in the words of another “she is there to offer I guess um a listening role and um to put her suggestions as she sees, but she’s, you know she is hearing my side of the situation” (participant 5). Similarly another consumer elaborated “he says these are the options that you have and you can choose to take them up or you can choose to leave them where they are, but it is your choice in the end” (participant 9). This process was described as empowering.

One participant provided an example of an instance where her case manager had supported her autonomy around decisions to do with her medication. She elaborated:

I tell her stupid things that I am going to do, like I want to go off my medication and all that and she doesn't say to me don't do it, she doesn't advise me not to do it, she just um she listens and she um she asks me why I want to go off my medication but she won't actually advise me not to... if someone gives you advice all the time that puts them in a position of power. (participant 7)

In contrast one consumer mentioned his concern that some people's case managers "just push you know, they don't actually ask you exactly what you want to do, they will just say you are doing this" (participant 11). This person went on to state that his own case managers had in contrast encouraged him to arrive at his own decisions, thus supporting his independence and sense of responsibility over his own life.

Having your own place or home in the community

A number of participants spoke about the importance of having their own place, or home as one important aspect of their recovery (co-occurrence of concepts 'own' and 'place' in theme six). For three people this was a goal that they had already achieved in their lives, for another three participants it was something that they were currently working towards. For example, "it feels good having my own place" (participant 18) and "I would like a place of my own" (participant 8). One person stated that his preference was to have his own place, however he was currently living with other people with mental illness and felt that he lacked choice in these regards.

Several other people discussed a personal goal with respect to achieving financial ownership of their own home, as opposed to renting. For example, when discussing their long-term goal one person said, "to become self-sufficient in the community and get to the point where I can buy my own home" (participant 3). For another person her long-term goal with respect to owning her own home was viewed as financially out of reach. Other research has identified that an important goal often mentioned by consumers is to find a place of their own (Kisthardt, 1993). One study found that independent housing increased individual's sense of control over their own lives (Krupa et al., 2005). Similarly for many

participants in this study having their own home appeared to be linked to a sense of responsibility and ownership in the community.

Exploration of concepts ‘job’, ‘comfort zone’ and ‘risks’

Additional concepts including ‘job’, ‘comfort zone’ and ‘risks’ were located outside the key themes visible in Figure 3. They are interpreted here with respect to their relationship with other key concepts.

Obtaining work

Whilst obtaining work or paid employment were not directly asked about during interviews they were discussed by many participants, most commonly within the context of talking about their goals or longer-term recovery vision. See location of concept ‘job’ adjacent to theme circle three in Figure 3. The concepts ‘work’ and ‘working’ located within theme circle four also picked up on some participants talking about employment either in a paid or voluntary capacity, however this was not the main usage of this concept (see section 7.5.2, p.184 for further discussion of concepts ‘work’ and ‘working’).

Five participants spoke about obtaining paid employment within the context of discussing their goals. Some participants had already achieved this goal. For example, “well where I am working that is what I want to do, storeman and packer, I have been there what, five years. It is a permanent job you know, permanent part time, so that is what I wanted” (participant 21) and in the words of another person “I have got a job now and that was one of my goals” (participant 16).

However the majority of participants in this study spoke about finding work as something they were currently working towards. One person said, “getting a job is you know like a year of work away” (participant 20). Another participant spoke about employment as something that she had been able to achieve within her longer term recovery process, however discussed that a recent relapse had meant that she had been unable to continue working at present, “I think in the last six months, yeh the end of last year I um, I got a job...I held them but um I had a relapse so I stopped doing the jobs” (participant 14).

Three consumers spoke about their desire to obtain paid work within the context of discussing their recovery vision, again emphasising the longer-term nature of this process. For example, one person spoke about her longer-term recovery vision in terms of travelling around Australia with her partner whilst earning money as she went. She identified the necessity of undertaking several years of study in order to obtain paid work, eventually making her dream a reality. Employment has been emphasised in other studies as one important aspect of recovery which can provide meaning in life (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Shepherd, Murray, & Muijen, 1995). Paid employment has also been linked to increased empowerment (Resnick, Rosenheck, & Lehman, 2004), higher self-esteem (Mueser et al., 1997) and is likely to lead to improved well-being and social inclusion in society (Boardman, Grove, Perkins, & Shepherd, 2003).

A number of participants stressed the importance of work in terms of financial incentive and providing activity during the day. For example, when discussing the benefits of work one person said, “it’s the money I earn, it’s not only that just too, I always think that it works best because you have got something to do in the morning” (participant 21). Another participant spoke about his desire to find work in terms of providing activity for the day “you need activity otherwise you send yourself up the walls” (participant 16). Four people identified that one of the reasons they had, or desired paid work was so that they could do the things that ‘normal’ people were able to do in the community. Economic benefit is one factor influencing consumers desire to return to work mentioned in other studies (Boardman, Grove, Perkins, & Shepherd, 2003)

However work, as discussed by some consumers within this study was identified as an avenue for experiencing meaning in their lives and did not necessarily involve traditional paid work but also volunteer work in the community. One person when discussing a longer-term goal spoke about his desire to find an avenue by which he could “contribute” when engaging in work. He did not rule out the possibility that this would involve paid work however this was clearly not the most important factor. He said, “it could be in volunteering, it could be in writing something that somebody enjoys, it could be in having a paid job” (participant 15). From his discussion it was clear that finding an opportunity to

contribute and give to others was clearly the definitive factor driving his incentive to work. A further 7 out of the 22 people taking part in this study spoke about their work regarding helping other people in a volunteer capacity, primarily people with mental illness (see section 7.5.2 p. 185 for further discussion). Other studies have identified that some consumers find participation in volunteer work particularly meaningful (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Mental health staff have a key role in assessing and assisting consumers to return to relevant work, either directly or by way of referral to specialist employment services in the local community (Boardman, Grove, Perkins, & Shepherd, 2003).

In summary, having a job or engaging in work was not necessarily tied to financial reward for participants in this study. It also included volunteer work in the community. Work was valued for a range of reasons including financial gain, providing activity for the day and as an avenue whereby people were able to give to and assist other members of the community.

Stepping out of your comfort zone and taking risks

When discussing risk taking with respect to their recovery, many consumers used the phrases getting out of your ‘comfort zone’ or ‘challenging yourself,’ or a similar combination of these terms to describe this process (see location of concepts ‘risks’ and ‘comfort zone’ located in close proximity below theme six, Figure 3). For example, one person said “there is a place for comfort and everyone needs it but um if you stay in, in your comfort zone all the time then you are not challenging yourself and I think it is important to challenge yourself in life, it’s part of moving forward” (participant 7). Similarly another consumer elaborated:

I think recovery has to be about growing and um so yeh, you are not really challenging yourself if you don’t take those risks, you, you are sticking to what you already know and perhaps that’s what’s part of the problem in the first place is that, that there is not enough there to sustain you in what you already know, you need to venture out and explore...try something different. (participant 5)

Stepping out of your comfort zone or challenging oneself was viewed as a valuable process, linked to processes of self-growth and personal development as evident from the quotes above. Other participants' comments further reinforced the value of this process as an opportunity for self-development. For example, "you have got to get out of your comfort zone sometimes to um learn new things and um progress" (participant 13) and "it's what makes you stronger" (participant 19). Similarly another person said "nothing can give you that sense of what you are capable of without taking those risks" (participant 17). It has been suggested that risk is inherent in the experience of life (Mead & Copeland, 2000) and without risk there cannot be personal progress or development (Roberts & Wolfson, 2004).

One person discussed a major challenge that she had undertaken to do with travelling overseas on her own and reflected on the way that this had impacted both on her own, as well as other person's views of what she was capable of achieving:

It made me realise if you don't take risks you can't grow a better understanding of who you are. You know like...service providers you know might have this really narrow view of what you are capable of and if you take risks and they come off you have managed to expand that completely...even for yourself and for other people to show...and say look I did it. (participant 17)

In contrast several people mentioned that one potential downside to challenging yourself, was that a particular risk may not always come off. In some instances this could result in a relapse or making your mental health worse as a result of attempting something and not achieving it. Four people emphasised the benefits of having the support of mental health staff in order to step out of their comfort zone and challenge themselves. For example, "the other thing is not to take unsupported risks, like to actually use your support workers so that you can step outside what is comfortable just in case something goes wrong" (participant 17). When discussing her relationship with her case manager another person said:

It does make me take risks but not dangerous risks just risks in the sense of going out of my comfort zone and doing something that I need a bit of pushing to do, something that is positive but that I probably wouldn't have done without that encouragement.

(participant 7)

Several other people discussed that the support provided by case managers allowed them to challenge themselves in aspects of their life that they would not normally have attempted on their own.

When discussing risk taking one person stressed the importance of the person ultimately being in control of decisions around whether to proceed with a particular challenge. He spoke about how in his relationship with a previous case manager (not involved in the AIMhi HSS project) that he was pushed into commencing study and the detrimental impact of this process on his recovery. He said of this process:

I think it hurts the recovery, you know like um it can push you right backwards. Like this course I would go there, I did it for about two weeks or three weeks, a couple of times a week but no, it was just too much for me, you know at that stage um I was thinking, but I was pushed, but I didn't have any say in that...it made me even worse.

(participant 11)

7.6 ANALYSIS 3: UNHELPFUL ASPECTS OF EXPERIENCE AND SUGGESTIONS FOR IMPROVED PRACTICE

7.6.1 Method

This analysis proceeded as per analysis two, with the additional steps as outlined below. A detailed outline of all steps undertaken in Leximancer is available in Appendix M.

Diverging from the previous two analyses Leximancer settings were customised in order to search for instances in the data where consumers discussed any unhelpful aspects of experience and suggestions for improved practices. The focus on 'unhelpful' and 'improvement' based aspects of discussion raised by consumers is consistent with the overall aims of this research. That is, to obtain information that can contribute to the ongoing improvement of the Collaborative Recovery Model and its delivery and use in

services. The research also provides general insights into how practices can be improved within case management settings. This information was not readily accessible in earlier analyses since aspects relating to unhelpful experiences and suggestions for improvement occurred rarely in the text. As a consequence, these elements did not emerge as automatic concepts on the concept map.

In order to gain insight into unhelpful and improvement based aspects within the text two user defined concepts ‘unhelpful’ and ‘improve’ were manually created by the researcher (the ‘user defined concept’ option is available at the concept editing stage in Leximancer). Additional terms relevant to these user-defined concepts were added in order to improve the likelihood of locating all relevant sections of text. Identification of other relevant seed terms were located in a number of ways. Firstly examination of a thesaurus provided insight into other potentially relevant terms (e.g. terms such as ‘advance’ and ‘progress’ were added to concept ‘improve’). Secondly the frequent word list (listed under the ‘concept editor’ in Leximancer) was reviewed to identify additional terms that were considered potentially relevant (e.g. the terms ‘prefer’, ‘better’ and ‘change’ were added to the concept ‘improve’). Thirdly, interview transcripts were manually inspected by the primary researcher to examine any other additional terms used by consumers within the context of describing unhelpful experiences or improvement based aspects (e.g. terms such as ‘develop’ and ‘rather’ were added to the concept ‘improve’ and terms such as ‘frustrating’ and ‘annoying’ were added to the concept ‘unhelpful’).

This analysis was also re-run with interviewer dialogue left in the analysis (i.e. interviewer tag not selected as a ‘kill class’ under locate concept occurrences). This was undertaken in order to check for any relevant instances that may have been overlooked when removing interviewer dialogue from the analysis. A limited number of additional instances were identified during this checking process, relevant to the concepts ‘unhelpful’ and ‘improve.’

7.6.2 Findings and discussion

Overview

Summary of findings in relation to unhelpful experiences and suggestions for improved practices both specific to the Collaborative Recovery Model, as well as case management more generally are detailed in Table 12. This includes an overview of the ‘unhelpful’ area or aspect of concern (including specification of number of participants raising each particular aspect in brackets), identified directions for improvement (where relevant) and examples of relevant quotes taken directly from the text.

Also summarised in Table 12 are unhelpful and improvement based findings relevant to ‘mental health services,’ and ‘beyond mental health services.’ Mental health services’ includes for example, consumers’ negative experiences with hospitals and crisis services, including psychiatrists and doctors. ‘Beyond mental health services’ includes some interviewee’s unhelpful experiences and concerns in relation to interaction with family members, other members of the community and more general concerns with respect to financial situation. Whilst these findings are not central to this research and will not be explored in detail, they are considered important to report. Firstly some of these findings are likely to have indirect implications for case management delivery, highlighted during discussion (e.g. potential role of case managers in advocating for more equal relationships with staff providing medication). Secondly these findings provide the reader with a more holistic perspective of the environment in which interviewees are situated and processes and aspects of experience, which may impact on individual’s recovery process. Thirdly, the very fact that interviewee participants raised these aspects whilst not being queried directly about them, suggests that they were of significant importance to the people concerned.

In summary Table 12 provides a snap shot of unhelpful domains and suggestions for improvement not only specific to the Collaborative Recovery Model, but also more broadly as relevant to mental health service settings and beyond. The remainder of this section provides a more detailed description and discussion of key findings listed in Table 12 with an emphasis on aspects of relevance to the Collaborative Recovery Model, consistent with the central concerns of this thesis.

Critical feedback or unhelpful content in relation to the Collaborative Recovery Model and delivery of this model in services as part of the AIMhi HSS project was relatively scarce. This is particularly notable when taking into account the number of participants raising each area of concern. From Table 12 it can be viewed that on average only 1-3 participants raised concerns relevant to each aspect, with the exception of more general concern around difficulty of working towards goals when unwell (raised by five participants). Despite this relative lack of data, interesting findings emerged.

