

Should recovery practices within mental health services be monitored?
If so, how can organisational recovery orientation be measured?
A qualitative inquiry.

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Submitted to Auckland University of Technology in partial fulfilment of the requirements
for the Degree of Master of Health Science (MHSc)

School of Psychology

2009

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgement), nor any material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Lola Ianovski



Signature of Author

Date 18th December 2009

Acknowledgments

This report would never have been completed were it not for the extraordinary kindness of everyone who supported me throughout the process. First and foremost, my husband Ilia did more than I dared hope for to ensure that my dream of seeing this project through became a reality. Without knowing what ‘recovery’ is, Ilia continues to provide the most ideal recovery-oriented environment for me to grow in even in times when going gets beyond tough. My dear friend Patricia and my family-in-law dealt with the ‘spillovers’ and put me back together when Ilia was not around. I owe them all forever.

I am grateful to all my colleagues and to all the wonderful strangers who took part in this research. I am not allowed to name you, but you know who you are. Your time, effort, and insights were appreciated when we met and are appreciated now. I learned something new from you still every time I read our interviews. The stories you shared with me were often personal and emotionally laden. Thank you for trusting me with them. I hope I used them well.

I have severely tried the patience of my supervisors Kate Diesfeld and Rex Billington. I apologise for being such a ‘messy’ student. When nothing seemed to go as planned, and deadlines kept being pushed further, Kate and Rex remained calm and supportive. Thank you, truly.

I would also like to acknowledge that I have built on the existing work by Mary O’Hagan in compiling the table of measures of recovery orientation (Appendix A). Mary graciously shared her work with me at the early stages of this research, thus allowing me to focus on expanding it rather than having to start from scratch. I do this every time I look at the sheer size of that table.

This study has been approved by the Northern Y Regional Ethics Committee on the 9th of April 2009. Reference number NTY/09/03/030. See Appendix B for details.

Abstract

This study is a stakeholder consultation about recovery policies and practices in Aotearoa/ New Zealand. Six consumer advocates and five policymakers were interviewed on whether evaluating mental health services' adherence to recovery philosophy would be useful in facilitating implementation of national recovery policies and the shape and function of such evaluation. Two focus groups and six individual interviews were conducted and transcribed. Textual data was subjected to software-assisted and manual thematic analyses. One of the key findings is participants' lack of confidence in the current implementation of the recovery paradigm within the New Zealand mental health sector. Participants generally supported the idea of measuring recovery orientation at organisational level, although for different reasons and with reservations. Evaluating the process of service delivery appeared to be preferable to measuring outcomes.

INTRODUCTION

The idea that mental healthcare is a highly politicised field is not new and continues to be elaborated on by many (Foucault, 1967; Laing, 1982; Martinez, 2005). The broad reforms that are attempted in health systems around the world bring a number of issues from the sphere of healthcare philosophy into the realm of very tangible and practical concerns. For example, many terms and concepts are contestable, have multiple meanings, and are not uniformly accepted by all stakeholders (Henderson & Petersen, 2001; Martinez, 2005). The priorities for systemic goals, or ways of achieving them, may not be shared by all stakeholders either, even in a relatively small country such as New Zealand (Jacobson, 2007; Jenkins, McCullough, Friedli, & Parker, 2002). Translating broad systemic goals into practice is further complicated by the fact that learnings from overseas research and implementation initiatives may not apply to all health systems in a straightforward fashion. Thus, many concepts and research findings related to promoting systemic change warrant contextualisation and discussion.

Recovery is a complex concept

The concept of ‘recovery’ with regard to mental illness is not new and has enjoyed an on and off popularity within caring profession for at least 200 years (Ralph & Corrigan, 2007). Until the last few decades however, the definition of the term has been based on biomedical model and defined by caring professionals. It was used to indicate complete remission of symptoms, or cure, from mental illness (Davidson, Harding, & Spaniol, 2006; Jacobson, 2007; Ralph & Corrigan, 2007). This is not the way the term is used in the vast majority of the modern recovery literature.

In 1970’s, the emergence of consumer/survivor/ex-patient movement on one hand, and the acceptance of biopsychosocial paradigm of mental illness on the other, led to development of two dramatically different recovery paradigms. Both shared an understanding that recovery is a complex multidimensional construct which refers to the process as much as the outcome (Kiesler, 2000; Mead & Copeland, 2000; Ralph & Corrigan, 2007). The biopsychosocial paradigm promoted an understanding that both mental illness and recovery from it are transactional and multidimensional processes, and

need to be understood in terms of biological and psychological phenomena as well as in terms of interpersonal, environmental, socio-political, and socio-economic factors in each and every individual case (Kiesler, 2000; Ralph & Corrigan, 2007; T. W. Smith & Nicassio, 1995).

Models of recovery based on perspectives of people who experienced it further added to the complexity of the recovery concept by maintaining that: a) recovery is a highly personal process and its meaning varies from person to person, b) institutional and other medically based interventions designed to promote recovery may in fact hinder it, and require recovering from in their own right, c) recovery is a non-linear ongoing process, of which relapse is a part and not an indication of failure, and d) recovery cannot take place without the person's active involvement, but the person alone cannot be accountable when recovery does not occur because of the transactional nature of the process (Frese & Davis, 1997; Mead & Copeland, 2000; Ridgway, 2001; Roe, Rudnick, & Gill, 2007; Townsend & Rakfeldt, 1985; S. L. Young & Ensing, 1999).

Consistent with the divergence of the theoretical backgrounds from which current notions of recovery take root, there is no single universally accepted definition of the concept. Instead, there are multiple recovery paradigms and models in existence, and debates about their relative usefulness and about core values implicit in the concept (Bellack, 2006; Davidson, Lawless, & Leary, 2005; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Roberts & Wolfson, 2007; Roe et al., 2007; Tanenbaum, 2006). Multiple attempts have been made to extract common denominators of recovery from the huge variety of recovery paradigms, models, perspectives, and discourses. These attempts are underpinned by stakeholders' desire for the recovery principles to inform public policy, service development and delivery, and research. These common denominators of recovery are usually presented in list forms. Although there is no firm consensus on their composition and extent, the review of the international and New Zealand literature indicates the following key principles and elements of recovery experience (Bellack, 2006; Borg & Kristiansen, 2004; Cunningham, Wolbert, Graziano, & Slocum, 2005; Davidson, Lawless et al., 2005; Gagne, White, & Anthony, 2007; Jacobson & Greenley, 2001; O'Connell, Tondora, Croog, Evans, & Davidson, 2005; O'Hagan, 2001; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Ralph & Corrigan, 2007; Townsend & Rakfeldt, 1985):

- The person is the agent of recovery – it is up to the person to find meaning and purpose essential for recovery, to re-author the meaning of mental ill health, and to establish personal goals and aspirations
- Recovery can be construed as a non-linear, multidimensional, and highly personal *process* as well as the *outcome*
- Recovery involves personal growth and redefining self
- Hope is essential for recovery
- Empowerment and self-determination are cornerstones of recovery
- Peer support is an important recovery promoting process
- Effective recovery-oriented interventions are holistic, person-centered, are in active partnership with the person, offer a variety of support and treatment choices, focus on strengths and wellness, and send a strong message of respect for the person
- Finding a meaningful social role in a person's community is essential – stigma and social exclusion hinder recovery

Symptomatic rehabilitation is neither a sufficient nor even necessary step towards recovery in the above sense of the word. The person may be said to be in recovery even if they continue to experience symptoms of diagnosable mental illness (Davidson, O'Connell et al., 2006; Deegan, 2003; Gagne et al., 2007; Jacobson & Greenley, 2001). Shifting of primary clinical focus away from functional outcomes often meets with understandable resistance from some clinicians who are accountable to a number of third parties and held responsible by the general public in cases of adverse events (Cowan, 2008; Meehan, King, Beavis, & Robinson, 2008). As focus on recovery increasingly becomes an end in itself, it is important not to conflate recovery philosophy with anti-psychiatry or to wrongly assume that focus on recovery removes symptomatic relief from clinical concern (Meehan et al., 2008; O'Brien, Woods, & Palmer, 2001).

Recovery in policies/politics

While recovery is not generally new as a mental health concept, it is new as a variable in policy/politics discourses (Jacobson, 2007; Jacobson & Curtis, 2000) and especially new as a guiding principle for top-down health system change initiatives (Cunningham et al., 2005; Davidson et al., 2007; Felton, Barr, Clark, & Tseberis, 2006; Gagne et al., 2007; Goldman, 2006; Jacobson & Curtis, 2000; McVanel-Viney, Younger,

Doyle, & Kirkpatrick, 2006; O'Connell et al., 2005; Pennsylvania Department of Public Welfare: Office of Mental Health & Substance Abuse Services, 2005). Government directives in New Zealand and abroad have set the recovery orientation/focus as one of the key criteria against which the usefulness of new and existing mental health services is to be judged (Mental Health Advocacy Coalition, 2008; Mental Health Commission, 1998, 2007a, 2007b; Minister of Health, 2005, 2006; O'Hagan, 2001; Standards New Zealand, 2001).