Table 12

Summary of findings from interviews with consumers relevant to concepts ‘unhelpful’ and ‘improve’

Summary of ‘unhelpful’ area or concern	Direction for improvement	Example quote/s where relevant
Collaborative Recovery Model		
(1) Delivery of training to case managers to teach consumers about recovery	<ul style="list-style-type: none"> Consumers need to teach other consumers about recovery, not service providers teaching about recovery. Part of the picture is to educate the service provider 	<i>“If you want people to recover you get consumers in to teach them about recovery, not service providers teaching about recovery. You are doing it the wrong way around” (participant 17)</i>
(1) Collaborative Recovery Model no relevance in life (goals and homework). Achieved all goals in life (paid job, attends church) Identified that model/goal striving process may be more appropriate for people starting out on recovery	<ul style="list-style-type: none"> Not identified 	<i>“Well it can’t get any better”(discussing his life) “There is only one thing I want to do and that is to make a living and have a good time and be a fair dinkum Aussie and have a cold drink and a good smoke” (participant 21)</i>
(3) Term ‘homework’ inappropriate within context of Collaborative Recovery Model Note- whilst not directly stated as inappropriate many other participants used the terms goal/s or variations on this such as ‘small goals’ when referring to the homework component	<ul style="list-style-type: none"> Suggested use of term other than homework to describe ‘homework’ component of Collaborative Recovery Model e.g. mini goals 	<i>“I think it is really condescending to expect a person at the age of 45 to be doing homework...there is a fine line between someone who is unwell and treating them as a child” (participant 22)</i>
(2) Homework viewed as unhelpful One person said that homework reminded her that she was part of disability service (perceived as unhelpful)-didn’t see use in documenting simple tasks. Thought homework may help others if act of writing tasks aids memory and motivation Another person viewed homework as unnecessary. Described as “tedious” and like a “task manager”	<ul style="list-style-type: none"> Not identified 	<i>“Often the homework descriptions of the tasks were so, like the tasks were so simple. People don’t sit and write down about cooking dinner and analyse it to death like that...it certainly does remind me I am part of a disability service and bloody paper work” (participant 17)</i>

Note. Number in brackets indicates total number of participants identifying specific area of concern.

Summary of ‘unhelpful’ area or concern	Direction for improvement	Example quote/s where relevant
(2) Homework preferred when written in diary as opposed to on homework sheets	<ul style="list-style-type: none"> Homework more effective when written directly into personal diary 	<i>“We have to do this (discussing completion of homework sheets) but without putting it in my diary it doesn’t work as well” (participant 20)</i>
(1) Goal and homework sheets confusing	<ul style="list-style-type: none"> Suggested combine goal and homework sheet on one piece of paper to simplify 	<i>“I know a lot of clients would be struggling really, really hard to grasp it. I can’t grasp it let alone them. You just have to make it really easy and simple without being condescending” (participant 22)</i>
(1) Case managers deciding on goals for their clients	<ul style="list-style-type: none"> Engage outside person (other than case manager) to ensure goal ownership 	<i>“My case management team and support worker have been brilliant. I do know of ah case managers and stuff that do push stuff onto people that they don’t particularly like. The management teams are trying to change, set goals for people they don’t really need, or hear them you know” (participant 11)</i>
Mental Health Services		
(1) One participant reported lack of choice in decision making around service delivery Perceived areas of service involving lack of choice included: decision whether to participate in program, choice around living situation (lives with other people with mental illness). Also reports that service staff challenge him on a daily basis around the day’s activities-Reports this to be unhelpful and says creates “conflict”	<ul style="list-style-type: none"> Service staff stop “challenging” him on daily basis around plans for the day-instead assist him to see some “brighter lives”-for instance by “getting out a bit more” and “seeing the other side” 	<i>“We are always doing conflict here cause it is never fucking ending...they challenge you on a daily basis, every morning at nine o’clock” (participant 16)</i>
(7) Lack of collaboration with psychiatrists/doctors/hospital staff around medication	<ul style="list-style-type: none"> Case manager facilitate improved relationship with other staff Improved communication between staff prescribing medication and case managers Psychiatrists undertake Collaborative Recovery Model/similar project 	<i>“When you are dealing with your psychiatrist and you have to listen to a lot of that language and deal with a lot of that power play that goes on” (participant 6)</i>

Note. Number in brackets indicates total number of participants identifying specific area of concern.

Summary of 'unhelpful' area or concern	Direction for improvement	Example quote/s where relevant
Beyond Mental Health Services		
(4) Limited finances-impact on quality of life	<ul style="list-style-type: none"> • Seek paid work 	<i>"You don't get that much money on a pension...I just don't seem to have enough money for everything...I look around me, a lot of other people are in the same boat" (participant 8)</i>
(1) Finances managed by other party-lack of independence	<ul style="list-style-type: none"> • Manage finances on own-goals and homework to budget around finances • Worker to advocate for financial independence 	<i>"I will be happy when I have all my money back from public trust...I want to be independent" (participant 18)</i>
(5) Lack of understanding/stigma from family members and the general public	<ul style="list-style-type: none"> • More access to family support groups in community • Education of family members 	<i>"Like my sisters don't understand my illness, my brother doesn't understand it" (participant 1)</i> <i>"Somebody will say oh you are just a schizo and it really knocks you for six...the trouble with mental illness is you have always got a stigma attached with it" (participant 8)</i>

Note. Number in brackets indicates total number of participants identifying specific area of concern.

Unhelpful features of case management delivery

Several participants raised broad areas of concern to do with the Collaborative Recovery Model and case management delivery. For instance one participant expressed concern that case managers were teaching consumers about recovery, as opposed to people with lived experience of recovery sharing their experience and knowledge of recovery with peers. Several participants raised general concerns to do with case management around frequent change over of staff, lack of time due to large caseloads and concerns that some staff were driven by job descriptions, rather than what consumers considered important with respect to their recovery.

Difficulties to do with continual change over of staff, and inability to develop lasting relationships with staff in mental health services were raised by three participants. For example, one person said “the trouble with mental health is a lot of people get changed a lot, they get different case managers you know every couple of months and things like that and it’s hard you know” (participant 8). Another person identified that continual change over of staff was problematic, particularly within the context of something like the Collaborative Recovery Model. He elaborated:

Anything like this (Collaborative Recovery Model) is a long-term thing and you should have just one caseworker...it should not happen that you have a whole bunch of different ones. Um the only way to deal with these personal issues is to be able to have, ah the same support worker for an extended period of time. (participant 22)

Importance of developing long-term relationships when supporting recovery and concerns with respect to frequent staff change over have been mentioned by consumers in other studies (Krupa et al., 2005; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Redko, Durbin, Wasylenki, & Krupa, 2004; Watts & Priebe, 2002).

The Collaborative Recovery Model was perceived as irrelevant by one consumer

One participant felt that the Collaborative Recovery Model and specifically the goal striving process was irrelevant for him at his particular stage of his life. This person stated

that he had reached his desired goals (prior to taking part in the AIMhi HSS project) of obtaining paid work and regularly attending church. When asked whether usage of the Collaborative Recovery Model may be of benefit to anyone else he did, however state that he thought that this model and the goal striving process might be more appropriate for other people ‘starting out’ on their recovery journey. Other participants had more specific concerns to do with practical components of goals/recovery visions and/or homework activities as outlined in Table 12.

Homework component

Of particular interest, within the context of earlier findings were specific critiques around use of the word ‘homework’ by some participants in this study. Elsewhere in this chapter (see section 7.5.2, p.187) it was discussed that participants commonly used the term ‘goal’, or a variation on this term when discussing the homework component of the model.

In addition three people made statements, which indicated that they did not believe that the term homework was appropriate. For example, “it is not homework it is goal setting” and elsewhere “it is not actually homework, it is challenging work” (participant 9). Another participant when discussing homework said that he personally did not consider the task of breaking down his goals to be homework per se, despite the fact that his case manager termed this processes ‘homework’. One participant was much more specific when offering concerns regarding the use of the term homework stating:

I think it is really condescending to expect a person at the age of 45 to be doing homework...there is a fine line between someone who is unwell and treating them as a child. (participant 22)

This participant suggested the term ‘mini goal’ as a possible alternative to the term homework, as it was perceived to be better aligned with the small baby steps that people take towards their three monthly goals. When discussing the potential benefits of using such a term she said, “it actually means that you are going in little steps baby steps and it helps you, it makes you feel more comfortable knowing that they are small steps, but they

are also necessary and fulfilling steps” (participant 22). Whether it is viewed as preferable to replace the term homework with an alternate more favourable term requires further exploration in collaboration with mental health consumers.

Several participants specified that they did not find the homework component helpful. One person did not elaborate their reasons for this, beyond specifying that he found the homework component unnecessary and tedious, describing it as like a “task manager” (participant 16). This feedback raises some questions around whether this participant was clear as to the rationale for homework, and specifically the link to goal strivings. Furthermore whether this component was being completed collaboratively with staff, consistent with the training protocol.

A further participant expressed a number of concerns with homework within the Collaborative Recovery Model including that it reminded her of being part of a “disability service” (viewed as negative) and that the tasks were often so simple that they gave her a sense of feeling abnormal (didn’t see any rationale for documenting them on homework sheets). This particular person went on to discuss how she felt that homework sheets were a way for staff to continually document things and expressed concern around how consumers were actually supposed to ‘use that information’. She elaborated:

Often the homework descriptions of the task were so, like the tasks were so simple, people don’t sit and write down about cooking dinner and analyse it to death like that...to me it’s a um, a way of them tactically, documenting things all the time rather than actually, like what’s the use in that, like where does, how are you supposed to use that information you know? (participant 22).

Feedback provided by this participant suggests that the process of engaging in homework activities was likely to be inconsistent with Collaborative Recovery Model training provided to staff. For example, the perception that tasks were too simple may indicate that the level of difficulty for homework tasks was not being set appropriately, or negotiated by the worker. Further this participant’s inability to recognise the purpose of homework could indicate that it was not clearly linked to goal strivings. Consumers’ acceptance of the

purpose or rationale for homework in terms of contribution towards achieving goals has been identified as an important factor contributing to likelihood of homework completion (Dunn, Morrison, & Bentall, 2002).

Interestingly during the course of the interview this same participant identified a difficulty with goal striving to be that it could “be used quite poorly, in that you just put down what your goals are and ignore it for three months, I mean that is no different to any other mental health service” (participant 22). This commentary suggests that this person was most likely unclear about the rationale for the homework component in terms of assisting people to take smaller steps towards achieving their goals.

It is also possible that this participant potentially had the ability to accurately remember and complete smaller steps towards goals without the need for documenting this information. Indeed during the interview this participant discussed a number of meaningful goals that she had achieved in her life with the assistance of her case manager. This participant also went onto comment that she thought the homework sheets could potentially be helpful for others, in particular if they had memory difficulties, or found the process of writing down homework motivating.

Design of Collaborative Goal Technology and homework sheets

Only one participant raised direct concerns around the actual design of Collaborative Goal Technology (CGT) and homework sheets, although several participants made relatively minor comments to do with size of font and spacing. This person raised concerns that the goal and homework sheets were too confusing, suggesting that they may potentially be improved by combining them onto one sheet.

It is possible that the confusion expressed by this person may be reflective of inadequate time spent by the particular case manager orienting this person to the use of the CGT and homework components. Alternatively, it is possible that the homework and CGT components would be improved by simplifying them to make them more ‘user-friendly’. It needs to be kept in mind however, that no other interview participant expressed similar

difficulties with sheets offered as part of the AIMhi HSS project. Moreover, it is unclear to what degree participants were actively involved in filling out and completing CGT and homework sheets (although feedback from interviews suggests that at least some staff appeared to be filling out sheets on behalf of consumers). Clearly there are benefits to designing these practical components with a view to supporting mental health consumers to complete these components independently, facilitating greater ownership over this process.

Documentation of homework in a personal diary was preferred by several participants

Several participants stated that they found the homework component most helpful when they wrote it in their personal diaries, as opposed to on the homework sheets supplied. Whilst these participants did not specify reasons for this preference, it is possible that this process may have encouraged them to feel that they had more ownership over the process. It is also possible that the act of writing the homework in their diaries may have been perceived as more convenient, as opposed to having tasks outlined on separate sheets of paper. One person when discussing benefits of writing homework in his diary alluded to value regarding enhanced ownership stating:

It has been good to have a diary just for (my case manager) and me because um, because we plan it and I put it straight in the diary, but I have never done that before on my own...I think it is better than these sheets, you know we have to do this (homework sheets) but without putting it in my diary it doesn't work as well, so I thought having a diary of my own was um good. (participant 20)

Similarly another participant described how she viewed homework sheets as something that staff completed, preferring to write down tasks directly in her own diary. Elsewhere this participant went on to discuss how she also used her diary for other things, for example to document a particular goal striving around returning to study and perceived advantages and disadvantages of this activity, as well as for making notes of any appointments and documenting daily progress towards reducing her cigarette intake (identified as a goal striving). It is possible that a diary format was preferred by this participant partly because it

was a handy way of documenting not only homework tasks, but also daily progress towards goals and other relevant information with respect to planning and organising her life.

Other authors have suggested that there may be benefits to having homework documentation in one place, such as a file or folder, as opposed to on separate pieces of paper as such formats are less likely to be misplaced or overlooked. Furthermore utilisation of any existing format that a particular person finds useful to remember important tasks in their lives, such as a diary or calendar is also likely to be beneficial (Dunn, Morrison, & Bentall, 2002) in terms of tailoring the approach to the individual. Further work is needed to clarify mental health consumers' perceptions regarding the existing design of practical components of homework sheets and CGT and possible benefits of updating existing formats and/or tailoring approaches to the individual.

Recovery vision

Three participants raised concerns to do with the 'recovery vision,' emphasised as part of the CGT. Concerns raised by two consumers appeared to be directly tied to use of the term 'recovery vision', as opposed to the process of actually formulating a recovery vision per se. One person said "I don't have a vision for recovery, you know what I have a vision for more than anything else and don't ask me how it works, I get up every morning and do everything like a normal person does that doesn't even have a mental illness" (participant 10). Elsewhere this person expressed that she preferred to conceptualise this process in terms of living her life, as opposed to her illness. It is possible that the term 'life' may have been preferred since the term 'recovery' implies recovering from something (for example medical illness or disability) as opposed to life vision or direction, which may be perceived as more consistent with language used by the general public or 'normal' population.

Another two participants used the term 'life' when asked about their 'recovery vision'. For example, "I feel very strongly on that, what my vision is in life" (participant 19). Another participant similarly raised concern with the appropriateness of the term 'recovery vision' stating:

I don't really believe um in my case there is actually a recovery vision at all. I think it just goes back to I am coping and doing the best I can, um recovery is a bit abstract, you know what is recovery, when you don't need your pills anymore or that you can get into a relationship and have a fulfilling life? (participant 22)

This person appeared somewhat conflicted in relation to medical and more recent understandings of recovery, consistent with the consumer movement. This potentially suggests that staff took too little time introducing and orienting this person to the concept of recovery. However, confusion around the use of the term is also consistent with broader confusion in the wider community and academic literature (Roberts & Wolfson, 2004). Addressing appropriateness of the term 'recovery vision' is clearly important and requires further exploration in collaboration with consumers.

One participant when asked about her recovery vision said that she did not want to write down her vision, perceiving it as unrealistic. Cross comparison with return of CGT sheets indeed revealed that no recovery vision had been documented. When explaining why she did not wish to document her recovery vision she elaborated:

My vision for my life has got to do with, um obtaining a partner that loves me and actually a functional relationship and possibly children to go with it...but how much can I actually impact on that vision, well bugger all so I don't bother writing it." (participant 17)

This finding, rather than highlighting problems with the process of conceptualising a recovery vision per se, may suggest that staff spent inadequate time engaging with this consumer and discussing the process and rationale for identifying a 'recovery vision'. It may also suggest that staff spent inadequate time enhancing self-efficacy using motivational enhancement strategies (component one of Collaborative Recovery Model).

Difficulty of working towards goals during periods of illness

Five participants discussed the difficulty of continuing to strive towards their goals when they were unwell. Whilst this finding in itself is hardly surprising, it does highlight one aspect that is likely of relevance to other mental health consumers. It is probable that this would be one potential barrier to goal striving, which could be flagged initially by staff and discussed openly in order to alleviate concerns and/or discuss an appropriate plan of action. For example, if a person became unwell to the degree that they felt unable to continue working on their goal striving, this process could be temporarily halted and a note of this made on the CGT sheet. Alternatively the three month time frame for CGT completion could be adjusted as appropriate depending on period of illness. Further discussion with consumers would assist in determining the best way of addressing this concern as raised by some interview participants.

Negative interactions with psychiatrists, hospital staff and family members

Seven interviewees described negative interactions with psychiatrists and hospital staff around medication usage. Content of discussions indicated that people often felt that they were not listened to, or ‘heard’ in relation to decision-making processes with respect to their medication. It is hardly surprising that consumers raised this as an aspect of concern since a number of interview participants also spoke about medication, or finding the right medication as one central aspect of their recovery (see section 7.5.2, p. 164). Other authors have suggested that when a doctor hands some power or control to the person with mental illness, that this equates to recognising the person beyond the illness (Topor et al., 2006). Recent research has been undertaken by Deegan and colleagues (2007), specifically to develop a program to support shared decision-making around medication usage. Clearly shared decision-making and supporting autonomy also parallels the underlying philosophy of the Collaborative Recovery Model.

When discussing hospital staff one participant said, “the medication I am on, I don’t think it is working at the moment, I think I need to be changed to a different medication but they don’t listen” (participant 1). Another person highlighted the power play that was often observed in relationships between consumers and psychiatrists stating:

You have enough with doctors just telling you how and when to take your medications...when you are dealing with your psychiatrist and you have to listen to a lot of that language and deal with a lot of that power play that goes on. (participant 6)

When discussing improved ways of working a number of participants spoke about the possibility of case managers facilitating improved relationships with doctors/ psychiatrists or communicating their needs on their behalf. For example, “I wish she could come, yeh and see...my psychiatrist and explain to him you know, how I am feeling” (participant 1). Another participant discussed how his case manager had been responsible for following up his concerns regarding medication use, and initiating positive change in these regards.

In facilitating better relationships between consumers and psychiatrists one person suggested that it might be good for psychiatrists to be involved in something like the Collaborative Recovery Model, “if a psychiatrist did this sort of thing (Collaborative Recovery Model) that might be good too, instead of them taking notes all secretly” (participant 20). Another consumer suggested that there was a need for improved collaboration between case managers and psychiatrists saying, “I guess perhaps better communication with the doctors, or with the treating um people who are giving out the medication, cause it just seems to be a, I don't know almost like a, just a real divide, like between um sort of psychologists and psychiatrists (participant 5). Findings from a national review of mental health services undertaken in Australia similarly highlighted that consumers perceived a strong need for improved collaboration and partnerships between GP's, psychiatrists and other mental health professionals (Groom, Hickie, & Davenport, 2003). The degree to which other consumers are likely to value staff efforts with respect to facilitating more collaborative relationships with psychiatrists and other professionals, or advocating on their behalf is unclear.

Four participants in this study discussed experiencing stigma or lack of understanding from family members in relation to their illness. For example, “my sisters don't understand my illness, my brothers don't understand it” (participant 1). Suggestions were made for improved education efforts and better access to family support groups in the community.

Whilst not mentioned by interviewees, case managers could also potentially assist in this area. For example, either through direct education of family members and/or by linking family members to relevant services and supports in the community. Education of family members is known to improve outcomes for both consumers and their families (Dixon et al., 2001). Social connectedness and relationships with significant others based on love, patience and trust are also necessary for the occurrence of recovery (Onken, Craig, Ridgway, Ralph, & Cook, 2007).

Financial situation and impact on quality of life

A number of participants discussed less helpful experiences, in terms of limited available finances and subsequent impact on quality of life. Four people identified that one of the reasons they had, or desired paid work was so that they could do the things that ‘normal’ people were able to do, like go out for a coffee or simply get through the week and pay their bills. For example, “cause I actually have the money from working I can actually go out and have coffee and cake” (participant 17). Another participant described financial hardship as a barrier to reaching his goal of building model boats “it takes me a long time to accumulate any tools, it is so expensive” (participant 3). Other research has identified the negative impact that financial hardship and poverty can have on people’s recovery, for example impairing people’s ability to achieve their goals and participate in regular activities in the community (Krupa et al., 2005)

7.5 CONCLUSIONS

Importantly, this study has moved beyond establishing the value of key parts of the Collaborative Recovery Model to understand in detail which particular processes were beneficial or meaningful from a consumer perspective. Other authors have demonstrated the importance of qualitative studies for illuminating processes of therapy or service delivery that are important to success (Anthony, Rogers, & Farkas, 2003; Wykes, 2003) and identifying aspects and areas for improvement (Buck & Alexander, 2006; Schwarz, Landis, Rowe, Janes, & Pullman, 2000). For example, when discussing the practical activities of goal striving and homework, participants identified the value of these activities in relation to providing a sense of direction for life, encouraging ownership and

responsibility, benefits of formal documentation and positive feelings of achievement and personal growth, among others.

Similarly when discussing relationships with mental health staff, feedback provided insight into factors contributing to ‘helpful relationships’. For example, provision of support and encouragement (both in general and with respect to goal striving) was an essential characteristic of the relationship as mentioned by consumers in this study. Other aspects of ‘helpful relationships’ included for example, assistance with problems and everyday challenges, case managers who were perceived as ‘friendly’ and case managers who listened carefully.

Findings from this study also provide broader insight into the context of recovery and factors beyond case management settings that consumers identify as important and often challenging when building better, or more meaningful lives in the community. For example, consumers discussed aspects such as development of relationships with family, friends or partners, medication and/or self-management of symptoms, staying out of hospital, having their own home or place of residence, obtaining volunteer or paid work and assisting other people with mental illness. Mental health staff would benefit from recognising and considering such areas as target areas for intervention when working within a recovery framework. Other authors have recognised that factors such as “living conditions, income, employment/unemployment, and social interactions outside of treatment settings are central to processes of recovery and cannot be seen as lying outside of the scope of clinical or rehabilitative practice” (Borg & Davidson, 2008, p. 139).

Critiques and concerns raised by participants in this study have relevance both to the Collaborative Recovery Model and its delivery and use by staff, as well as broader application to mental health service delivery and beyond. Aspects mentioned by consumers relevant to the Collaborative Recovery Model ranged from concerns around appropriateness of the the term ‘homework,’ to several consumers’ preference for documentation of homework in their diary as opposed to on homework sheets, to concerns with respect to the goal striving component during periods of illness, among others. Some participants also appeared to show a preference for use of the term ‘life,’ as opposed to the

term 'recovery.' For example, a number of people used alternate terms such as 'life goals' or 'life vision.' Examples of more general aspects of concern mentioned by consumers included frequent turn over of staff, lack of collaboration with psychiatrists and other hospital staff around medication usage and stigma from family members.

The next chapter outlines the final study for this thesis including background to and recommendations arising from several focus group meetings undertaken with mental health consumers in New South Wales and Queensland, Australia. The purpose of this study was two fold. Firstly and primarily it was undertaken in order to obtain further practical recommendations for improvement of the Collaborative Recovery Model and its use and delivery in mental health services. To a lesser degree this study sought to provide an opportunity to further validate some findings identified as part of studies one and two (questionnaire and interviews). Consistent with the emphasis on consumer participation, consumer researchers facilitated all focus-group meetings in collaboration with the primary researcher.

CHAPTER 8:
STUDY 3- FOCUS GROUPS

IMPROVING THE
COLLABORATIVE RECOVERY MODEL
AND ITS DELIVERY AND USE IN SERVICES:
RECOMMENDATIONS FOR THE FUTURE

“Optimal service provision is a profoundly human enterprise that needs both science and the perspectives of people who have personally experienced severe mental illness” (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005, p. 98)

This study describes the background to, development of and findings arising from two focus group meetings, involving a total of 18 mental health consumers. All consumers taking part in these groups had been working with staff who had received training in the Collaborative Recovery Model and been encouraged to work in these ways. The main focus for these groups was to draw on consumers’ experiences with a view to obtaining practical recommendations for improvement of the Collaborative Recovery Model and its use and delivery in mental health services into the future.

This chapter will begin by describing the background and aims for this study, development of focus group protocol, sampling and recruitment procedure, description of participants and data analysis procedure. This will be directly followed by a summary of key issues raised during these meetings, including proposed recommendations for improved practice.

8.1. INTRODUCTION

Face-to-face focus groups were the chosen methodology for this study. Focus group methodology essentially involves engaging a small number of people in an informal group discussion, or series of discussions, which are ‘focused’ on a particular issue or aspect of interest (Wilkinson, 2003). Focus groups have also been described by some as a form of group interview (Kitzinger, 1995; Patton, 2002). However, focus groups vary from traditional forms of interviewing in that they rely on interaction between the group, based on topics provided by the researcher (Morgan, 1997).

Focus groups were selected over other possible qualitative methodologies (such as interviews) for a range of reasons. Firstly these methods allow for direct observation and relatively quick assessment of interaction of similarities and differences in opinions and experiences, among individuals. In addition participants are able to hear other people’s responses which can lead to questions, and comments on others’ experiences and points of view, beyond the participants’ own personal experiences (Kitzinger, 1994; Patton, 2002).

Of further relevance to this study is that focus groups have been recognised as particularly beneficial when engaging participants in quality improvement and action based research (Kitzinger, 1995; Schwarz, Landis, Rowe, Janes, & Pullman, 2000).

A group interactive context was also considered to be particularly appropriate for discussing and building on consumers' unhelpful experiences and concerns in relation to the Collaborative Recovery Model and its use in services. For example, one of the potential advantages of focus groups is that they may encourage contributions from people who feel they have little, or nothing to say, through engaging in discussion generated by other group participants (Kitzinger, 1995). Further, it has been suggested that the feeling of being part of a group may encourage the discussion of 'taboo' topics, with less inhibited group members creating an atmosphere where less confident members may feel encouraged to speak up (Kitzinger, 1995).

In addition to the advantages described above, focus group methodologies have also been described as potentially empowering to research participants (Kitzinger, 1995). For instance, focus groups involve participants in the decision making process (Kitzinger, 1995; Race, Hotch, & Parker, 1994), and may enable them to feel valued for their expertise, through the opportunity to collaborate with researchers (Goss & Leinbach, 1996). As discussed elsewhere (see section 2.4.5) the potential to positively impact on research participants through the process of undertaking research activities was an explicit consideration during methodological design of this thesis.

In summary, focus group methodology was considered a particularly viable avenue for focused discussion regarding identified aspects of concern and recommendations for improved practices, taking into account findings from earlier studies and participants' direct experiences. Unlike the structured interviews described in the previous chapter, the focus group study provides detailed exploration of people's experiences and further insights into obtaining practical recommendations that can progress the delivery of the Collaborative Recovery Model into the future.

8.2 STUDY AIMS

The key aims of this study were to consult consumers who had worked with mental health staff trained in the Collaborative Recovery Model in order to:

- 1) Discuss any concerns with the Collaborative Recovery Model and its delivery and use in services and identify recommendations for improvement, both within the context of participants' direct experiences and key findings from other consumers as part of study two.
- 2) Assist in interpretation and confirmation of key findings from studies one and two.

8.3 METHODOLOGY

8.3.1 Development of focus group protocol

The primary researcher developed the guiding structure and supportive documents for the focus group meetings. A considerable degree of structure was sought for focus groups consistent with the aims of this study. The flow chart below (see Figure 4) outlines the key stages and processes undertaken in preparation and development of focus group protocol and related documents. Focus group materials were distributed to four consumer researchers (involved in previous interview study) for review and comment. Feedback offered guided further refinements.

Materials produced for reference by focus group facilitators and participants are outlined below:

Focus group facilitators: 1) guiding document outlining key findings to raise/discuss with group members during focus groups and 2) power-point slides to support and complement the presentation of findings (see Appendix N)

Focus group participants: 1) one page handout summarising key findings from earlier studies and 2) a Collaborative Recovery Model diagram for reference during brief recap/overview of model (at commencement of group) (see Appendix O)

Groups commenced discussion with a brief overview of the Collaborative Recovery Model and an emphasis on topics covered during training of mental health staff. This discussion had three main purposes. Firstly, to act as a refresher for participants prior to discussing their own as well as other people's experiences of this model. Secondly, from study two, as

well as preliminary findings from the AIMhi HSS project it was anticipated that some participants' exposure to certain aspects of the Collaborative Recovery Model would be limited. By briefly presenting the model in the first instance this would provide an opportunity for all group members to be clear about the key principles and practical components (i.e. presentation of the conceptual model or the Collaborative Recovery Model in an 'ideal' sense). Thirdly, it was anticipated that group members would not have seen the Collaborative Recovery Model presented in this manner and may have been unaware of what was covered during training of mental health staff. Therefore it would add an additional dimension by which participants could potentially offer their critique and opinions.