Recovery is defined in New Zealand policy documents in a particular way. Like any other interpretation of recovery, it is not value neutral and reflects a particular political stance in an ongoing theoretical debate. Te Kokiri: The Mental Health and Addiction Action Plan document (Minister of Health, 2006) defines recovery as "*living well in the presence or absence of mental illness and the losses that can be associated with it*" (p.79). It is not apparent from documents such as Te Tahuhu, Te Kokiri, and The Blueprint, how this particular definitional choice was arrived at, although the influence of the consumer-survivor movement and biopsychosocial approaches are clear. One may only hypothesise that policy writers chose among various recovery paradigms in favour of one model's definition, or alternatively that multiple paradigms were amalgamated to create an understanding of recovery that suited New Zealand's particular characteristics and needs. To sum up, the definition of recovery in policy documents is neither absolute nor value neutral, and does not necessarily reflect the understandings of all mental health stakeholders in Aotearoa/New Zealand.

Benefits and drawbacks of broad definition

New Zealand definition of recovery is purposely broad and open to a wide degree of interpretation (Mental Health Commission, 2001, 2007a; Minister of Health, 2005). This has its advantages as well as drawbacks. The broad and flexible definition has the advantage of being consistent with the body of literature which suggests that the process and the end result of recovery are unique to each individual (Davidson & Roe, 2007; Mead & Copeland, 2000; Mental Health Advocacy Coalition, 2008; O'Hagan, 2001; Ridgway, 2001; S. L. Young & Ensing, 1999). "Living well" would indeed need to be defined, aspired to, and experienced by the person in recovery rather than by health professionals or other helpers. Another advantage of policy definition being so broad is that interpretive

possibilities allow for genuine innovation as well as, potentially, for services that are diverse in their understanding/choice of the recovery paradigm (Majumdar & Marcus, 2001). This is consistent with the general recovery principle that consumers need a variety of choices and treatment options. The growing number of non-government organisations (NGOs) providing mental health services (MHSs) since the introduction of The Blueprint (Mental Health Commission, 1998) may be an indicator of such diversity beginning to develop (Minister of Health, 2005). However, the availability and access to such services is mitigated by limited case-load capacities, resources, locality, ethno-cultural influences, and other factors that may mean that, while these services exist, they may not in fact be available to the vast majority of people who need them (Oakley Browne, Wells, & Scott, 2006).

The downside of having interpretive flexibility around the recovery concept is the increased likelihood of mis-understanding or even mis-use of recovery rhetoric (Clossey & Rowlett, 2008; Deegan, 2003; Meehan et al., 2008). Several authors mention that the definition of recovery may have become too broad to be useful as a guide in promoting any serious systemic change (Davidson & Roe, 2007; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Kiesler, 2000; Marrone, 1994). Others voice concerns that conventional psychiatric practices are being ‘repackaged’ with recovery language without any authentic change, and that virtually any practice can be framed as recovery-oriented without actually being so (Curtis, 1998; Curtis & Hodge, 1994; Davidson, O'Connell et al., 2005; Davidson, O'Connell et al., 2006; Deegan, 2003; Goldman, 2006; Marrone, 1994; Meehan et al., 2008; Tanenbaum, 2006). There is an argument that recovery language makes it fairly easy to describe practices that some may term tokenistic, negligent, or even abusive to appear as promoting recovery of service users (Deegan, 2003; Meehan et al., 2008). Anecdotal evidence indeed points to instances where practices that were described in recovery language nevertheless led to patients' and/or clinicians' preventable injury and loss of life (Barton, 2009; Booker, 2008; Gower, 2008; Health and Disability Commissioner, 2006; Shaw, 2007).

Translating policies into practice

Many authoritative sources agree that orienting health systems towards promoting recovery of service users requires profound systemic transformation which cannot be

achieved by merely adding new ‘recovery modules’ to existing services (Curtis, 1997; Davidson et al., 2007; Mental Health Advocacy Coalition, 2008; O’Hagan, 2001; Pennsylvania Department of Public Welfare: Office of Mental Health & Substance Abuse Services, 2005; President’s New Freedom Commission on Mental Health, 2003). Having recovery agenda feature in national health policies is not, in and of itself, sufficient for eliciting such a change in many and diverse MHSs that constitute the mental health system (Jenkins et al., 2002; Kemp, 1993; O’Connell et al., 2005; President’s New Freedom Commission on Mental Health, 2003). This is not to undermine the value of recovery policies as a major step towards systemic transformation (World Health Organisation, 2001). However, research suggests that even for well-established health policies there are often gaps between recommended approaches to care and actual practices (Ganju, 2003; Goldman, 2006; Hermann, 2005; Kemp, 1993; O’Connell et al., 2005). In addition, there is wide variability in degrees of integrity with which MHSs apply policy recommendations (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Ganju, 2003; Hermann, 2005; President’s New Freedom Commission on Mental Health, 2003; Ridgway & Press, 2004). In case of recovery policies, these difficulties are further compounded by a lack of clear consensus about what constitutes recovery-oriented practice and conspicuous paucity of guidelines about how to achieve it at a service level (Clossey & Rowlett, 2008; Davidson, O’Connell et al., 2006; Davidson et al., 2007; Meehan et al., 2008; Whitley, Gingerich, Lutz, & Mueser, 2009).

There is an empirically supported positive link between quality of mental health interventions and their fidelity to the theoretical models they are intended to represent (Hermann, Chan, Zazzali, & Lerner, 2006). In the last few decades health systems in developed countries such as New Zealand have changed from centralised systems of care to decentralised, and often fragmented, health systems where responsibility for policy implementation and quality of care has been transferred from central to local structures (Compagni, Adams, & Daniels, 2006; Goldman, 2006; Jenkins et al., 2002; World Health Organisation, 2001). In New Zealand it is generally the role of the District Health Boards (DHBs) to negotiate the balance between national directives and local needs. Through such negotiation, organisations across country may obtain variable degrees of discretion about how they comply with national level policies. Majumdar and Marcus (2001) have found that in the context of systemic change, ambitious goals are indeed achieved with least

resistance and with maximum efficiency/innovation if associated regulations grant latitude in how goals are to be reached. Thus, flexible recovery policies and decentralised health systems appear to be consistent with tenets of recovery philosophy.

There is, however, a downside to opportunities for self-determination and innovative approaches to service delivery. Organisations inherit the burden of implementation responsibility that in more centralised health systems may be shouldered by central agencies. The extensive chain of decisions involved in organisational transformation draws on advanced knowledge of recovery models, in depth understanding of a wide range of conflicting demands and pressures, competency in logistics of implementation, and ability to deal with resistance to change (Clossey & Rowlett, 2008; Majumdar & Marcus, 2001; Marrone, 1994; Prochaska, Prochaska, & Levesque, 2001; Whitley et al., 2009). Few service managers are likely to have *all* these attributes or training necessary to proceed with organisational conversion into the recovery model. Many may find external guidance useful.

Yet, implementation research in general and implementation guidelines/protocols for adopting the recovery model specifically are sparse (Whitley et al., 2009). Part of the reason for such a lack of implementation evidence base is to do with ongoing debate about the recovery concept itself (Ganju, 2003; McVanel-Viney et al., 2006; Tanenbaum, 2006; Whitley et al., 2009). Another explanation is that implementation research incorporates and yet goes beyond the established scope of a number of disciplines, including specialty mental health studies, economics, political studies, management, and organisational/industrial psychology (Ganju, 2003; Roth, Pananzo, Crane-Ross, Massatti, & Carstens, 2002). The deficit of implementation research and guidelines means that the degree to which various initiatives adhere to the recovery philosophy is often left to trial and error.

What does it take?

From the limited implementation research that is available from overseas sources, it appears that dissemination of recovery knowledge and skills, and training of staff are necessary but not sufficient steps for translating policy into practice (Clossey & Rowlett, 2008; Roth et al., 2002; Tanenbaum, 2005; Torrey & Wyzik, 2000). A two year implementation study by Dartmouth Psychiatric Research Center has found that the presence or absence of strong recovery-oriented leadership could enhance, but could also

reverse reverse, the effects of training (Whitley et al., 2009). That same study also found a strong positive link between recovery focused supervision and fidelity to the recovery philosophy (Whitley et al., 2009). Committed and stable workforce, leadership that inspires and empowers front-line staff, and organisational culture that embraces rather than resists innovation are consistently cited in the literature as crucial factors in successful implementation initiatives (Ashcraft & Anthony, 2005; Clossey & Rowlett, 2008; Ganju, 2003, 2006; Hermann et al., 2006; Plaut, 1997; Whitley et al., 2009). Likewise, awareness and understanding of resistance to change, and addressing resistance issues in strategic planning, are vital to success of implementation efforts (Clossey & Rowlett, 2008; Ganju, 2006; Plaut, 1997; Whitley et al., 2009; World Health Organisation, 2001). In addition to that, several authors stress the importance of explicit implementation guidelines with clearly outlined incremental steps in assisting mental health service providers to adopt new paradigms and practices (Davidson et al., 2007; Goldman, 2006; Pascaris, Shields, & Wolf, 2008; Roth et al., 2002; Tanenbaum, 2005; Whitley et al., 2009).