Following a brief presentation of the Collaborative Recovery Model facilitators also flagged to group members relevant issues regarding limited exposure to practical components within the context of the AIMhi HSS project (i.e. statistics regarding what people actually received in practice with a focus on practical components). Facilitators then moved on to raise relevant findings for discussion among group members with a focus on unhelpful aspects/any areas of concern and suggestions for improved practices.

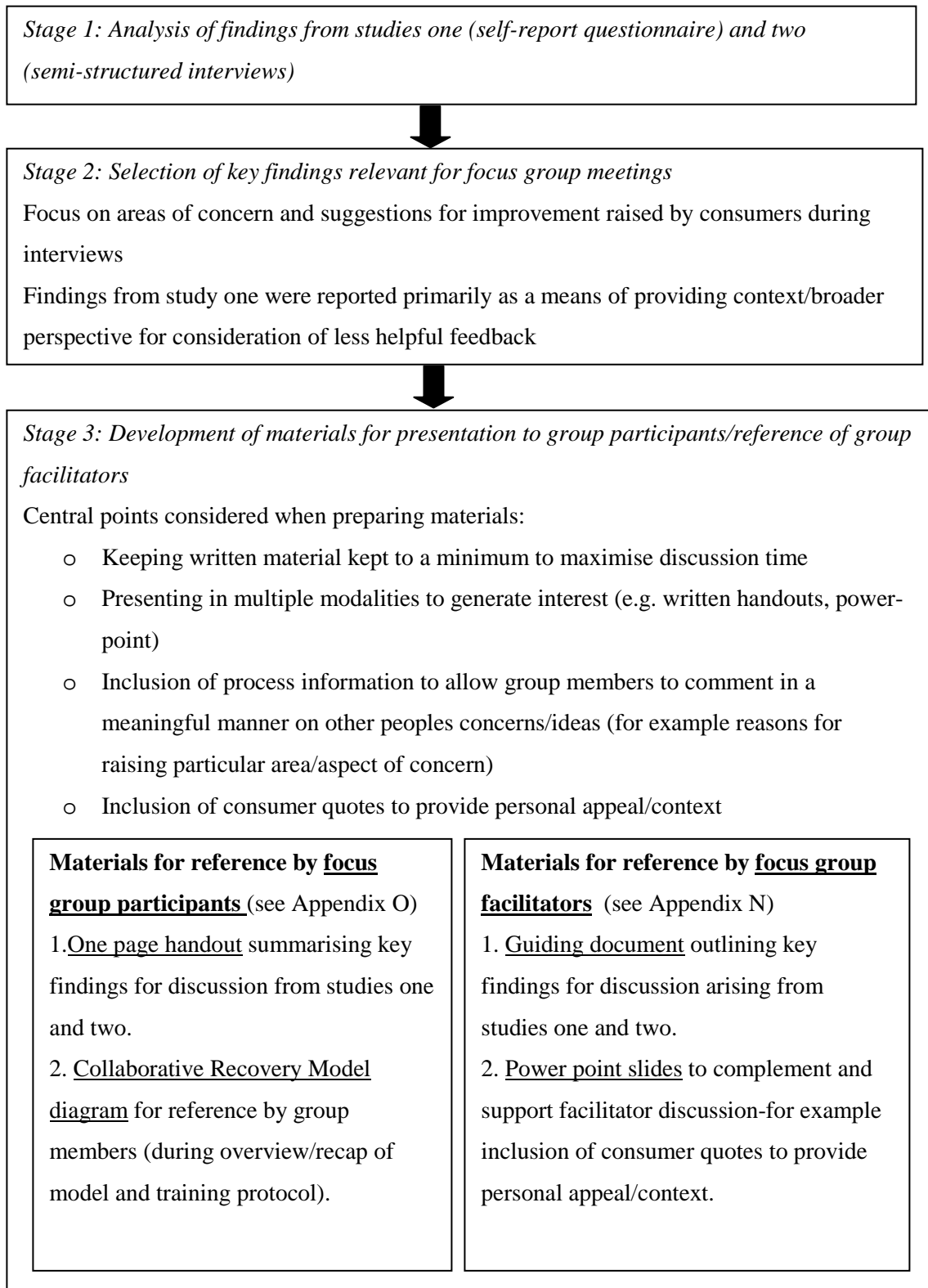


Figure 4. Key stages and processes leading to development of focus group protocol

8.3.2 Sampling

Purposive sampling is often utilised within qualitative studies. The logic behind purposive sampling strategies is that information rich cases are selected for study in depth (Patton, 2002). Purposive sampling and more specifically maximum variation sampling utilised in this study is discussed in more detail elsewhere (see section 7.3.3).

One of the key selection criteria for focus groups (in keeping with study two) was to recruit people who were critical of the Collaborative Recovery Model or certain aspects of it. This was considered desirable with a focus on discussing and identifying aspects of concern and directions for improved ways of working. Considering the difficulty of recruiting people meeting this criteria for study two a decision was made to invite people whom had previously met this criteria as part of the interview study. In addition recruitment also focused on attempting to identify additional people meeting this selection criteria who had not previously taken part in study two.

As part of this study there was also a desire to involve some participants who had already taken part in interviews (study two). Involving some people who had participated in this earlier study was consistent with the one of the aims, focusing on interpretation and clarification of earlier findings. The rationale for inviting some people who had not taken part in earlier studies was to ensure that there was adequate opportunity for discussion of potentially new and contrasting points of view.

In sampling for focus groups there was also an attempt to balance gender and age of participants to ensure a representation of people across the range of ages participating in the AIMhi HSS project (at baseline mean reported age for AIMhi HSS project participants was 39.85 years, with a SD 12.15 years). There was also an attempt to interview people from the range of participating organisations, with a representation of people from both public mental health services and non-government organisations in different states of Australia. In addition this study aimed to hear from individuals with a range of diagnoses (participating in the AIMhi HSS project), including individuals with diagnoses of schizophrenia, bipolar,

schizoaffective disorder and depressive psychosis (keeping in mind that the majority of individuals participating in the AIMhi HSS project were diagnosed with schizophrenia).

8.3.3 Focus group procedure

All participants in this study were provided with detailed information about focus groups by way of an information sheet and were required to sign formal consent, as approved by the relevant ethics boards of the participating universities or organisations. The primary researcher was available to answer any questions as required. Key ethical considerations for this study and how they were addressed are included in Appendix P, along with the relevant information and consent sheet.

Focus group meetings were held in July and August 2007 involving a total of 18 participants who had been working with Collaborative Recovery Model trained mental health staff. The first meeting was held in Queensland, Australia and was attended by 7 people. The second focus group was held in New South Wales, Australia and was attended by 11 people. Ideal recommendations for numbers of focus group participants is in the range of approximately six to ten people (Patton, 2002). Each group meeting ran for approximately 2.5 hours including a refreshment break of about 30 minutes. Other authors have emphasised the importance of creating a relaxed, comfortable setting for participants (Kitzinger, 1995). All focus group meetings were audio-taped for later analysis.

Two consumer researchers facilitated each focus group meeting in collaboration with the primary researcher. At the commencement of the meeting all facilitators introduced themselves and consumer researchers identified themselves as people who had lived experience of mental illness, as well as experience in research activities. The purpose of this was to create an atmosphere where other group members might feel more comfortable talking about their own experiences. Consumer researchers were paid for their involvement according to guidelines for casual workers specified by the University of Wollongong.

Focus group participants were provided with a nominal payment of \$45 by way of a money order in recognition of their contributions to the study. Where participants expressed difficulties with travel arrangements to and from the group, taxi vouchers were made

available in addition to the nominal payment received. Several days after attending the focus group meeting participants received a formal letter of thanks from the primary researcher, thanking them for their contributions.

8.3.4 Consumer researcher training and support procedures

Details of consumer researcher's existing experience in relation to research activities and exposure to the Collaborative Recovery Model is reported elsewhere (see section 7.3.2). Specific to this project all consumers had previous experience in facilitating focus group meetings.

Prior to running focus group meetings consumer researchers attended a training session. During this session refresher training materials specific to undertaking focus groups were reviewed and discussed. Facilitators were also oriented to focus group training protocol and materials (see Appendices L & M). Decisions were made in relation to the presentation of different topics/questions and facilitators rehearsed the presentation of relevant material. Consumer researchers were encouraged to undertake further preparation and familiarisation with the focus group material in their own time. The primary researcher was available to answer any remaining questions following the training session.

The primary researcher was available immediately following focus group meetings to provide support to consumer facilitators as required and more generally to allow an opportunity to debrief. A decision to have two consumers facilitating each focus group was also deliberate to allow for an additional avenue of support both during, as well as following group meetings.

8.3.4 Description of focus group participants

All consumers taking part in focus group meetings were part of the AIMhi HSS project. Criteria for eligibility in this study are reported elsewhere (see section 4.2). This study involved a total of 18 consumers participating in two focus groups in New South Wales and Queensland, Australia. Participants taking part in this study were attending either a public

mental health service in regional Queensland (N=4) or a regional or rural site of a non-government organisation in New South Wales (N=7) or Queensland (N=6), Australia.

Out of the total number of interview participants (N=18), 11 (61%) were female and 7 (39%) were male. Participants had a mean age of 38 years with a SD of 5.9 years, comparable to the larger sample of consumers taking part in the AIMhi HSS project (M=39.85 and SD=12.15, at baseline). Diagnostic information for the 18 participants was collected from clinicians and is available in Table 13. Consistent with the larger population of consumers taking part in the AIMhi HSS project, the vast majority met the diagnostic criteria for schizophrenia.

Table 13.

Diagnoses for consumer participants in focus group study

Diagnosis	N (%)
Schizophrenia	9 (50%)
Schizoaffective	4 (22.2%)
Depressive	4 (5.6%)
Psychosis	
Bipolar	1 (22.2%)

Note. N=18 consumers participated in focus group meetings

Three participants who had previously been selected to participate in study two based on their critique of the Collaborative Recovery Model agreed to participate in a focus group meeting. Each of these three participants attended the focus group held in QLD, Australia. An additional person who had been selected for participation in the interviews based on their particularly positive experience of the model also agreed to take part in this study (consistent with sampling criteria to include a number of people who had previously participated in study two). This person attended the focus group in QLD, Australia. A number of other participants from study two were approached to be involved in this study and expressed interest in taking part, however were unable to follow through due to other

commitments. A total of four participants taking part in this study had previously participated in interviews as part of study two.

8.3.5 Analysis of focus group data

Focus groups were audiotaped and transcribed verbatim. Thematic analysis was undertaken on this data set. In contrast to study two, it was not of interest to identify relationships between various concepts therefore Leximancer was not utilised. Rather, the focus of this study was on using thematic analysis to summarise and present key ideas and recommendations raised during group meetings, with a view to contributing to the ongoing refinement of the Collaborative Recovery Model and associated training package for staff into the future.

In order to achieve this aim, the primary researcher summarised key themes obtained from focus group data in the manner outlined below:

1. Firstly the primary researcher became familiar with the focus group data by reading and re-reading transcripts several times.
2. Transcripts for each focus group were then read in turn and group members responses to the various areas for discussion outlined in the focus group schedule were located within the transcripts. These themes were summarised into a table for ease of reference. Example quotes were also located and included (see Table 14).
3. Transcripts were also checked for other relevant information that fell outside the areas for discussion identified on the focus group schedule, but remained relevant for the improvement of the Collaborative Recovery Model and associated staff training. This information was also summarised into a table.
4. Summaries for the two focus groups were then cross-referenced to compare whether findings were similar for focus groups held in New South Wales and Queensland, Australia.

8.4 FINDINGS AND RECOMMENDATIONS

Findings and recommendations reported in this chapter outlining aspects of concern and possible directions for improved ways of working are testament to the value that can be gained from involving consumers in research activities with a focus on service

improvement. This is in lieu of other possible benefits to the consumer which may arise as a result of participation in research discussed elsewhere (see section 2.4.5). Recognition of the ability of many consumers participating in this study to comment meaningfully not only on their own experiences, but also on the experiences of other consumers with a view to improving services is important. In particular, in recognition of the scarcity of research that has been undertaken in this area. It is also of significance within the context of encouraging other researchers to pursue research in collaboration with consumers, with a view to improving service delivery.

Findings from this study lend further evidence to some aspects of concern identified by other consumers during interviews (study two). In particular some consumers raised concerns regarding appropriateness of the use of the word 'homework' and 'recovery vision', existing design of goal and homework sheets, goal striving during periods of illness, lack of collaboration between consumers and psychiatrists and constant turn over of mental health staff. Consumers also raised new concerns and suggestions for improved practices, in addition to those already identified during interviews.

Table 14 summarises key findings arising from this study including 1) overview of unhelpful aspects/areas of concern, 2) identification of whether aspects had been previously raised during study 2, 3) key areas implicated by findings (including staff training, use of terminology or design of practical components), 4) summary of directions for improvement and 5) examples of relevant quote/s where relevant.

Consistent with interview findings as part of study two it was found that some people taking part in focus groups had limited exposure to key parts of the Collaborative Recovery Model (including goal striving and homework components). Furthermore there was some indication that the model was not always being provided by staff in a manner consistent with the training protocol. Whilst this was not explored in detail as part of this study, it was readily apparent during group discussions and has particular relevance for enhanced staff training and support procedures discussed below. It also highlights potential benefits of

attempting to involve consumers more actively in the model from the outset, consistent with some consumer recommendations arising from this study.

Key areas of concern raised by participants during focus group meetings (summarised in Table 14) are elaborated and discussed below with respect to ongoing development of the Collaborative Recovery Model and associated training program for mental health staff. Many aspects also hold broader relevance, in relation to supporting consumers' recovery in mental health contexts.

Table 14

Summary of unhelpful and improvement based aspects identified by consumers participating in focus groups

Summary of 'unhelpful' area or concern	Raised during study 2	Key area/s implicated by finding: 1) staff training, 2) terminology or 3) design of practical component/s	Possible directions for improvement	Example of relevant consumer quote/s
<ul style="list-style-type: none"> Perception that some staff had negative attitudes towards the model, (in particular completion of paperwork requirements-goal and homework sheets). This can, in turn negatively influence consumer attitudes. Perception that some staff felt unsupported 	X	<ul style="list-style-type: none"> Staff training Design of practical components 	<ul style="list-style-type: none"> Provision of ongoing training and support of mental health staff following initial training Redesign goal/h/w sheets into book format that is owned and can be personalised by the consumer 	<p>"If a support worker makes you understand that they don't agree with the paperwork you're going to go oh good I'll get out of this, because they don't want to do it anyway. So maybe that is something in your training that has to be changed" (participant, QLD group)</p> <p>"I think the support workers might feel that they've been you know, got into this great new model but then have been left with it" (participant, QLD group)</p> <p>"That goes back to the training and also the fact that they have to have ongoing training" (participant, QLD group)</p>

Summary of 'unhelpful' area or concern	Raised during study 2	Key area/s implicated by finding	Possible directions for improvement	Example of relevant consumer quote/s
<ul style="list-style-type: none"> Existing format of goal and homework sheets may place too much emphasis on written documentation for some people 	X	<ul style="list-style-type: none"> Staff training Design of practical components 	<ul style="list-style-type: none"> Train and encourage staff to use strategies other than verbal documentation to convey goals/ homework. For example, consider illustration/collage (tailor to individual) Redesign goals and homework sheets into book format owned by the consumer. Could also allow for more personalised approach 	<p>"I hate reading. I just usually go through it and write down whatever and ignore it...I find that annoying too much reading" (participant, NSW group)</p> <p>"If it is word based then straight away I have to do something, I can't do it, it agitates...you wanted to get your own place or something just cut a picture from the newspaper of a house that you love...I know it is a method but I don't think people use it enough or are encouraged as a support worker to do it"(participant, QLD group)</p>
<ul style="list-style-type: none"> Some case managers inadequate discussion with consumers around recovery 	X	<ul style="list-style-type: none"> Staff training 	<ul style="list-style-type: none"> Workers to take adequate time discussing and orienting consumers to the concept of recovery (existing knowledge should not be assumed) Consumer run forums to introduce people to the concept of recovery 	<p>"It was a bit like the birds and bees scenario (reflecting on staff discussions of recovery)...I got the talk but it wasn't a warm and friendly discussion about who you might marry or whatever it was just the talk"(participant, QLD group)</p> <p>"I was really disappointed that it wasn't a consumer driven thing...it really was an opportunity for us as consumers to work together and to really enjoy it in terms of learning about recovery and learning about ourselves"(participant, QLD group)</p>

Summary of 'unhelpful' area or concern	Raised during study 2	Key area/s implicated by finding	Possible directions for improvement	Example of relevant consumer quote/s
<ul style="list-style-type: none"> Collaborative Recovery Model not presented to consumers in appealing manner 	X	<ul style="list-style-type: none"> Staff training 	<ul style="list-style-type: none"> Introduce consumers to model in group format with other peers-may generate more interest 	<p>"You present it to the consumers first...we all get together and get excited about it and then the support worker comes along and says ok lets do this, because I didn't receive it that way. The way I received it is that she landed on my doorstep with these big fat books and just said basically this is the way we have to do it" (participant, QLD group)</p> <p>"We didn't get warmed up as a group...when it was just presented" (participant, QLD group)</p>
<ul style="list-style-type: none"> Difficulty regarding goal striving during periods of illness 	√	<ul style="list-style-type: none"> Staff training 	<ul style="list-style-type: none"> Approach to goal striving during periods of illness best negotiated between individual consumer and staff 	<p>"I don't think it's actually important to actually have a goal when you're unwell because that can actually make you more unstable...well I believe that you should be working on it, but not so much"(participant, NSW group)</p>
<ul style="list-style-type: none"> Use of word 'homework' inappropriate 	√	<ul style="list-style-type: none"> Terminology 	<ul style="list-style-type: none"> Alternate terms suggested by consumers included goal work, goal tasks, short-term goal, mini-goal 	<p>"You're an adult, it's really offensive for someone to tell an adult to do their homework" (participant, QLD group)</p> <p>"Homework-it's actually something I have to do but I don't want to do it...like your back at school again" (participant, NSW group)</p>

Summary of 'unhelpful' area or concern	Raised during study 2	Key area/s implicated by finding	Possible directions for improvement	Example of relevant consumer quote/s
<ul style="list-style-type: none"> Three people expressed concern with the term recovery vision 	√	<ul style="list-style-type: none"> Terminology 	<ul style="list-style-type: none"> The term recovery vision may be more appropriately replaced with alternate term such as 'life vision' (requires further investigation in collaboration with consumers) 	<p>"I don't see it as a vision"(participant, NSW group)</p> <p>"I don't think of recovery vision automatically and think alright what's my life plan or something, what's the next goal"(participant, NSW group)</p>
<ul style="list-style-type: none"> Perception that goal and homework sheets/books owned by mental health staff, as opposed to consumers 	X	<ul style="list-style-type: none"> Design of practical components 	<ul style="list-style-type: none"> Possible alternate format for documentation of goals and homework is consumer owned personalised diary/book 	<p>"When you do something that's your own...your own diary or your own journal it's very different then if you do something like that (goal and homework sheets) which looks so official" (participant, QLD group)</p> <p>"I think you should have your own book and keep it yourself...well they can look at it but you can keep it yourself so you can write stuff down in it if you need to from week to week" (participant, QLD group)</p>
<ul style="list-style-type: none"> Homework and goal sheets getting lost/misplaced 	√	<ul style="list-style-type: none"> Design of practical components 	<ul style="list-style-type: none"> Homework and goals documented in one place e.g. book or diary as opposed to on individual sheets of paper 	<p>"With the collaborative model every bit of paper was like a paper chase trying to find last weeks homework"(participant, QLD group)</p> <p>"I find it irritating when you have to look for everything all the time" (participant, NSW group)</p>

Some staff members' negative attitudes towards the Collaborative Recovery Model

Several consumers identified that mental health staff with whom they worked held negative attitudes towards the model, in particular written documentation or 'paper work' requirements for goal and homework sheets. These perceived negative attitudes in turn influenced consumers' perceptions of these practical aspects. One person said, "if they are kicking and screaming we're not going to turn around and say, well hold on a second that is a good idea"(participant, QLD group). Another consumer raised concern that perceived pressure placed on staff to complete written documentation in some instances flowed through to the consumer. For example, "they had a set date to have everything done...that's not pressure you should put on a client"(participant, QLD group). Recent research indicates that case managers who hold more positive attitudes towards homework, report that their consumers respond more positively to homework, complete homework of a higher quality and more frequently (Kelly, Deane, Kazantzis, & Crowe, 2007).

A related concern echoed by several participants was their belief that staff might not have been receiving adequate ongoing support, following their initial training in the Collaborative Recovery Model. One participant said "I think the support workers might feel that they've been, you know got into this great new model but then they have been left with it" (participant, QLD group). One possible solution to this area of concern, as raised by several group members is to improve ongoing training and support procedures for mental health staff. A need for enhanced support of staff, for example through more active practitioner management has been discussed elsewhere as part of the Collaborative Recovery Model (Deane, Crowe, King, Kavanagh, & Oades, 2006). This includes support of middle managers and team leaders so that they understand and can effectively communicate and lead recovery-focused change among their staff (Crowe, Couley, Pedro, & Humphries, 2007). Other possible changes to support dissemination of research protocols into practice in service settings include, for example, better integration of the new ideology and protocols, regular monitoring of progress, workplace coaching, additional staff incentives and examination and targeting of pre-existing staff attitudes towards evidence based practice (Uppal et al., in press). See section 9.4 point 6, for further relevant discussion.

Another possible means for addressing this concern (drawing on suggestions from some group participants) would be to reconsider the design and orientation of goal/homework sheets to consumers in order to enhance consumer ownership over their use. Evidence from study two suggests that case managers were most likely to have been completing required written documentation on goal and homework sheets, at least for some people (see section 7.5.2, p. 182 & 192). This finding was also supported among some consumers in focus group meetings. Clearly completion of goal and homework sheets by staff could be viewed as an added burden to workload, indeed one challenge to implementing recovery-based practice includes staff concerns in relation to additional workload and competing time demands (Deane, Crowe, King, Kavanagh, & Oades, 2006). However, most importantly, completion of homework and goal sheets by staff does not encourage consumer responsibility and ownership of this process, important for recovery consistent with the guiding philosophy of the Collaborative Recovery Model (Andresen, Oades, & Caputi, 2003).

Emphasis on written documentation inappropriate for some persons

A number of consumers expressed concern that goal and homework sheets placed a heavy emphasis on written format, identified as an unfavourable means of communication for some people. For example, it was suggested that the existing format might be inappropriate for people with reading or writing difficulties and/or for people who had preferences for other forms of communication such as in the visual, rather than verbal domains.

One suggestion for improvement of this aspect was to encourage staff during training sessions to consider and discuss alternate methods of communicating goals and homework with consumers (such as through illustration or collage). One consumer when discussing her concern with goal and homework sheets said, “I hate reading, I just usually go through it and write down whatever and ignore it...I find that annoying, too much reading” (participant, NSW group). Similarly another group member elaborated:

If it is word based then straight away I have to do something, I can't do it, it agitates...you wanted to get your own place or something just cut a picture from the

newspaper of a house that you love...I know it is a method but I don't think people use it enough or are encouraged as a support worker to do it. (participant, QLD group).

One participant from the Queensland group suggested that homework sheets could be redesigned into a book format suggesting this approach could prove beneficial in allowing consumers the opportunity to personalise expression of their goals. Other group members supported this suggestion.

Some staff members' inadequate discussions regarding recovery principles

A number of participants raised their concern that mental health staff had spent an inadequate amount of time, if at all, discussing and orienting them to the concept of recovery. In addition a number of consumers participating in interviews (study two) as well as focus groups expressed confusion with the term recovery. This potentially indicates that other consumers may have been inadequately oriented to the concept of recovery. For example, one person said that the word recovery was "foreign" to them stating, "I've heard the word recovery before, but what it actually means or is supposed to be I didn't know" (participant, NSW group) and another "we hadn't had any kind of discussion about what recovery is or anything" (participant, NSW group). Other group members made similar comments.

One person discussed how staff had brought up the concept of recovery, however described this discussion as totally inadequate. They stated, "it was a bit like the bird and the bees scenario...I got the talk but it wasn't a warm and friendly discussion about who you might marry or whatever, it was just the talk" (participant, QLD group).

Such findings are of concern, as at least for some consumers it appears that the message of the possibility of recovery and conceptual understanding of this concept was not being clearly conveyed by mental health staff. At some level this is not surprising since confusion and misunderstandings with respect to usage of this term is evident in the wider literature (Roberts & Wolfson, 2004). Some authors have suggested that the concept of recovery is yet to be embraced in Australia and New Zealand. In part this may reflect misunderstanding

or ignorance around what the term actually refers to, with everyday usage implying a return to previous state of wellness (Rickwood, 2004). However, conveying the message of recovery and facilitating an understanding of this concept, consistent with the consumer recovery movement is an important underpinning for the Collaborative Recovery Model.

Following on from group discussion in relation to these concerns one consumer suggested that it might be helpful to introduce consumers to recovery from the initial stages of commencement in the project within a peer-lead group setting. This person elaborated:

I was really disappointed that it actually wasn't a consumer education thing, it wasn't a consumer group education thing, it was really an opportunity for us as consumers to work together and really enjoy it in terms of learning about recovery and learning about ourselves. (participant, QLD group)

If such a suggestion were implemented it would be important to ensure that meetings were facilitated by a consumer knowledgeable in the area, to ensure that accurate messages were conveyed in relation to recovery (e.g. understanding of various definitions of recovery and conceptual underpinning of recovery within the context of the Collaborative Recovery Model). Possible benefits of implementing such a suggestion include ensuring that consumers are oriented to and familiar with recovery right from the initial stages, as well as creating an opportunity for sharing ideas among consumers with respect to their recovery journey. Swarbrick and Brice (2008) undertook a successful project where consumers were trained as trained peer educators in psychiatric hospitals, with the aim of conveying the message of recovery to other consumers. These authors identified the benefits of having peer educators in terms of providing proof that recovery is possible as well as sharing their own ideas and experiences. Peer support has been identified in the literature as an important resource in facilitating recovery (Coatsworth-Puspoky, Forchuck, & Ward-Griffin, 2006; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Findings in this area also suggest that mental health staff need to be encouraged during Collaborative Recovery Model training to take the time to thoroughly introduce and discuss

the concept of recovery with consumers (knowledge of recovery should not be assumed). It may also be beneficial to spend more time with staff during Collaborative Recovery Model training sessions to ensure that they are personally knowledgeable in this area, as well as confident in conveying the message and understanding of recovery to consumers. When reiterating the importance of having staff taking the time to introduce and orient people to recovery one person said:

If you basically know what recovery is all about then it's something to work towards...I always thought to myself personally, I thought recovery was like getting over your mental illness and not having it any more. (participant, NSW group).

Individual approach to goal striving during periods of illness

Findings from interviews (study two) as well as focus group meetings indicated that some consumers, not surprisingly, experienced difficulty regarding goal striving during periods of illness. Discussion of people's responses to this scenario whilst not extensive, indicate that the most appropriate approach may be best negotiated at an individual level. For example, some people expressed a preference to continue talking about their goals with staff members even during periods of illness, or to continue working towards their goals, to a lesser degree. For example, "I believe you should be working on it (goals) but not as much" (participant, NSW group). Other people felt that during periods of illness it might be most appropriate to take a break from goal striving and for mental health staff to provide guidance around returning to goal striving when the consumer indicated that they were ready. The Collaborative Recovery Model accounts for this possible scenario by encouraging staff to engage in motivational enhancement strategies with consumers if they are not ready/willing to engage in the goal setting component.