While the success of organisational implementation of recovery philosophy may depend to a large degree on the abovementioned factors, it is the larger scale dynamics that influence the feasibility and *sustainability* of any authentic change (Coddington, 2001; Davidson et al., 2007; Horwitz & Schied, 1999; Prochaska et al., 2001; World Health Organisation, 2001). Central to the discussion of system level dynamics is the concept of alignment. With increasingly common and complex relationship between public funding and private or local mental health service provision, MHS providers have to negotiate and reconcile an overwhelming range of demands that are often in conflict with one another (Ganju, 2006; Kemp, 1993; Marrone, 1994; Meehan et al., 2008; President's New Freedom Commission on Mental Health, 2003; World Health Organisation, 2001). Because transforming services to become recovery-oriented requires re-negotiation of the service's place in the social system, it stands to reason that the more aligned the various demands on the service are with recovery philosophy, the more likely the services are to adhere to that philosophy (Ganju, 2006; Meehan et al., 2008; Norcross, Beutler, & Levant, 2007; Plaut, 1997; Prochaska et al., 2001; World Health Organisation, 2001).

To operate in a recovery oriented way, service providers need to balance the recovery priorities of service users against accountability to general public and funders (Brookbanks & Simpson, 2007; Jacobson, 2007). They also need to find ways to align clinical work

with policies, regulations, available resources, legislative demands, multiple and competing stakeholder demands, and many other dimensions (Brookbanks & Simpson, 2007; Ganju, 2003; Jacobson, 2007; Meehan et al., 2008). The tensions between service users' rights to self-determination and risk-taking and providers who operate from professional paradigms, evidence base values, and a sense of accountability should adverse outcomes ensue, are well documented examples of conflicting demands the service provider is expected to bring into line in order to deliver recovery-oriented care (Caird, 2001; Coddington, 2001; Curtis & Hodge, 1994; Davidson, Lawless et al., 2005; Davidson, O'Connell et al., 2006; Horwitz & Schied, 1999; Meehan et al., 2008; Mountain & Shah, 2008).

A level up, MHS managers face the additional challenge of ensuring that various recovery-focused practices within their service are consistent with funding mechanisms and accountability procedures (Hermann, 2005; Horwitz & Schied, 1999). In this and many other ways, the recovery potential of any given mental health service is affected by multi-level dynamics both within and outside the health system. Because this is the case, it is not surprising that many authors consider the success of implementation initiatives to depend to a large degree on intersectorial coordination and alignment of systemic demands in ways that consistently prioritise recovery objectives (Jenkins et al., 2002; Meehan et al., 2008; Plaut, 1997; Prochaska et al., 2001; World Health Organisation, 2001, 2003).

Role of evaluation in policy implementation

Any public health system has a limited number of mechanisms for moving the sector in the desired direction, one example of which may be recovery orientation. These few mechanisms rely mostly on either power of sanctions or enticement by incentives (Ganju, 2003). The information about the degree of policy implementation, if collected at all, is used by most health systems primarily to reflect value to funders and as a regulatory mechanism (Compagni et al., 2006; Ganju, 2006). However, Fixsen, Naoom, Blase, Friedman and Wallace (2005) in their systematic review of implementation literature warn against "paper implementation" or lip service. Westphal, Gulati, & Shortell (1997) found that a business model is often formally adopted on paper, but is not implemented in practice. Thus the benefits are not passed on to consumers. Fixen and colleagues estimate that up to 90 percent of people-dependent innovations stop at the paperwork level of

implementation. Paper implementation is especially common when external agencies monitor compliance only, without evaluating process or performance associated with the desired models of care (Rogers, Wellins, & Conner, 2002).

Experts in the field consistently cite the importance of quality feedback loops in initiating and maintaining the momentum of systemic change (Armstrong & Steffen, 2009; Davidson et al., 2007; Ganju, 2003, 2006; Goldman, 2006; Hermann et al., 2006; Meehan et al., 2008; Plaut, 1997; World Health Organisation, 2001). Depending on the focus of the specific resource reviewed, ongoing evaluation of policy and practice is variously linked to value frameworks of evidence-based practice, accountability, evaluation of best practices, performance monitoring and quality improvement frameworks, the need for information support, and internal or organisational motivator for change, as well as external (e.g. funding, policy, legislation) pressure for consistency in systemic transformation (Armstrong & Steffen, 2009; Ganju, 2003, 2006; Stephenson, 2000; Tanenbaum, 2005; World Health Organisation, 2001, 2005; Zahnister, Ahern, & Fisher, 2005).

From the top down perspective, evaluation of practice informs the policymakers what the system is doing well, which stage of change it is at, whether there is consistency across the sector, which areas of policy are translating well into practice and which areas meet with resistance (Prochaska et al., 2001). By providing answers to these and similar questions, systematic information gathering allows strategic allocation of limited resources to address areas of resistance and/or in need of improvement, and consequent streamlining of policy implementation efforts. The advantages of having the information go back to the top levels of the health system are generally recognised, and the New Zealand health system is no exception in that most of the performance reporting goes from lower to higher strata of the hierarchy (Figure 1). Te Tahuhu and Te Kokiri (Minister of Health, 2005, 2006) documents talk of service evaluation in terms of formal accountability and monitoring. These are legitimate uses of evaluation in running a health system, undoubtedly a complicated enough task. However, monitoring does not reach its potential as a policy implementation tool until the feedback loop is closed (Ganju, 2006; Goldman, 2006; Hermann et al., 2006; Prochaska et al., 2001).

Many authoritative sources agree that evaluating services against target indicators and against best performers in the field is in itself a potent mechanism for promoting change (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and

Addictive Disorders, 2005; Plaut, 1997; President's New Freedom Commission on Mental Health, 2003; Prochaska et al., 2001; World Health Organisation, 2005). Documenting implementation efforts, reporting results of evaluation back to the field, and incorporating them into service improvements efforts as well as into reports of successes can have a powerful impact on achieving implementation potential and overcoming grassroots resistance to policy ideas (Armstrong & Steffen, 2009; Ashcraft & Anthony, 2005; Bond, Evans, Salyers, Williams, & Kim, 2000; Clossey & Rowlett, 2008; Cunningham et al., 2005; Curtis, 1997; Davidson et al., 2007; Ganju, 2003, 2006; Goldman, 2006; Hermann, 2005; Hermann et al., 2006; Jenkins et al., 2002; Kemp, 1993; Norcross et al., 2007; Tanenbaum, 2006; World Health Organisation, 2005).