Whilst not directly discussed it is also apparent that the severity of illness and symptomology would likely influence consumer and staff decisions relevant to this aspect. Further clarification is needed in this area, however based on existing knowledge it is recommended that staff discuss the possibility of becoming unwell with consumers as one possible barrier to goal striving. This may help allay concerns, in particular if a plan is discussed as to how consumers would prefer to proceed in the event of becoming unwell or

experiencing an exacerbation of their symptoms. For example, this could be as simple as making a plan that if a particular consumer was to become unwell (at a degree determined by the consumer) that this could be documented within the CGT and that goal striving would be ceased and recommence in due course. It could also be of benefit to negotiate with particular consumers whether they would like to extend the three-month goal-monitoring period, relevant to their period of illness.

Inadequacy of orientation to the Collaborative Recovery Model

There was a perception among some consumers that the Collaborative Recovery Model was not presented to consumers in an appropriate manner that maximised its appeal. In particular several people spoke about the emphasis on paperwork and the sense that the model was something that they had to do. For example, one person said, “the way I received it is that she landed on my doorstep with these big fat books and just said basically this is the way we have to do it” (participant, QLD group). Along similar lines another person commented “when they got the clients it was like lets just get the paper work done” (participant, QLD group). Clearly a perception that the Collaborative Recovery Model is compulsory and heavily focused on paperwork is unlikely to appeal.

One group member suggested that a better way of introducing and orienting consumers to the Collaborative Recovery Model might be within a peer-group setting, before commencing with staff saying, “we all get together and get all excited about it and then the support worker comes along and says “okay let’s do this” because I didn’t receive it that way” (participant, QLD group). Such an approach could prove appealing for encouraging interaction among consumers in a supportive environment, where concerns or questions around the Collaborative Recovery Model could potentially be raised. It could also provide an avenue for increased empowerment of consumers through informing them directly about the model upfront.

Currently Collaborative Recovery Model training has been developed for mental health staff, however there are possible benefits in terms of empowering consumers through similar introductory sessions, sharing knowledge and encouraging consumers to take more

responsibility and ownership over practical aspects of goal striving and homework from their early commencement in the project. This could also potentially assist in easing the burden felt by staff in terms of their responsibility for completing ‘paperwork’ requirements. Several organisations participating in the AIMhi HSS project independently held consumer forums to introduce participants to the Collaborative Recovery Model. Whilst no direct feedback is available on the benefits of this process per se, these organisations were among a limited number identified as showing significant organisational support around facilitating the conceptual model into practice within mental health services (Crowe, Couley, Pedro, & Humphries, 2007).

Use of the term ‘homework’

The majority of people taking part in focus groups agreed that the term homework was inappropriate (with the exception of three people participating in the group held in New South Wales who expressed that they did not have concerns with the use of this term). Three consumers taking part in interviews as part of study two expressed similar views regarding the inappropriateness of the term homework. Other consumers taking part in interviews intuitively used the term goal, or some variation on this term, when referring to the homework component (see section 7.5.2, p.187).

Consumers’ concerns with the term homework appeared to focus on issues to do with perceived lack of choice and paternalism implied by the use of this term. Consumers taking part in focus group meetings used words such as “disgusting”, “offensive” and “condescending,” when discussing use of the term. For some participants the term conjured up strong negative associations with experiences at school, where they were told to do something, as opposed to being involved in this process. For example, one person said, “I don’t like the word homework, I never liked it at school so I still don’t like it” (participant, NSW group). Another person stated “homework it’s actually something I have to do but I don’t want to do it...like your back at school again” (participant, NSW group).

Similar views were echoed in the experiences of other consumers. For example, one person from the Queensland focus group said that the term homework brought up strong negative associations around her experiences with homework at school. These negative associations

alone were reportedly enough to turn her off the homework component (she stated that she completed only two homework sheets during her involvement in the AIMhi HSS project). Another person in the Queensland group spoke about the associations between homework and authority saying that the use of such a term made her think, “You’re making me do this. I don’t want to do this. So it brings up all issues – everybody’s issues with authority” (participant, QLD group).

Consumers participating in the earlier interview study, as well as focus group meetings suggested a range of alternate terms that could potentially replace the term homework such as goal work, goal tasks, short-term goal and mini goal. In summary it appears that use of the word ‘homework’ is viewed as inappropriate for at least some consumers. Whilst further research is needed in order to clarify which particular term/s are more appropriate, it is recommended that the term homework not be used with mental health consumers within the context of supporting them to work towards their goals.

A recent recovery-based self development program informed by the findings of this research used the term ‘action plan’ when referring to what was previously identified as homework (Oades et al., 2008). One way of approaching this issue at present would be through direct discussion with a particular consumer, in order to identify a personally appropriate and meaningful term for what has traditionally been referred to as homework. Findings also highlight the need for researchers to explore the relevancy of the term homework when working with other populations (for example cognitive behavioural therapy for anxiety and depression). Research addressing the appropriateness of this term as perceived by mental health consumers appears to be lacking in the literature.

Use of the term ‘recovery vision’

Findings from study two and focus groups indicate that some participants had concerns with the use of the term ‘recovery vision’, used within the context of the Collaborative Goal Technology (CGT). As identified in study two, three people used the term life vision, as opposed to the term recovery vision when discussing this aspect of the CGT. Concerns raised by another two participants during interviews with respect to formulating a recovery vision appeared to be tied to terminology, as opposed to the process of formulating a

recovery vision per se (see section 7.5.2, p. 214). In addition three people taking part in focus groups expressed direct concern with the term recovery vision, suggesting that use of this term was inappropriate. One person appeared to link the term ‘vision’, with experiencing hallucinations, viewed as too closely associated with illness. Reasons why other consumers viewed the term as inappropriate remained unclear. It may be that case managers spent inadequate time exploring this aspect with consumers and assisting them to formulate an appropriate vision, reflecting a need for enhanced training and support around this component. Alternatively, it is possible that this may be reflective of some consumers’ confusion with the meaning of recovery (see section 7.5.2, p. 214).

Based on existing knowledge at this point in time, it is recommended that mental health staff using the CGT take the time to thoroughly explain this component to consumers. Development of a recovery vision within the Collaborative Recovery Model focuses on assisting a person to clarify their life dreams or key values in life, linking this vision to their shorter term goals (Clarke, Oades, Crowe, & Deane, 2006). Separation of distal goals (personal life vision) from more proximal goals (three month plan) has a number of advantages. Firstly, distal goals typically have high meaningfulness, even though they may not be attainable in the near future. In contrast proximal goals have a higher level of manageability, although they may be less meaningful in the immediate term. The presence of distal goals also tends to increase the meaningfulness of proximal goals (Oades et al., 2005). Case managers should also consider discussing and identifying a term appropriate to the individual. For example, the term ‘recovery vision’ could be replaced with terms such as ‘life vision,’ ‘life direction,’ ‘life dreams,’ ‘valued direction,’ or whatever provides most meaning for the person. Further research is needed in collaboration with consumers to determine whether the term recovery vision would be more aptly renamed with respect to ongoing use of CGT sheets.

Some persons may also prefer to identify their recovery vision through illustration or other visual means, as opposed to providing written documentation. For example, this could occur by way of drawings, pictures or photographs. The Life Journey Enhancement Tools (LifeJET) informed by the findings of this research includes a ‘good life album.’ This

album encourages consumers to engage in reflection and documentation of their vision of a 'good life' -including strengths, valued directions, goals and achievements during their journey, utilising their preferred medium such as drawings or photographs etc (Oades & Crowe, 2008) This should be encouraged where appropriate and is in line with the recommendation from several consumers that there may be too much emphasis on written documentation in the existing format of goals and homework sheets for some people.

Perceived ownership of goal/homework books by staff

Concerns were raised by a number of consumers in the Queensland focus groups regarding the perceived ownership of goal and homework sheets/books by case managers, as opposed to consumers. It was discussed that even though staff were encouraged to provide consumers with a copy of every sheet completed, there was still a perception by some people that in reality goal and homework books and subsequently sheets were owned by staff (since case managers brought in goal and homework books and took them away). One person said of goal and homework sheets/books, "see they own that book...they brought it with them" (participant, QLD group) and another "even if you get a copy it is not the same" (participant, QLD group). Similarly when discussing the goal and homework books one consumer said, "it wasn't ours" (participant, QLD group). One consumer said that their case manager failed to provide them with copies of goal or homework sheets, leaving them uncertain as to their responsibilities around actions that they were supposed to take.

One recommended way of addressing this concern was to have a book or diary that was owned, kept and written in by the consumer where they could record their goals, homework and other relevant information. For example, one person said, "I think you should have your own book and keep it yourself...well they (staff) can look at it but you can keep it yourself so you can write stuff" (participant, QLD group). Similarly another person said "I would prefer to see it come in like a book form, like just pages and have your goals in the front, open the book, there are your long term goals and here's week one and have them illustrated" (participant, QLD group).

One consumer when describing the benefits of a ‘book’ format said, “just by writing your goals down and reflecting on them in your own words it’s healing because you gain that sense of autonomy back” (participant, QLD group). Other group members supported this perspective, for example describing such a format as “empowering”. One person elaborated, “when you do something that’s your own-like your own diary or your own journal it’s very different than if you do something like that (referring to goal and homework sheets) which looks so official” (participant, QLD group). Additional benefits of a book format included the opportunity to personalise it, for example through use of colour, illustrations and stickers. One person suggested that a book format could potentially include testimonies of other people who had succeeded in achieving their goals, providing a potential source of hope and ideas for other consumers. One possible way to implement suggestions around individualisation of goal and homework components is through mass customisation. Mass customisation is a paradigm that involves customisation and personalisation of products or services for individual customers at a mass production price. That is products are personalised to meet the needs of the person and at the same time costs are kept to a minimum (Pine, 1993).

This recommendation for a book type format to record goals and homework, which is owned and personalised by the consumer is consistent with the guiding principles and philosophy of the Collaborative Recovery Model including encouraging consumer responsibility and autonomy support. If a book format were implemented it was discussed that staff may need to separately record details of homework and goals for their own/service records. Another option not discussed during groups which may go some way to addressing this concern would be to encourage consumers to keep goal and homework books (in their existing format), as opposed to staff.

Difficulties finding individual goal and homework sheets

A number of people in the New South Wales and Queensland group meetings mentioned concerns with misplacing goal and homework sheets. For example, one person said “with the Collaborative Recovery Model each bit of paper was like a paper chase trying to find last week’s homework” (participant, QLD group). Similarly a New South Wales group participant said, “I find it irritating when you have to look for everything all the time”

(participant, NSW group). One person said that she solved this difficulty by placing all goal and homework sheets in a plastic sleeve. Another person when suggesting the benefits of a book format said “why not put them in a book so that they’re always there, because people -mental illness often gets you very scattered” (participant, QLD group).

Such suggestions add further weight to the possible benefits of a book type format for documentation of goals and homework. Other authors have raised the possible benefits of having homework documented in one place, such as in a folder, as opposed to on separate sheets of paper due to the likelihood that they may be misplaced (Dunn, Morrison, & Bentall, 2002).

Frequent turn over of psychiatrists and lack of collaboration

Several consumers in focus groups raised concerns about the constant turnover of mental health staff. For example, “my psychiatrist gets changed every six months, so you’re talking and spilling everything out and then he’s gone so you start with a new one” (participant, QLD group). Another person said “I get a different psychiatrist every time I go in there and they just look in the notes and stuff...makes it hard” (participant, NSW group). This area of concern was raised by a number of participants during the earlier interview study (see section 7.6.2, p. 209). Some participants expressed concern to do with the nature of their relationship with psychiatrists and lack of collaboration around medication usage, as discussed by other participants during interviews (see section 7.6.2, p. 216). Several participants thought that it might be helpful for case managers to attempt to facilitate improved working relationships between consumers and psychiatrists. However it was reiterated that such decisions should remain at the discretion of the individual consumer.

In response to the unequal power relationships often described by consumers in relation to the use of psychiatric medications, Deegan (2007) has undertaken some work to develop a recovery-based program to support shared decision making regarding medication usage. This program was developed in response to the often unequal power relationships described by consumers’ in these contexts. Shared-decision making is based on the underlying premise that there are two experts in a meeting, both the consumer as well as the

practitioner. It also takes into account not only medications but also non-pharmaceutical self-taught strategies that people often use to enhance their well-being (termed personal medicine). One aspect of this program under development includes training case managers to support consumers using medication in their recovery process. This includes assisting consumers to identify personal medicine and to create statements that include their individualised overarching recovery-oriented goals around using psychiatric medication to share with practitioners (hence encouraging shared decision making) (Deegan, 2007).

Similarly Byrne and colleagues (2004) have undertaken some research around developing and trialing a multidisciplinary training program around medication adherence strategies focusing on strategies to improve the adherence skills, attitudes and knowledge of mental health clinicians (entitled Medication Alliance). The training program was developed following extensive review of the literature and included consultation with consumers, carers, clinicians and researchers. The training program focuses on areas such as developing a medication alliance, general skills supporting client engagement (normalisation/involving carers), core skills (motivational interviewing, problem solving, CBT for irrational beliefs) and agenda setting and homework.

Helping and supporting other disadvantaged people in the community

Further support, to that already discussed during interviews (see section 7.5.2, p. 185) was identified during this study regarding the meaning obtained from helping and supporting other disadvantaged members of the community. For example, this included comments such as “it’s just a really good thing to help others” (participant, QLD group).

Beyond the intrinsic benefits that could arise when supporting other people, a number of other possible benefits were also discussed. This included taking the focus off the consumer and their own difficulties, the opportunity to learn more about how to help themselves through gaining knowledge into other people’s experiences, providing meaningful activity for the day and personal motivation that came from seeing other people make positive change in their life. For example, comments such as “it was good being able to help someone else instead of worrying about myself” (participant, NSW group) and “I think the benefits of giving the support to others is important because you can learn more through

them, as well to help yourself with your own illness” (participant, NSW group). Another person when discussing the benefits of supporting others said, “helping other people that are disadvantaged...especially if you can see their life change, motivates you even more” (participant, NSW group).

The means by which consumers identified that they were supporting others varied greatly. For example, several people discussed a particular friend with mental illness whom they had stood by during periods of illness. One person was working in volunteer role for a local organisation supporting homeless individuals and another person had volunteer experience supporting and assisting others through his membership as part of a Clubhouse. Other group participants identified that whilst they were not actively engaged in work that directly helped others they could find meaning in other people’s experiences with comments such as, “that sounds like something I would want to do”(participant, NSW group).