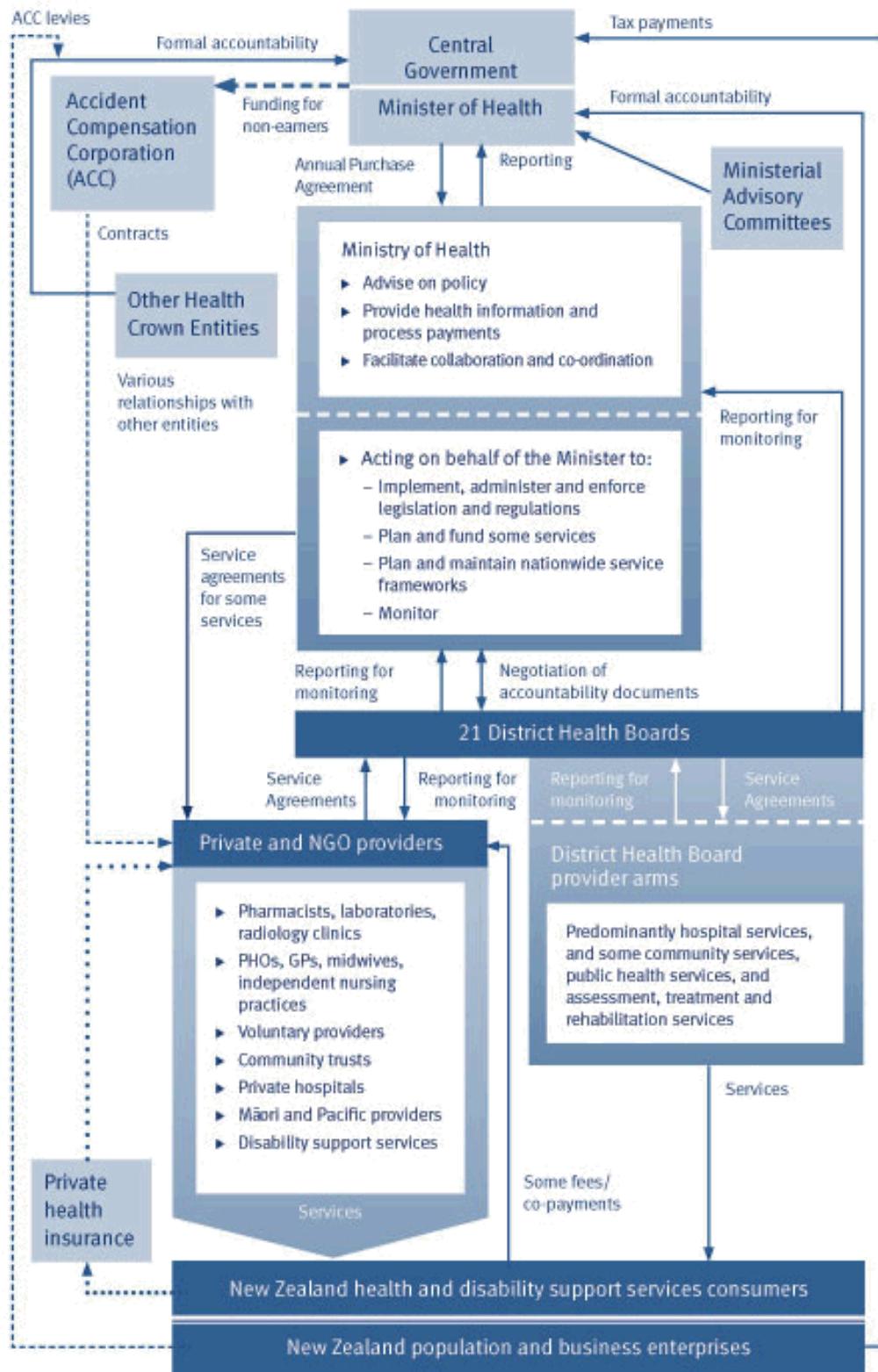


Figure 1: New Zealand health system. Reproduced from New Zealand Ministry of Health website.

Measuring performance for adherence to recovery philosophy

The uses that service evaluation can be put to depend to some extent on the type of information that is gathered from such evaluation. Typically, outcome indicators are used to assess how well the health system and its constituents perform (Curtis, 1997; Davidson, Harding et al., 2006; Jacobson, 2007; Minister of Health, 2005; Norcross et al., 2007; Pennsylvania Department of Public Welfare: Office of Mental Health & Substance Abuse Services, 2005; Salyers, Tsai, & Stultz, 2007). These outcome measures may include dimensions such as the number and demographics of service admissions and discharges, number of days in hospital, length of disability, types and ranges of problems treated as well as interventions offered, client satisfaction surveys, and many others (Norcross et al., 2007; Oakley Browne et al., 2006; Standards New Zealand, 2001; World Health Organisation, 2001).

These types of outcomes may have limited usefulness in assessing the degree to which services facilitate *recovery* (Bellack, 2006; Brown, Rempfer, & Hamera, 2008; Browne, 2006; Frese et al., 2001; Harding, 1994). Some go as far as to say that routine outcome measures are contradictory to recovery philosophy because recovery is a process rather than outcome, it is unique to each individual, and its objectives and measurement should be driven by people in recovery rather than by third parties (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005; Curtis, 1997; Curtis & Hodge, 1994; Lakeman, 2004; Salyers et al., 2007). Other authors attempt to reconcile the values of evidence based practice with recovery philosophy. They do so by focusing on the clinical and recovery outcomes most relevant to recovery, and by suggesting the types of outcomes and sources of information that fit with service-user driven approach (Browne, 2006; Champ, 2002; Frese et al., 2001; Gagne et al., 2007; Hermann, 2005; Tanenbaum, 2006; Torrey & Wyzik, 2000).

However, even those who attempt to reconcile the two value systems qualify that the commonly measured outcomes are not the most direct or exhaustive measures of recovery (Bellack, 2006; Brown et al., 2008; Browne, 2006; Curtis, 1997; Davidson & Roe, 2007; Frese et al., 2001; Harding, 1994). Browne (2006) advises: “*if we are to embrace outcome measures, let's measure things that are relevant to the new culture [recovery]*” (p.154). Clinical outcomes are relevant for recovery, but are only a part of it, since causes and consequences of mental illness reach beyond symptomatology or days in hospital (Bellack,

2006; Brown et al., 2008; Cowan, 2008; Horwitz & Schied, 1999; Jacobson, 2007; Mead & Copeland, 2000; Mental Health Advocacy Coalition, 2008; Mental Health Commission, 1998, 2007b; Onken et al., 2007).

Another relevant measurement issue is outcome attribution (Health Research Council of New Zealand, 2001; Norcross et al., 2007). Consumer outcomes, clinical or otherwise, are implicitly attributed to professional interventions. Consultation conducted by Gordon and colleagues (2004) with New Zealand service users revealed that they found attributing health changes exclusively to service interventions inappropriate and lacking in insight. A considerable number of accounts from consumer movement support this, suggesting that service users may thrive despite, rather than because of, professional interventions (Deegan, 2003; Harding, 1994; Mancini, Hardiman, & Lawson, 2005; Mead & Copeland, 2000; Stephenson, 2000). Conversely, in keeping with the principle that the person is the agent of recovery, some service users may not recover even in the most ideal of settings if they do not take responsibility for initiating change. Alternatively, with the best of service intentions and the great personal motivation, the person may not “recover”. How does outcome based evaluation take account of this? Using service user outcome measures to make inferences about how well MHSs incorporate recovery philosophy into their operations is therefore fraught with conceptual and practical difficulties.

A more straightforward approach may be assessing service as dynamic environment, to see if the processes and dynamics in it are such that they create *opportunities* for service users’ recovery. That way the services are neither blamed for service users’ failure to recover nor are credited with recovery-promoting power when none has been directly demonstrated. Empirical literature and expert opinions that have been reviewed all converge in emphasising the importance of assessing the *process* of service delivery in order to ensure that services are a positive influence on service users’ recovery journeys (Bond et al., 2000; Deegan, 2003; Harding, 1994; Hermann, 2005; Lakeman, 2004; McGrew, Bond., Dietzen, & Salyers, 1994; Meehan et al., 2008; O’Connell et al., 2005; President’s New Freedom Commission on Mental Health, 2003; Racine, 2000; Salyers et al., 2007; Stephenson, 2000; Tanenbaum, 2006; Teague, Bond, & Drake, 1998; Whitley et al., 2009; World Health Organisation, 2005). Measures that do that are variously known as fidelity measures, measures of recovery-orientation, recovery promotion measures, measures of program integrity, and degrees of implementation (McGrew et al., 1994).

Meehan and colleagues (2008) warn that unless program integrity is routinely evaluated, services can assert to be oriented towards promoting recovery in the knowledge that their claim will not be disputed. Testing only outcomes and not the process of service delivery can therefore contribute to “paper implementation” of recovery policies and reduces incentives for authentic change (Fixsen et al., 2005; Hermann, 2005).

Measuring recovery orientation: to standardise or not?

While there is a number of individual level recovery and recovery-related measurements, there are only few instruments and approaches to assessing how recovery-oriented various environments are. A review of literature, extensive internet search, and consultation with field experts, using terms ‘recovery’ and ‘measure’, yielded eight formal approaches to evaluating the degree of organisational commitment to recovery vision. Their characteristics and relative merits and limitations are presented in a table form in Appendix A in lieu of wordy description. Of the eight approaches, seven are from international sources and one is by a New Zealand author. The eight approaches differ greatly with regard to recovery domains assessed, sources of information used and the degree of formal testing to support their psychometric properties. There are also considerable differences in the extent of service user involvement in the development of each instrument. This is a relevant consideration given that recovery as a concept has strong roots in consumer movement and emphasises leadership and participation of service users (Jacobson, 2007)

Of the eight evaluative approaches found, six are standardised measures with predetermined number of questions or response categories. On closer examination, those six measures shared in common an aspiration to facilitate system transformation efforts (Allott, Clark, & Slade, 2006; Armstrong & Steffen, 2009; Campbell-Orde et al., 2005; Ridgway & Press, 2004; Salyers et al., 2007). The focus on system transformation was less articulated in the two qualitative approaches reviewed: the Systematic Recovery Framework (O'Hagan, n.d.) and Indicators of Recovery-Orientated Service System (IROSS) (Pennsylvania Department of Public Welfare: Office of Mental Health & Substance Abuse Services, 2005).

The obvious advantages of a standardised approach to evaluation is ability to make direct and meaningful comparisons between different organisations, as well as tracking

changes over time within organisations, with ease and in a quantifiable manner (Perrin & Koshel, 1997; Punch, 2005). Standardised measures tend to be easier to administer, complete, and score, and cheaper in use than labour-intensive qualitative approaches (Perrin & Koshel, 1997). They are, however, notoriously expensive and time consuming to develop and validate in the first place (Isaac & Michael, 1997). Another drawback of standardised tools is that, because response categories in them are predetermined, they are less flexible and responsive to organisation-specific recovery variables than an individualised qualitative approach can be (Kline, 2009). It is possible that innovative services may therefore be disadvantaged or lose their competitive edge if assessed in a standardised way.

If standardising: against which criteria?

With the exception of the Systematic Recovery Framework (O'Hagan, n.d.), all organisational measures of recovery orientation were grounded in recovery criteria articulated by stakeholders in the country or state of its development. Recovery Promotion Fidelity Scale (RPFS)(Armstrong & Steffen, 2009) was developed to link with recovery policies of Hawai'i in order to facilitate policy implementation in that state's health system. Although the authors of RPFS do not elaborate on policy-instrument link beyond that, there may be additional value to grounding evaluation initiatives in policies of a particular state or nation.

It takes considerable effort and sophistication to filter through and integrate diverse and sometimes confusing views on recovery in such a way as to represent stakeholder needs in a particular nation. If national policy writers have done this work, individual service providers may not have to repeat the exercise (World Health Organisation, 2001, 2005). This would free more of their time for frontline work with clients. Also, reference to recovery policies may give diverse mental health services and clinicians a common language to talk about this important phenomenon. If all services are evaluated against the same criteria, it can improve consistency in terms of the degree to which different professions and organisations across the country promote recovery of service users. National policies are in good position to be chosen as such standard criteria because they have directive power to break through inter-professional power struggles that characterise mental health sector and which detract from recovery focus (Borg & Kristiansen, 2004;

Caird, 2001; Champ, 2002). New Zealand's current Mental Health and Addiction Plan (Minister of Health, 2005) is in that spirit as it aims to provide a uniform set of directions to govern services "no matter which agency provides them or how they are funded" (p.3). From a consumer perspective, consistency of standards in service delivery is valuable because one better knows what to expect and there is reduced disparity between different communities in terms of access to services that promote recovery.

Of course, all of those benefits rely on an assumption that policies reflect recovery understandings and needs of key stakeholders. This assumption is contestable. Policies often reflect the views of only select stakeholder groups and notions of recovery expressed in national policies may not be acceptable to all or even most stakeholder groups (Brown et al., 2008; Jacobson & Curtis, 2000; Kemp, 1993). There is no telling whether or not this may be the case in New Zealand. There are no publicly available documents which outline the degree of stakeholder consultation and research that went into writing national mental health policies such as Te Tahuhu and Te Kokiri (Minister of Health, 2005, 2006). One of the questions posed by the present project was whether policy definition of recovery is acceptably aligned with stakeholders' notions of the concept.

It is unlikely that *all* the stakeholders will come to a complete consensus on every measure or item in service evaluation protocol even if there is support for the policies' vision of recovery (Hermann, 2005). There are a number of possible solutions to this. One option is to create/select a panel of standardised measures to meet a variety of needs, and thus retain the benefits of standardisation while making the evaluation protocol acceptable to a range of diverse stakeholders. An alternative option is semi-standardisation where the criteria for evaluation are predetermined but services have choice how to meet them because different types of actions can demonstrate adherence to the same recovery indicator. This flexible regulation means that innovative services are not put at disadvantage but it also promotes creativity and effectiveness in established organisations (Majumdar & Marcus, 2001). Indicators of Recovery-Orientated Service System (IROSS)(Pennsylvania Department of Public Welfare: Office of Mental Health & Substance Abuse Services, 2005) and Scottish Recovery Indicator (SRI) (Scottish Recovery Network, 2009) are good examples of semi-standardised approach to service evaluation.

Can tools developed in other countries be used in New Zealand?

It is a general principle of social research that caution needs to be exercised in translating any research findings to different contexts (Horwitz & Schied, 1999; Punch, 2005). The same principle applies to evaluation tools (McNaught, Caputi, Oades, & Deane, 2007), since they are grounded in social research and each is developed in a particular socio-political context. Any internationally developed tool will at the very least require validation to be used in New Zealand context, and will most likely need to be modified to fit it.

An international comparison of stakeholder views suggests that while the general list of factors important for recovery is similar between different countries, in each nation stakeholders tended to *rank* and prioritise those factors differently (Turton, Wright, White, & Killaspy, 2009). However, other comparative studies suggest that New Zealand shares similar health policies visions and implementation problems as other developed countries, thus making international research on recovery implementation applicable at least with respect of systemic transformation mechanisms (Compagni et al., 2006).

Most of the measures assessing recovery-promoting environments were developed in the United States and Europe (see Appendix A). New Zealand is different from those localities on a number of dimensions that affect ability to directly translate international tools for use in Aotearoa. Our cultural history and unique blend of populations have a bearing on the diversity of understandings of both mental illness and recovery from it (Ida, 2007; O'Brien, Boddy, & Hardy, 2007). The American and European tendency to emphasise the role of the individual as agent of recovery may clash at times with focus on community and family participation in recovery journeys that are acutely relevant to many New Zealanders (Lapsley, Nikora, & Black, 2002; Mental Health Commission, 2007b). Finally, the interplay between structural advantages as well as barriers to recovery may be unique to each country (Coddington, 2001; Horwitz & Schied, 1999) and therefore prevent straightforward adoption of international measures in Aotearoa/New Zealand.

Considering the effort and the amount of testing required for validating and/or modifying international measures, it may be more practical to develop a measure of organisational recovery orientation designed specifically for use in New Zealand. Similarly, developing *one* such measure for use across all mental health services may be more effort- and cost-effective than creating evaluation protocols for individual

organisations. Costs are unavoidable in implementing any evaluation initiative, whether adapted from overseas experiences or developed specifically for New Zealand context.

Recovery implementation in New Zealand

In comparing national plans and policies of seven countries, Compagni, Adams and Daniels (2006) have found that New Zealand has much in common with other developed countries in terms of a national vision for the mental health field. Promoting person-centered, recovery focused, responsive mental health care that is measurable and accountable was among key priorities in New Zealand as well as other countries. Compagni and colleagues also report common problems and deficiencies in policy implementation between the nations they compared. The implementation problems New Zealand shares with other countries include: a) great variability in quality and effectiveness of service provision, partly due to lack of inter-sectorial coordination, and b) delays in application of quality improvement tools, information technology, and evidence-based practices.

New Zealand health system has been through a series of radical changes in the last few decades, and our healthcare workforce are said to be growing weary of change and resistant to reforms (Beddoe & Duke, 2009; Coalition for Public Health, 1992). Because recovery focus is commonly discussed in a literature as requiring a dramatic shift in mental healthcare paradigm, it too is likely to meet with some inertia and resistance from the workforce (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2005; Davidson et al., 2007; Jacobson & Curtis, 2000; Pennsylvania Department of Public Welfare: Office of Mental Health & Substance Abuse Services, 2005). Health service providers in New Zealand/Aotearoa are consistently reported as being overstretched for resources and struggling to meet with demand (Cowan, 2008; Kemp, 1993; Ministry of Health, 1996, 2009a). Services may be understandably reluctant to add to this burden the costs associated with implementing any dramatic change (Hermann, 2005). Beginning to promote many and varied aspects of ‘recovery’ instead of focusing mainly on time honoured clinical outcomes would require a dramatic change in service delivery indeed.

A growing body of research suggests that service users evaluate effectiveness of services based on the degree to which services promote ‘recovery’ or incorporate

associated ideas in their practice (Happell, 2008; Mancini et al., 2005; Racine, 2000; Ralph & Corrigan, 2007; Torrey & Wyzik, 2000; World Health Organisation, 2001; S. L. Young & Ensing, 1999). Although efficacy research on recovery is sparse, few seem to contest the promise of recovery practices in terms of their real-world usefulness or effectiveness (Borg & Kristiansen, 2004; Brown et al., 2008; Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2005; Cunningham et al., 2005; Curtis, 1997; Davidson, Harding et al., 2006; Davidson et al., 2007; Farkas, Ashcraft, & Anthony, 2008; Frese et al., 2001; Happell, 2008; Ida, 2007; Jacobson & Greenley, 2001). Focus on recovery seems to be a promising model for service delivery.

Several reviews have found that positive clinical outcomes were linked to the fidelity of the intervention to the empirically proven or promising model (Adelman & Taylor, 2003; Armstrong & Steffen, 2009; Ganju, 2003, 2006; Meehan et al., 2008). Often, the cost of not doing things right or not doing right things is borne by other social systems such as justice system, welfare system and so forth (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2005). Mis-implementation of promising models results in misuse, underuse, or overuse of services (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2005; Fixsen et al., 2005; Whitley et al., 2009; World Health Organisation, 2001, 2005). This means increased costs exertion by health system but diminished benefits to populations served, compared to the intended model.

If New Zealand's health system is directed towards becoming more recovery oriented, it stands to reason that this change needs to be authentic and go beyond paper implementation. Yet the degree of recovery implementation is difficult to judge at present. Being a relative 'outsider' to the system level dynamics, the author had to rely on information available publicly on Ministry of Health and District Health Boards' websites, and in specialised libraries such as Te Pou and the Mental Health Foundation. Some of the knowledge pertaining to implementation of recovery policies in practice may be either less transparent or less available than this. Therefore, a disclaimer is warranted. Some of the implementation issues identified in this report may be more a reflection on lack of transparency or of public availability of information rather than on gaps in the implementation process per se. For that reason, the present research posed a set of

questions set to elicit participants' understandings of the current state of recovery policy implementation in Aotearoa/New Zealand.