Moreover, when discussing their reasons for participating in focus group meetings a number of consumers mentioned the opportunity to help their peers. For example, one person said he was participating to “give something back,” another person said “I’d like to share this experience with everybody” (participants, NSW group). One person in the New South Wales group said that his reason for attending the group was to hopefully acquire some new knowledge that he could share and use to help others with disabilities, at the service where he worked. Similar feedback was offered by several consumers in the Queensland group, e.g. “the whole idea of research is that the poor buggers come in behind us get a better deal than we did...if we don’t get a say nothing gets changed” (participant, QLD group). Whilst research in this area is limited several authors have identified that one of the reasons identified by consumers for taking part in mental health research is to help others/peers with mental illness (Cary et al., 2001; Roberts, Warner, & Janet, 2000).

Further research is needed to clarify whether this experience is shared more widely among other consumers, however some evidence is available in support of these findings (Deegan, 2005; Jacobson & Greenley, 2001) . Whilst preliminary, these findings suggest that one

valued life direction which may be appealing to other consumers would be to identify mechanisms by which consumers can support and assist other people, in particular disadvantaged members of the community. Mental health workers engaged in discussion regarding goals and recovery visions with consumers may benefit from raising this as an area where other consumers have identified meaningful directions in their lives. People with mental illness may also value the opportunity to take part in research activities in particular where they feel that sharing their own experiences can contribute to assisting others in similar situations.

8.5 CONCLUSIONS

This study demonstrated that many consumers were able to meaningfully comment on their own, as well other consumers' experiences of the Collaborative Recovery Model.

Furthermore consumers taking part in this study offered practical suggestions and ideas regarding improved ways of working when utilising the Collaborative Recovery Model as an intervention within case management settings. This is important to recognise considering research in this area, seeking consumers perspectives regarding case management delivery and improvement is lacking (Marshall, Crowe, Oades, Deane, & Kavanagh, 2007).

Further support was found for a number of aspects of concern raised during the previous interview study including: concerns regarding appropriateness of the terms 'homework' and 'recovery vision', existing design of goal and homework sheets, goal striving during periods of illness, lack of collaboration between consumers and psychiatrists and constant turnover of mental health staff.

Consumers taking part in this study also raised a number of additional concerns and recommendations that have the potential to direct improvement of the Collaborative Recovery Model, and related training and support of mental health staff into the future. For example, some consumers expressed concern in relation to staff members' perceived negative attitudes towards documentation of homework and goals. They also perceived a need for ongoing training and support of staff following initial training. Some consumers stated that staff spent inadequate time orienting and introducing them to the concept of recovery. Furthermore there was some discussion that the model was inadequately

introduced from the outset. A number of consumers also expressed their concern that goal and homework sheets/books were perceived as owned by staff, as opposed to consumers and that individual sheets were easily misplaced.

It is apparent that consumers want to be more empowered and involved in the use of the Collaborative Recovery Model from the outset. Possible avenues to support this process are offered. For example through peer-run recovery forums/introductory sessions and use of a hand held diary or book to record goal striving that is personalised and owned by the consumer.

Many of the concerns and recommendations offered by consumers within this study have broader relevance and applicability to case management practice and recovery-focused service delivery. For example, appropriateness of the term 'homework,' encouraging consumers to consider expression of their goals in alternate modalities (such as visual), upfront approach to address goal striving during periods of illness and exploring opportunities to personalise and enhance consumer ownership over goal plans.

The next chapter summarises key findings from the suite of three studies comprising this thesis. Implications and limitations arising from these studies are discussed, as well as future research directions.

CHAPTER 9:

CONCLUSION

The concluding chapter highlights the main findings from the suite of three studies comprising this thesis as well as implications and limitations of this research. Study two and three are discussed concurrently as they are complementary in design with findings from study two feeding into study three. Thus study three adds support to and builds on findings from the earlier interview study. This thesis concludes with key recommendations and suggestions for future research.

This thesis primarily focused on capturing consumers' experiences of the actual interactions that occur between consumers and staff in case management settings, within the context of evaluating and improving the Collaborative Recovery Model and its use and delivery in mental health contexts.

Check with earlier research gaps

This thesis sought to begin to address gaps in the previous research regarding:

- a) Few known studies, if any, have attempted to evaluate consumers' perceptions of recovery oriented service provision as received in mental health services
- b) To date, consumers have infrequently been involved as co-researchers in the evaluation of case management activities, in particular with reference to supporting recovery

The broad aims of this research were to examine:

- a) consumers' perceptions regarding the effectiveness of the Collaborative Recovery Model in assisting their recovery, as experienced in case management settings
- b) consumers' perceptions in relation to the degree with which they engaged in recovery-focused support practices consistent with the Collaborative Recovery Model when working with their case managers
- c) consumers' perceptions in relation to the ongoing improvement of the Collaborative Recovery Model and its use and delivery in mental health services

This thesis achieved these aims by usefully combining qualitative and quantitative methodologies including a quantitative self-report questionnaire (study one) with semi-structured interviews (study two) and focus group meetings (study three). Consumers' perceptions regarding the degree to which key aspects of the Collaborative Recovery Model

were implemented within case management settings were examined as part of studies one and two. Study two further focused on examining consumers' positive and negative experiences of the Collaborative Recovery Model as received in services, as well as examining recommendations regarding improved practices. Using a reflexive design, key findings from earlier studies were presented back to consumers as part of several focus group meetings. This study primarily focused on examination of consumers' perceptions regarding improvement of the Collaborative Recovery Model and its delivery and use in case management contexts, building on findings from the earlier studies.

As stated earlier, this thesis is significant since it is a rare example of research involving consumers in the evaluation of recovery-oriented practice. Importantly studies two and three within this thesis demonstrated that many consumers were able to meaningfully comment on their own, as well other consumers' experiences of the Collaborative Recovery Model. Furthermore consumers offered practical suggestions and ideas regarding improved ways of working when utilising the Collaborative Recovery Model within case management settings. Recognition of findings arising from this research, broadly speaking, will hopefully encourage other researchers to actively seek consumers' perspectives when evaluating mental health service delivery.

Research as part of this thesis was undertaken in close collaboration with a number of consumer researchers. Whilst recognition of the value of consumers in research activities is increasing in mental health and medical research (see section 2.4), uptake by researchers remains slow. This is certainly the case regarding evaluations of case management activities as per the review outlined in chapter three. Only four studies were identified as part of this review that involved consumers directly in research activities, several of which were limited to data collection activities, failing to involve consumers extensively throughout other aspects of the research process. This thesis contributes to this research gap through active involvement of consumer researchers in various aspects of the research process, with some limitations regarding time and resources. For example, consumers were involved to varying degrees in each of the three studies, in the data collection phase, as well as in the interpretation and discussion of findings.

Benefits of involving consumers in research activities as part of this thesis remain anecdotal and were not a specific focus of investigation due to limited time and resources. However, systematic investigation regarding the costs and benefits of involving consumers in research activities are likely to become increasingly important, within the context of encouraging other researchers to pursue collaborative research. Guidance regarding engagement in collaborative research activities including provision of training and support are available for interested parties (Linhorst & Eckert, 2002; Malins, Morland, & Oades, 2002; Oades, Viney, Malins, Strang, & Eman, 2005).

It is argued that consumer involvement as co-researchers and development of truly collaborative research endeavours in evaluation of mental health services is increasingly becoming pertinent for a range of reasons. Firstly the emphasis on ‘action research’, or the opportunity to improve services is a key reason repeatedly emphasised in the literature when providing a rationale for consumer involvement in research activities (Birkel, Hall, Lane, Cohan, & Miller, 2003; Department of Health, 2000; Lloyd & King, 2003; Salyers & Macy, 2005; Townend & Braithwaite, 2002). Mental health consumers in particular are likely to value improvement of services as a key aim of collaborative research (Carrick, Mitchell, & Lloyd, 2001). An emphasis on service improvement and collaboration with multiple stakeholders in evaluation research is also consistent with contemporary conceptualisations of evaluation, such as formative and constructivist evaluation.

Furthermore with the rise of the recovery movement, related issues of collaboration and redistribution of power among multiple stakeholders are importantly coming to the forefront across all levels of mental health service delivery, including evaluation. In particular there has been a revaluing of the experiences of people with mental illness, both in relation to their personal experience of living with and recovering from mental illness, as well as their experiences as consumers of services. It has been argued that recovery oriented systems in particular should be accountable to outcomes and results that are deemed important by consumers (Onken et al., 2002). Recovery, consistent with consumer accounts, is after all owned and driven by the consumer. Services can orient themselves to support this process, but awareness of how and whether this is occurring requires the input of people with lived experience of both recovery and services. Hence there has been a

strong emphasis on consumer involvement in recovery research both in relation to examining consumers' experiences and perceptions of mental health services (Ralph & Corrigan, 2005), as well as more specifically in relation to their involvement as co-researchers in research endeavours (Onken et al., 2002).

There is also a need for a reframing of evidence-based practice to include evidence by experience if recovery based services are to be informed. Much of the existing published research on EBP was conceived or implemented prior to the advent of the recovery movement as a driving vision for mental health services (Anthony, Rogers, & Farkas, 2003; Campbell-Orde et al., 2005). Hence traditional notions of evidence based practice do not necessarily include the sorts of epistemologies that may enhance knowledge around recovery. Furthermore lived experience of consumers has not traditionally been valued within this domain (Campbell-Orde et al., 2005). Despite this, recovery oriented services and evidence based practices have not always been described as mutually exclusive (Anthony, Rogers, & Farkas, 2003; Solomon & Stanhope, 2004; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). To the contrary, some authors have suggested that recovery and evidence based practice principles are critical for effective service delivery-drawing on scientific practices and the lived experience of people with mental illness (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). The above issues regarding the importance of truly collaborative research endeavours in mental health service evaluation are crucial for the broader mental health recovery/rehabilitation field.

9.1 SELF REPORT QUESTIONNAIRE: STUDY ONE

Preliminary findings suggest that consumers working with Collaborative Recovery Model trained staff were able to identify significant changes to service delivery in relation to the frequency with which they were encouraged to take responsibility for recovery, degree with which they collaborated with staff and completed homework activities to assist them to achieve their own goals. The vast majority of consumers and case managers appeared to value, or place importance on Collaborative Recovery Model principles and components, regardless of whether they had been working consistently with this model. However, consumers working with staff who had been trained in the model placed significantly

greater importance on homework activities, when compared to consumers receiving services as usual (non Collaborative Recovery Model trained staff).

Consumers reported that staff were generally supportive of their recovery processes, irrespective of whether they had attended Collaborative Recovery Model training. Similar findings were reported for case manager participants, with no differences in ratings of helpfulness in assisting recovery between conditions. However, in contrast to findings for consumer participants, case managers did not report that they engaged in activities consistent with the model more frequently when they had received training, compared to staff that had not attended Collaborative Recovery Model training.

Implications

Findings provide preliminary evidence for consumer and staff valuing of Collaborative Recovery Model principles and components when working in case management settings, within the context of supporting consumers' recovery processes. This is important since limited evidence exists at present examining the importance of these activities from consumer and staff perspectives. This is particularly apparent for homework activities, motivational enhancement and needs assessment. Clearly further research is required to understand the reasons such activities are valued (or indeed are not valued) by staff and consumers (such as was undertaken for consumers in study two as part of this thesis). However, this is an initial step forward in terms of evaluating the importance of particular case management activities within the context of supporting recovery.

Whilst recovery has been rising to the forefront as a guiding vision for mental health services (Slade, Amering, & Oades, 2008) it often remains unclear to what degree recovery oriented services are implemented in practice. This study is one example of an early attempt to examine the extent to which various aspects of a recovery oriented service model are being received in services from consumer and staff perspectives. This is clearly a significant step towards assessing the operationalisation of recovery principles from consumer and staff perspectives. Research of this nature is likely to take on increasing importance if the emphasis on recovery oriented mental health services is to be realised.

Limitations

A clear limitation of this study raised elsewhere (see section 6.2.1) is that it utilises a questionnaire that requires further psychometric testing in order to more extensively establish its validity and reliability. Therefore results are reported as preliminary and are interpreted with caution. Limitations in terms of the design characteristics are also evident as it was also not possible to match either case manager or consumer data in the delayed and active conditions. Consideration should also be given to the possible impact of sample attrition and missing data.

A further limitation of this study is that the CEO-CRM and SEO-CRM provide only an indirect indicator of consumers and staff exposure to Collaborative Recovery Model relevant practices. Consumers were also not provided with an opportunity to comment in any detail about services they received, or to offer any suggestions for improvement. However this study was usefully combined with qualitative methodologies as part of studies two and three, in recognition of such limitations. For further discussion see section 6.2.1.

9.2 SEMI-STRUCTURED INTERVIEWS AND FOCUS GROUP MEETINGS: STUDIES TWO AND THREE

Studies two and three provided a source of in-depth information regarding consumers' experiences and perceptions of various recovery based support practices consistent with the Collaborative Recovery Model when working within case management contexts. For example, findings from study two (interviews) provided insight into processes that consumers considered valuable with respect to goal striving and homework activities such as providing a sense of direction for life, encouraging ownership and responsibility, benefits of formal documentation and positive feelings of achievement and personal growth, among others.

Similarly when discussing relationships with case managers, feedback provided insight into factors contributing to 'helpful relationships'. For example, provision of support and encouragement (both in general and with respect to goal striving) was an essential characteristic of the relationship as mentioned by consumers in study two. Other aspects of

‘helpful relationships’ included for example, staff assistance with problems in day-to-day life, case managers who were perceived as ‘friendly’ or like a friend and case managers who listened and ‘heard’ the person.

Findings from study two also provided insight into some factors beyond case management settings that consumers identified as important when building better, or more meaningful lives in the community. For example, consumers discussed aspects such as development of relationships with family, friends or partners, medication and/or self-management of symptoms, staying out of hospital, having their own home or place of residence, obtaining voluntary or paid work and assisting other people with mental illness. The meaning that can be derived from supporting other people with mental illness was a finding that appeared to also resonate with many consumers in study three.