The most recent national level policies that mention recovery as a goal are Te Tahuhu - Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (Minister of Health, 2005) and Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015 (Minister of Health, 2006). They intrinsically link quality of mental health services (MHSs) and the workforce culture that supports recovery of service users and tangata whaiora. Te Tahuhu is perhaps the more explicit of the two documents about what recovery oriented services would need to look like and through which mechanisms the transformation will take place. It indicated the goal of aligning funding mechanisms with recovery demands on services. It also explicated the need to strengthen public trust in MHSs with immediate emphasis on availability of information systems to underpin service development and improvement. Te Tahuhu recognises the importance of service accountability in maintaining the momentum of change generated by the policy itself.

From the challenges and action agenda specified by the policies, it would seem that the need for measurement-based quality improvement (MBQI) approach is signalled. Hermann's (2005) definition and explanation of MBQI is consistent both with policy agenda and with implementation factors discussed earlier in this report:

Measurement-based quality improvement (QI) is a method of evaluating and making changes to structures and processes of care with the goal of improving health outcomes and reducing adverse events. It can be used to address suboptimal clinical outcomes, reduce variability in the performance of critical tasks, and narrow gaps between evidence-based guidelines and actual practice. (...) Although it is derived from principles and practices of scientific investigation QI differs from research in that its goal is to produce change through intervention rather than to prove causation between intervention and outcome. (p.97)

In New Zealand there is an apparent trend for measurement of outcomes rather than of the *process* of service delivery (Health Research Council of New Zealand, 2001).

Mental Health Standard Measures of Assessment and Recovery Initiative (MH-SMART) commenced in 2005 as a way of introducing "outcome culture into 'New Zealand's mental

health services”, according to Te Pou website. Five identified domains for MS-SMART suite of measures are clinical symptoms, measures of functioning, consumer outcomes measures, drug and alcohol outcome measures, and Maori outcome measures. No process-based measures to assess recovery orientation of New Zealand mental health services were identified. The Health of the Nation Outcome Scale tools (HoNOS) are mandated by Ministry of Health to assess clinical symptoms, and are currently the main source of information of the degree of recovery implementation. There are at present no mandated tools for other four MH-SMART domains, although work in these areas is in progress (Te Pou, 2009). The present study may contribute to evidence-base of some of these efforts by providing information on New Zealand stakeholder perspectives regarding usefulness and limitations of current recovery implementation initiatives.

There are benefits and drawbacks associated with any type of evaluation, and an overwhelming number of factors and possible uses to consider in selecting any one method. Measurement based quality improvement may be a theoretically sound approach to supporting adoption of the recovery practices by New Zealand mental health services. This does not mean, however, that it would be accepted in practice by key stakeholders.

To begin with, the operational definition of recovery itself may vary considerably between different groups within the field. There was no information found on the degree of consultation that went into policy definition and explication of recovery, and whether it is acceptable to a variety of stakeholders in Aotearoa/New Zealand. Secondly, there are different perspectives about the usefulness of measurement. It may contribute to and motivate authentic change, but when used for monitoring only it can encourage lip service and paper implementation. There are also practical considerations such as recent taking of mental health away from the list of top priorities for New Zealand health system (Ministry of Health, 2009b). This may affect the both top-down policy drive towards recovery-oriented system transformation, and bottom-up ability of services to adopt new paradigm at times of funding insecurity. Measuring whether services promote recovery and creating a tool to do that may simply be deemed a non-priority.

Even if the above considerations were resolved, there is still a debate about whether the concept of recovery is consistent with outcome measurement, or whether service evaluation should focus on the process factors. Once that is determined, there is a question of standardisation, and whether diverse stakeholders can come to an agreement about the

criteria against which services should be evaluated. Any new measure should therefore surmount the gridlock of many levels of competing priorities by being consensus-based and of high value to services themselves as well as to overseeing agencies.

Methodology

There is a dialogical relationship between the aims and topic of the present study and its methods. The breadth of factors to consider with regard to measurement issues and the conspicuous lack of New Zealand implementation research calls for an exploratory qualitative approach (Kline, 2009). Qualitative methods were also deemed appropriate because rather than seeking a specific answer, the present study sought to establish whether the industry stakeholders themselves had questions about the state of recovery orientation of New Zealand health system. The research methods were chosen to maximise participation and collaborative partnership, while guarding confidentiality and emotional safety of the participants. Although the principles and methods of the research process were grounded in the Treaty of Waitangi, consultation with experts and ethical clearance process deemed them appropriate not only for Māori but for all ethnic groups (see Appendix B).

Throughout the study, the research process followed a semi-structured format. This was partly done to reflect the researcher's commitment to collaborative partnership with participants. The semi-structured and collaborative nature of the study allows for a more sensitive and responsive consultation than structured processes could permit (Ritchie & Lewis, 2003). Yet more importantly the semi-structured format allowed for emergent questions and the possibility of unexpected discoveries during the consultation and data analysis process. The semi-structured interview schedule in particular was selected with a view to reduce pre-determination of responses by the researcher.

The framework of critical realism was chosen for consistency with recovery values, in that it affirms individual responses as truthful versions of reality, but also recognises that the way reality is experienced, represented and interpreted is shaped by factors such as culture, language, and socio-political interests (Hugman, 2005; Kamberelis & Dimitriades, 2005). Similarly, the thematic analysis method was selected for being consistent with the framework of critical realism (Ritchie & Lewis, 2003). Thematic analysis also allows portraying participant's perspectives through their actual responses while permitting

researcher to draw overarching inferences and form theories from their comments. A number of practical checks and balances were put in place to ensure that analysis remained data driven and exploratory, rather than unduly influenced by the researcher's theories and predictions.

The study was designed as a consultation with a diverse range of stakeholders. Its focus is on stakeholder differences and similarities in regard to appraising recovery policies and practice in New Zealand, with particular attention being paid to the issues pertaining to measuring organisational recovery orientation. As the title suggests, the researcher was interested whether participants perceived systematic measurement of recovery orientation of New Zealand mental health sector as a useful avenue to explore in order to promote quality of mental health services. The scope of the study was dramatically reduced to only two groups of stakeholders due to unexpected obstacles and pressing deadlines. The choice of these two particular groups of stakeholders for research by no means indicates that their perspectives are of greater importance relative to other stakeholders in Aotearoa/New Zealand. Nor is there any assertion that their perspectives encompass the diversity of views among all New Zealand stakeholders within those groups. Instead, the project described below is best treated as an exploratory feasibility study. It aspires to inform further larger scale consultations but not to replace them.

METHODS

The study was approved by the Northern Y Regional Ethics Committee, and the related research documents are presented in Appendix B. The process of developing the research methods and obtaining ethics approval involved consultation with three Māori experts, one Pacific Islander expert, one Asian expert, academic supervision, early consultation with service user leaders, and a review of the research methodology literature. The chosen methods, therefore, were arrived at consensually from multiple stakeholder perspectives. The balance between sensitive explorative enquiry and academic rigour was an important methodological consideration for this project.

Participants

The initial ethically and academically approved study design proposed consulting six groups of stakeholders: 1) mental health policy makers, 2) mental health service managers/directors, 3) clinicians working in the area of mental health, including doctors, nurses, and case/key workers, 4) past or current users of mental health services, 5) consumer advisors/advocates or people in equivalent formal consumer roles within mental health services, and 6) family/whanau members of service users and/or members of general public. However, the delays in obtaining ethics clearance combined with unexpected practical obstacles to commencing the project necessitated reducing its scope to fit with the timeframe for completion.

The present project therefore focused on only two categories of participants, each group defined through a distinct, although not mutually exclusive, criteria. The first category of participants was defined as people with experience of having a formal consumer advocate or consumer advisor role within New Zealand mental health sector. The second group of participants consisted of people who have had direct input into New Zealand mental health policies. The selection of these two groups from the original list of stakeholder groups was based on convenience of already having some interviews with people in these roles, and having no data from other stakeholder groups, by the time the project deadlines became pressing.

Regarding capacity to consent, people receiving acute psychiatric services at the time of data collection were excluded from participation. The reasons for their exclusion were

to do with protecting vulnerable participants and also because participants' mental distress at the time of data collection may affect the fidelity of the data due to poor articulation of their views and/or altered mental state. Respondents under 16 years of age were excluded because policies related to child and adolescent mental health are outside the scope of this project. Also excluded from the study were respondents who had neither consumer advocacy nor policy experience. Respondents were not excluded, however, if they met criteria for both consumer advocacy and policy making inclusion criteria. This is partly because such exclusion would run counter to the recovery principle that people with experience of using mental health services should be actively involved in mental health policy development (Curtis, 1997; Jacobson & Greenley, 2001; Mental Health Advocacy Coalition, 2008; *Our Lives in 2014*, 2004). Also, in the context of qualitative enquiry, multi-role participants are valuable as providing bridging perspectives, which reconcile potential differences between stakeholder groups.

Snowball sampling was employed, whereby several existing mental health related organisations in the greater Auckland area were informed in detail of the upcoming research, and these organisations, in turn, had spread this information across their networks through mailing lists, newsletters, and word of mouth. As a result of this process, every participant had access to the research advertisement leaflet and to the information sheet prior to making the first contact with the researcher. On that first contact, every participant had an opportunity for a question and answer session, and information sheets were provided again if needed, along with indicative questions for the interviews. These documents are presented in Appendix B along with other relevant research documentation such as consent form, cultural consultation statement letters, ethics clearance letter, and the AUT Counselling Services statement.

Of the 21 people who responded, 11 participated in the study. Of the 10 people who did not participate, five did not meet the inclusion criteria, one met the exclusion criteria, and three withdrew after being unable to fit an interview meeting into their schedule. One other person consented to the interview and answered all interview questions, but did not consent to recording the session or to official research participation. Her comments are therefore not included in the analysis.

Some of the respondents are well known leaders or active participants within New Zealand mental health sector. Presenting the information about participants in a

conventional summary table would render those individuals easily identifiable. To protect participants' anonymity, the information about the sample is therefore provided in discrete descriptive categories instead of the summary tables.

Of the 11 study participants, six have indicated that at the time of data collection their primary role was as consumer advocate or equivalent position, five people have indicated that for the purposes of this research their primary role was to do with mental health policy development or implementation. Importantly, 6 out of 11 participants had overlapping experiences, in that they had both consumer advocacy and policy making backgrounds. Further to that, all participants except one have in common a personal experience of mental illness and/or mental health treatment. The distinction between consumer advocates and policy maker stakeholders is therefore somewhat blurred, making it difficult to compare and contrast. Additionally, of the 11 participants, five people indicated they had managerial/administrative role in a mental health service, seven participants indicated that a member of their family or whanau has had an experience of mental illness, and one specified he had clinical background in a mental health sector.

There were six males and five females in the sample. Three males and three females came from consumer advocate category of participants, while three males and two females comprised the sample of policy makers. Three people of each gender fell into the group that shared both consumer advocate and policy making experiences.

The ages represented in the sample are as follows: 34, 37, 39, 45, 47, 48, 51, 55, 61, 66, and 67, bringing the median age of study respondents to 48 years, and the mean to 50 years of age. Of the 11 participants, eight self-identified as Pakeha or New Zealand European, one identified as European/Cook Island Māori, one as New Zealand Chinese, and one noted his ethnicity simply as New Zealander. Five respondents were interviewed in Auckland, two in Wellington, two in Hamilton, and two more in rural Waikato. At least one of the consumer advocate participants build on an overseas as well as local experience, and two people participated in policy development in countries other than New Zealand. No information was collected about the nature or extent of participant's past or present mental state past confirming with them that they did not receive acute psychiatric treatment at the time of data collection.

Data collection

Data collection methods were guided by interrelated principles of partnership, maximising participation, and guarding safety and comfort of participants. To that effect, every respondent was given a choice of participating in either a focus group or semi-structured individual interview. Semi-structured format was chosen to minimise pre-determination of responses and to allow a more sensitive and responsive consultation than structured interviews could permit. See Appendix B for the list of indicative questions that were distributed to all prospective participants for their consideration prior to interviews, and which served as a structural backbone to each consultation.

In focus groups, consumer advisors were consulted separately from policy makers in order to minimise the impact of potential tensions and power dynamics between the two categories of participants on quality of the data. However, participants were encouraged to bring support people to the interview, should that make them feel more at ease, and these support people could come from other stakeholder groups as long as they did not themselves participate in the discussion. No participants brought support people with them.

Two small focus groups and six individual interviews were conducted in the course of this project. The focus groups lasted 60 and 105 minutes respectively, while individual interviews varied in length between 53 and 80 minutes, depending on how articulate participants were and/or on how much time they allocated for the interview. There were three consumer advocates or mixed role participants in the Auckland focus group. Waikato focus group consisted of only two consumer advisors after one of the scheduled participants did not arrive. The remaining two consumer advocates, and the four policy maker participants were interviewed individually. One of consumer advocates in a focus group indicated being more comfortable and articulate with written communication than spoken one. Thus, as requested, his group responses are supplemented by an individual document extracted from de-identified follow up email communication.

Both focus groups and individual interviews were run to the same semi-structured schedule (see Appendix B). The same questions, although worded slightly differently according to situation, were asked of consumer advisor and policy maker participants. The questions tapped into difference and similarities between individual understandings of recovery and recovery as it is represented in New Zealand national health policies such as Te Tahuhu and Te Kokiri (Minister of Health, 2005, 2006). Also of interest were the

hypothetical characteristics of “ideal” recovery-oriented services, with a specific focus on link with Recovery Competencies for New Zealand Mental Health Workers (O’Hagan, 2001). Recovery Competencies were selected as the most explicit New Zealand based document that outlines specific skills and conditions needed for promoting recovery in professional settings. The notion of accountability was addressed both top down and bottom up: the participants were asked whether current policy packages on recovery provided sufficient guidance and support to service providers, but also what accountability practices were in place and whether provider implementation of recovery philosophy was appropriate, sufficient, and/or optimal. Following that, the role of organisational recovery-orientation measurement was discussed in relation to implementing national policies in practice.

To encourage active partnership and to allow participants to plan their responses, every participant was provided with an electronic copy of the interview schedule at the time of arranging a meeting. Immediately before each interview, all respondents also received hard copies of the questions to refer to as needed during the process (see Appendix B). Finally, participants were given the option, and reminded of it regularly, to revise and edit the transcripts of their interviews. This last process was also ethically grounded as at this stage every participant was strongly encouraged to choose an alias and to edit out any information that personally identifies them, or which they may regret disclosing at a later stage. If the participant failed to review the transcript or conceal their identity, the researcher did it on their behalf, unless specifically requested otherwise. Finally, some of the participants volunteered to review and edit of the final draft of the research report, thus ensuring that their views are portrayed accurately and faithfully with minimal contamination of data by the researcher’s own pre-conceived ideas.

Each research session was video-recorded and later transcribed by the researcher and/or professional transcriber. For the interviews transcribed by professional typist, researcher reviewed the videos and edited the transcripts as needed prior to forwarding interview transcript for participant verification. All participants were encouraged to edit, add, delete, and clarify their comments on interview transcripts until they were satisfied that the resulting text represented their actual views on topics of discussion. However, no dramatic changes to original transcripts were made by any of the participants in the process of review. At one focus group, the recording stopped ten minutes short of the

interview completion due to technical problems, and the content of the remaining discussion was recorded through note taking. These notes were shared with participants prior to completing the interview, and verified there and then. The typed version of those notes is appended to the transcript of that focus group (Appendix D).

As a means of staying faithful to the original verbal nature of consultation, and for the purposes of later electronic analysis, no punctuation was assumed when transcribing. The only exceptions were apostrophes and question marks. Some non-verbal communication was also noted in transcriptions when it was seen as affecting the meaning of what was being said. All transcriptions, collaboratively taken notes, and the individual email communication supplementing one of the focus group discussions, are included in Appendix D. The transcription conventions are presented before each interview transcript. As was the precondition to ethical clearance of the project, all interview transcripts (Appendix D) are bound separately from the rest of the report and will *not* be publicly available beyond formal academic assessment of the project. This is done in respect of participants' confidentiality and to protect their anonymity. However, non-identifying direct quotes are used as much as possible in the results section of this report to give as much voice to participants as possible and to reduce distortions and researcher biases that would have come from unnecessary paraphrasing.

Data analysis

Data analysis procedures were designed to be data driven as much as possible. Multiple strategies have been put in place to reduce contamination of the inductive process by pre-conceived theories and researcher's own informal hypotheses. Transcribed text (Appendix D) from interviews and focus groups was subjected to thematic analysis in three stages.

The first stage involved intensive manual search for *codes*, or individual semantic instances that are relevant to the research questions (Braun & Clarke, 2006; Fischer, 2006). However, what qualifies as *relevant* data is well known in qualitative research to be affected by researcher's subjective ideas (Kamberelis & Dimitriades, 2005; Norcross et al., 2007). For that reason, a control transcript was parallel coded by both of the research supervisors, and results were compared to coding done by the researcher. There were no

significant differences between codes picked up by research supervisors and codes noted by the researcher in that control interview.

Following coding, a list of all themes pertinent to the research questions was generated. A table was then created, in which the occurrence or non-occurrence of each of those themes was marked against each respondent. A theme was not marked against the participant's initials if they never explicitly mentioned it; it was marked with a tick if they mentioned it as important or relevant; with a cross if they stated it was un-important or non-relevant; and with a question mark if they mentioned it but were undecided on their position. For example, if a participant spoke of standardised measurement of recovery orientation as an important factor in implementation initiatives, but then provided contradictory examples such as impossibility or drawbacks of standardisation, their response was marked as undecided with a question mark. In case of focus groups, explicit indication of individual participant's agreement/disagreement with responses of others was marked against relevant code as individual response. The resulting table allowed for visual scanning of differences and similarities between groups of participants. It also assisted in determining the organising themes, and reporting the results. The table of codes is presented in Appendix C.