Many concerns and recommendations offered by consumers within studies two and three hold relevance not only for improvement of the Collaborative Recovery Model, but also broader applicability to case management practices and recovery focused service delivery. For example, consumers concerns regarding use of the term ‘homework’ and encouraging consumers to express their goals in alternate modalities where preferred (such as the visual domain). Other findings with broader applicability include some consumers preference for the term ‘life’ over the term ‘recovery’ and better socialisation regarding how goals might be adjusted based on individual need during periods of illness. In addition general concerns at the service level included frequent turnover of staff, lack of collaboration with psychiatrists and other hospital staff around usage of medication.

Consumers taking part in study three raised a number of additional concerns and recommendations in relation to their experiences of working with Collaborative Recovery Model trained staff, to those offered during study two. For example, some consumers expressed concern in relation to staff members’ perceived negative attitudes towards documentation of homework and goals and saw a need for ongoing training and support of staff following initial training. Some consumers felt that staff dedicated inadequate time, if any, orienting and introducing them to the concept of recovery. A number of consumers also expressed their concern that goal and homework sheets/books were perceived as

owned by staff, as opposed to consumers and that individual sheets were easily misplaced. One suggestion for addressing this array of concerns was to create a book/diary format where goal strivings and homework could be documented, which could in turn be personalised and importantly owned by the consumer. It was also suggested that the Collaborative Recovery Model may be more appropriately introduced by way of consumer run-forums, thus allowing consumers to share their experiences in relation to recovery.

Implications

Findings arising from studies two and three have advanced understanding of consumers valuing of recovery focused practices consistent with the Collaborative Recovery Model when working with staff in case management contexts. Furthermore, practices and principles emphasised within the Collaborative Recovery Model have broader relevance to recovery focused mental health service delivery. For example, goal striving and homework are practical activities which may already be engaged in by case management staff. This research highlights some benefits of these activities perceived by consumers, as well as concerns around these practices which may help inform the way in which case managers can more effectively engage in these activities with consumers in the future.

Findings from studies two and three also have implications for improvement of the Collaborative Recovery Model and associated training package for mental health staff, as well as case management practices more generally. Recommendations arising from studies two and three are outlined in the respective chapters (see Tables 12 & 14). Some findings and recommendations arising from this thesis are already informing other related research initiatives evolving from the Collaborative Recovery Model research (see afterword)

Limitations

One limitation relevant to study two was the purposive sampling strategy utilised when attempting to identify consumers with ‘unhelpful experiences’ with respect to the Collaborative Recovery Model. Some participants in the AIMhi HSS project ceased involvement, or ‘dropped out’ in the early stages of commencement in the project. Whilst procedures were put in place retrospectively to examine ‘drop out’ lists, establish reasons for leaving the project (where available) and to contact the person to enquire as to their

experiences with the model, this was not always possible. In particular when participants had ceased contact with the mental health service they were attending. Ideally a procedure would have been implemented to follow up participants as soon as they ‘dropped out’ of the AIMhi HSS project to investigate their experiences of the Collaborative Recovery Model (and where appropriate to invite them to take part in interviews). It is possible that improved processes in this regard may have led to identification of additional dissatisfied consumers.

9.3 RECOMMENDATIONS

Key recommendations for future usage of the Collaborative Recovery Model informed by findings of this research are outlined below:

1. The word ‘homework’ should not be used and should be replaced with an alternate term that is more readily accepted by consumers such as ‘action plan’.

Ideally further consultation with consumers should occur prior to selecting an alternate term for use.

2. The use of the term ‘recovery vision’ in the Collaborative Goal Technology should be replaced with the term ‘life vision.’

This term appears more consistent with the everyday language used by consumers. It may also assist in shifting consumers to focus beyond their illness, to their broader life goals and visions. The use of the term ‘life’ within this context is also likely to be more consistent with language used by the general population when discussing their goals and future directions.

3. Equivalent Collaborative Recovery Model training should be developed for consumers.

Presently the standard Collaborative Recovery Model 2-day initial training package and booster session at 6 and 12 months, or the enhanced training with coaching mentioned above, are available for mental health staff. An equivalent training program should be offered to consumers. Mental health consumers should ideally facilitate training. This may assist in enhancing consumer ownership and responsibility at the very outset of

commencement in the program, which is in keeping with the philosophy of the Collaborative Recovery Model. It is also likely to assist in facilitation of more equal and collaborative working relationships between staff and consumers from the outset, as there will be less of a knowledge disparity between the two parties. Providing consumers with training may also assist in reducing demands on staff (who are often time poor). For example, if consumers are encouraged to take responsibility for documentation of their own goals and homework tasks this may leave staff and consumers quality time for other relevant activities, such as discussion of goal plans and progress.

4. Goal and homework sheets should be incorporated together into a book-type format that is owned and can be personalised by mental health consumers.

The current format (separate books containing goal and homework sheets kept by staff, with single sheets provided to consumers on completion) does not support consumer ownership or responsibility over this process. Furthermore practically there are likely to be benefits of having goal and homework plans in the one place, reducing the likelihood of individual sheets being misplaced. During the design process consideration should be given to minimising the burden of staff reporting requirements.

5. Consumers should be encouraged and provided with options to express their goals and recovery visions using alternate mediums such as drawings, photographs and pictures as desired. This should be considered during redesign of goals and homework into a book format (see bullet point 4).

6. Additional interventions should be developed and offered to address difficulties regarding transfer of training into practice in mental health services (e.g. to supplement 2 day initial training and one day booster sessions offered at 6 and 12 months as part of the AIMhi HSS project).

For example avenues for more intensive support of mental health staff working directly with consumers, as well as service managers/team leaders. Future changes to staff training and support procedures should be undertaken in consultation with service providers. This

should include exploration of key barriers to implementing the Collaborative Recovery Model in practice settings, as perceived by mental health staff. Some research has already been undertaken in this area (Uppal et al., in press). Key barriers identified by staff participating in the AIMhi HSS study were perceived to be to be ‘institutional constraints’ and ‘client unresponsiveness to the intervention’.

Possible changes to support dissemination of research protocols into practice in service settings includes, for example, support of management and team leaders, so they better understand, effectively communicate and lead recovery-focused change among their staff (Crowe, Couley, Pedro, & Humphries, 2007) and better linking of research practices with the ‘mission’ of organisations. Other suggestions include better integration of the new ideology and protocols, regular monitoring of progress, workplace coaching, additional staff incentives (Uppal et al., in press) and audit and feedback (Bero et al., 1998). Also worthy of consideration is interventions that target the external attributions of staff to encourage them to take responsibility for transferring research protocols into practice (Uppal et al., in press). For example clinicians’ perceptions regarding ‘client unresponsiveness to the intervention’ may in part reflect pre-existing attitudes held by individual clinicians, as opposed to external factors.

The importance of multifaceted interventions, which include a combination of methods, is highlighted (Bero et al., 1998). Findings from this thesis and another recent study (Uppal et al., in press) clearly indicate that training and booster sessions provided to staff were insufficient to facilitate and sustain changes in clinical/support practices. For example, many consumers did not receive essential components of the model such as goals and homework and some appeared to have been inadequately introduced to the concept of recovery. Furthermore it was apparent that even when components such as goals and homework were being completed, this was not always in a manner consistent with the conceptual model and training protocol.

7. At commencement in the Collaborative Recovery Model consumers should be brought together in a peer-run group setting to discuss the concept of recovery (consistent with consumer movement/Collaborative Recovery Model) and to share ideas regarding their own experiences of what has been of benefit in their recovery.

This meeting should be facilitated by a mental health consumer with lived experience of recovery who is sufficiently knowledgeable in relation to recovery and can ensure that people are adequately informed from the outset. This meeting could occur within the Collaborative Recovery Model training for consumers (see bullet point 3).

9.4 FUTURE RESEARCH DIRECTIONS

The following directions are offered for future research. Directions 1-3 are specific to the Collaborative Recovery Model and are informed by the recommendations outlined in the previous section. Directions 4 -6 are broader and non-specific to the Collaborative Recovery Model, also informed by the findings of this thesis.

1. Development and trial of an equivalent Collaborative Recovery Model training program for consumers, including development of facilitator training (training to be led by consumer facilitators). Consumers should be consulted during this process.

2. Redesign and trial of goal and homework books into a book-type format that can be owned/personalised by mental health consumers. Consumers should be consulted during this process.

3. Development and trial of an additional support program for staff working within the Collaborative Recovery Model with consumers (beyond existing 2 day training and booster sessions), as well as education and support program for managerial staff in relation to facilitating recovery-focused practices among their staff.

4. Further examination of perceptions of people with serious mental illness around possible preferences for the term 'life', when discussing their directions and goals for the future, as opposed to the term 'recovery'.

5. Examination of appropriateness of the word 'homework' among the broader population of consumers with serious mental illness.

This will assist in investigating whether concerns around use of this term are more widespread. In addition it appears warranted to examine the relevancy of the term 'homework' when working with other populations (e.g. cognitive behavioural therapy for depression and anxiety). At present research addressing the appropriateness of terminology 'homework' as perceived by people with mental illness in general appears to be lacking.

6. Further exploration of the extent to which consumers with serious mental illness have engaged in/perceived value in supporting other people within their own recovery process.

With reference to findings arising from this research, it is of particular interest to examine the extent to which people with serious mental illness have perceived value in supporting others with mental illness, as well as other vulnerable populations/community groups. However, examination of the role and possible benefits of supporting other people in general may also be of worthy of study with respect to recovery and more generally in terms of enhanced well being among this population.

Afterword

Findings from this research indicate that consumers were able to perceive some recovery-focused changes following staff training in the Collaborative Recovery Model. Consumers and case managers alike valued key guiding principles and components of this model. However consumers wanted to be more empowered and involved in the use of the model from the outset such as through an equivalent training/introductory session, a peer led group to introduce and share experiences of recovery and use of a hand held diary to record goal striving to be personalised and owned by consumers. Such directions around empowering consumers to take more responsibility for usage of the model and hence their own recovery, may also hold promise for addressing difficulties regarding transfer of the Collaborative Recovery Model from theory into practice within mental health services.

It was anticipated that the findings arising from this research would continue to have influence beyond the duration of this thesis. Indeed some findings have already informed other research projects within the Illawarra Institute for Mental Health, where this research was conducted. For example, aspects of a recovery based development program entitled 'Flourish' were informed by some findings from this research (Oades et al., 2008). The 'Flourish' program uses the terminology 'action plan' as opposed to 'homework', when supporting consumers to take smaller steps towards their goals. The program also utilises terms such as 'life goals' and 'values in life,' when supporting individuals to begin thinking about their preferred life direction, as opposed to the term 'recovery'. In addition the program incorporates a workbook that is owned by and can be personalised by consumers. Similarly a tool kit developed for mental health staff when working with consumers entitled the Life Journey Enhancement Tools (LifeJET), is another practical example of how this research has already informed the ongoing development of goal and homework components (Oades & Crowe, 2008). For example, through the use of term 'life', as opposed to 'recovery' within this training package. Furthermore, in recognition of the transfer of training problems (also recognised by the consumers) the Collaborative Recovery Model staff training was enhanced by providing staff with extra learning resources on a CD rom, written exercises to work with the CD rom material, and a team based one hour coaching session each month for 6 months post the initial Collaborative Recovery Model training

workshop. This has been shown to be associated with a substantial improvement in the rate of training transfer. Further work is planned at the Illawarra Institute for Mental Health to examine whether transfer of training difficulties can be improved through offering more intensive support to case managers, as well as service managers.

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APPENDIX A

ARTICLE: A REVIEW OF CONSUMER INVOLVEMENT IN EVALUATIONS OF CASE MANAGEMENT

Marshall, S. L., Crowe, T.P., Oades, L. G., Deane, F.P., & Kavanagh, D. (2007). A review consumer involvement in evaluations of case management: Consistency with a recovery paradigm. **Psychiatric Services**, 58, 396-410

APPENDIX B

TABLE OUTLINING COLLABORATIVE RECOVERY MODEL TRAINING PROGRAM AND RELEVANT KNOWLEDGE DOMAINS, PROTOCOL, SKILLS/ATTITUDES AND COMPETENCIES

This table is taken directly from the article by Oades et al., (2005) Collaborative Recovery: An integrative model for working with individuals that experience chronic or recurring mental illness. *Australasian Psychiatry*, 13, 279-

APPENDIX C

CAMBERWELL ASSESSMENT OF NEED SHORT APPRAISAL SCHEDULE (CANSAS)

APPENDIX D

COLLABORATIVE GOAL TECHNOLOGY SHEET

APPENDIX E

HOMEWORK SHEET

APPENDIX F

ARTICLE: MENTAL HEALTH CONSUMERS' PERCEPTIONS OF RECEIVING RECOVERY-FOCUSED SERVICES

Marshall, S.L., Crowe, T.P., & Oades, L.G. (in press). Mental health consumers' perceptions of receiving recovery-focused services. *Journal of Evaluation in Clinical Practice* (accepted 4/06/2008)

APPENDIX G

CONSUMER EVALUATION OF THE COLLABORATIVE RECOVERY MODEL QUESTIONNAIRE (CEO-CRM) & STAFF EVALUATION OF THE COLLABORATIVE RECOVERY MODEL QUESTIONNAIRE (SEO-CRM)

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ETHICAL CONSIDERATIONS STUDY ONE

APPENDIX I

INTERVIEW GUIDELINES

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CONSUMER FEEDBACK REGARDING INTERVIEW GUIDELINES

APPENDIX K

ETHICAL CONSIDERATIONS STUDY TWO AND CONSENT SHEET

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LEXIMANCER OPERATIONAL METHOD: THE 6 KEY STAGES

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INTERVIEWS: LEXIMANCER PROCEDURE ANALYSES ONE, TWO AND THREE

APPENDIX N

MATERIALS UTILISED BY FOCUS GROUP FACILITATORS: GUIDING DOCUMENT AND POWER POINT SLIDES

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MATERIALS UTILISED BY FOCUS GROUP PARTICIPANTS:
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APPENDIX P

ETHICAL CONSIDERATIONS STUDY THREE AND CONSENT SHEET