The second stage of analysis involved subjecting transcribed material to electronic thematic analysis by the Leximancer data mining tool (A. E. Smith, 2002). The resulting 'conceptual map' provides the following information: the main concepts and their relative frequency, which concepts most frequently co-occur within the text, and the thematic groupings of concepts as inferred from the similarity of contexts in which concepts occur(A. E. Smith, 2002). The brightness of labels on the map is related to frequencies of corresponding themes or concepts, so that the brighter the label the more that concept appears in the text, while the nearness of the concept labels on the map indicates their contextual similarity. The concepts are defined by Leximancer developers as collections of semantically related key words, whereas themes are formed of highly connected concepts. For example, the concept of 'autonomy' may contain keywords freedom, self-determination, and choice, and be subsumed under overarching theme 'recovery' together with concepts such as 'empowerment' and 'hope'.

To check for group differences and for stability of conceptual relationships, the data set was analysed as a whole and by participant category. Where the participant

representing both stakeholder groups participated in a focus group, his or her responses could not be separated from those of the group for the purposes of Leximancer analysis. This means that the combined policy/consumer advisor focus group was excluded from analysis by participant category, but included in the analysis of all responses combined. This shortcoming was partially compensated for by manual theme coding in the first and last stages of analysis. In addition, a separate Leximancer analysis was run on data grouped from individual interviews with multi-role participants. This was done in order to gauge whether having *both* consumer advocate and policy experiences makes such stakeholders either prioritise one experience over the other, or be altogether different from either of those participant groups, and therefore allow inferences about how their participation in the group may have affected the fidelity of findings.

The primary value of using Leximancer in this research is its ability to display thematic groupings of central concepts and inter-connections between the themes. Leximancer also contributes to determining that no important theme was omitted in the initial manual analysis, and serves as a base for later collapsing of multiple codes into key thematic groupings. Although useful in increasing the objectivity of the themes reported, Leximancer concept mapping is not the ultimate representation of the dataset. This is partly due to the fact that Leximancer assumes isolated words to be semantic units of interest, whereas multiple research manuals indicate that larger units of analysis may be more significant (Fischer, 2006; Hesse-Biber & Leavy, 2006; Ritchie & Lewis, 2003). The settings of the Leximancer program were adjusted in such a way as to increase the likelihood that the format of results would allow answering of the research questions (Roy, 2005). Table 1 describes the settings chosen.

The third and final stage of data analysis was another manual thematic extraction, which incorporated, and built on, the information obtained in the first two stages of analysis. In this last stage, the code labels were revised, the codes were sorted into overarching themes, and the relationships between themes were explored by the researcher. Whenever a participant has particularly fluently summarised or named a concept or an overarching theme, their wording was a preferred identifier to that theme, as opposed to researcher-derived identifiers. Similarly, the code labels in Appendix C and in Results section were based on original wording by one or more of the participants whenever possible. The participants were also recognised as 'key respondents' if their way

of articulating or labelling a theme was clearly supported by evidence obtained from other participants (Puchta & Potter, 2004).

Table 1: Leximancer settings, in order of processing, used for data analysis.

Option	Setting	Description
Remove stop words	Yes	Automatically removes words with obviously low semantic weightings (such as 'so' and 'and') prior to the analysis
Make folder tags	Do nothing	The folder/file name on which the analysis is based are not identified as concepts on the final map
Automatic concept identification	Yes (use automatic total number of concepts and total number of names)	The program identifies the most frequent concepts by itself (not the researcher)
Concept editing	<u>Delete</u> : yeah, mhm, pause, laughs, 'cos, stuff, umm, like, sort, think, <participants' names>, oh, okay, nods, that, yes <u>Merge</u> : policy/policies, experience/experiences/madness/illness people/person, group/groups, service/services/organisation/organisations, match/matching/matched, sharing/share, recovery/recovered/recovering, standard/standardised, measure/instrument/tool <u>Add</u> : outcome, process, competencies, standard/standardised/standardisation, qualitative	Allows researcher to edit concepts automatically found by Leximancer by: a) <u>deleting</u> from the analysis some of the automatically found concepts b) <u>merging</u> highly related concepts c) <u>adding</u> new concepts of interest from a list of all words found in a document
Thesaurus learning	Automatic	Specifies the ease with which Leximancer identifies keywords as concepts and incorporates them into broader themes
Locate concept occurrences	<u>Locate</u> : recovery, orientation, service, person, support, instrument, measure, definition <u>Kill classes</u> : <L>	<u>Locate</u> function allows researcher to select concepts which must be located on the final map <u>Kill classes</u> module allows deletion of the blocks of text in which the 'class' is found. In this case, killing class <L> results in deleting researcher's questions and responses from the analysis.
Map settings	<u>Map type</u> : Linear <u>Theme size</u> : varied, kept at the largest size where the concepts pertaining to research question were still visible. <u>Number of points</u> : varied, kept at the smallest amount where the concepts pertaining to research question were still visible, and the redundancy with theme labels is minimised. Iterations: automatic	<u>Map type</u> specifies whether the map will reflect the similarities between concepts (gaussian), or whether it discriminates between the concepts while noting the relationships between them (linear). <u>Theme size</u> refers to how broad or condensed the organising themes are, under which the concepts are subsumed <u>Number of points</u> refers to the percentage of concepts that are visible from the those identified

RESULTS

This study is about stakeholder appraisal of recovery policy and practice in Aotearoa/New Zealand. It was designed as a feasibility study of whether measuring organizational recovery orientation would be perceived by stakeholders as a useful avenue to explore in regard to implementing recovery policies. If such a measurement was to be perceived as being of value, which measurement issues and considerations would be of highest priority? Specifically, to which uses might stakeholders wish to put such a measurement to, and what would need to be key characteristics of the measurement for it to be useful in achieving stakeholder objectives for it.

The project, its focus and the processes involved have elicited very positive responses from participants. This suggests that the research questions were thought of as relevant by groups consulted and that methodology employed for answering those questions was acceptable. None of the participants indicated the precedence of other research directions with regard to recovery implementation in New Zealand. This confirms the potential usefulness of the present study as a pilot project for future inquiries on a larger scale.

The textual material obtained as a result of this consultation project (Appendix D) presented a tremendous wealth of information. The richness and density of acquired data could provide for a number of reports, many times surpassing the scope of the present project. Predictably, a tension arose between the necessity to contain the scope of the study and the drive to stay faithful to the consultation process including all its unexpected findings.

A degree of data ‘condensing’ was used to solve this problem. The manually extracted ‘codes’ presented in Appendix C represent as complete a list of micro-themes as the author could see from multiple re-readings of each and all interview transcripts. However, when a code has been articulated by multiple participants, each participant had their own way of expressing it. The table of codes (Appendix C) does not reflect that because code statements are either borrowed from one of the participants expressing it, or are researcher’s summary. Nor does the later direct use of interview quotes fully compensate for the loss of the original diversity of expressing ideas that form any given theme. In addition, for some participants certain codes were more central to their narratives

compared to other codes and to other participants. When that was the case, the author tried to reflect the participants' own emphasis by including direct quotes in theme discussion. Participants' feedback on the present report will be actively sought to ensure that the final publicly available version of it reflects their actual views and emphases.

A combination of manual and software-assisted analyses was employed to ensure that no data were dismissed due to researcher's own pre-determined ideas. Leximancer analysis is best thought of as a bird's eye view of the findings (A. E. Smith, 2002). Maps and ranked concepts are useful in displaying the main features of the data and how they inter-relate. Software-assisted analysis adds a degree of objectivity to eliciting organising themes from the abundance of data obtained. However, it does not substitute for the manual analysis and its attention to detail or to the emphases in participants' expressions. The manual analysis and software-assisted findings are therefore complementary to each other rather than conclusive on their own.

Software-assisted findings

Most frequently used concepts by consumer advisors (CA), by policy makers (PM), by participants from both backgrounds (P/CA), and from overall dataset are presented over the next two pages in Tables 2, 3, 4, and 5, respectively. These data suggest that participants have focused their responses on concepts that are useful in addressing research questions. Across all participant subgroups and in the overall dataset the concepts of 'recovery', 'services', and 'measurement' are prominently used. The concept of measurement was central to all subgroups but was less frequent than the concepts of 'recovery', 'service(s)', and 'person'/'user'/'consumer'. This is consistent with the study premise that measurement of recovery orientation needs to be discussed in reference to context.

Interestingly, when referring to individuals seeking recovery, CAs used the concept 'person', policy makers spoke of 'users', while P/CA participants used both of these concepts as well as 'consumer' (Tables 2, 3, and 4, respectively). On closer examination, it appears that the meaning CAs were conveying was closely aligned with the notion of 'tangata whaiora' (Mental Health Commission, 2004). That is, the participants were communicating that person's recovery supports may not be limited to the use of professional mental health services. By contrast, policy makers and multi-role participants

spoke of ‘service users’ and ‘consumers’. This may be because they were more focused on answering research questions, which were expressly about delivery of professional services. Alternatively, the difference could be due to participants’ primary role affiliation, in that people with policy background focus their concerns on service level as part of the job description.

Table 2: Leximancer extraction of most frequently used concepts in interviews with Consumer Advisors.

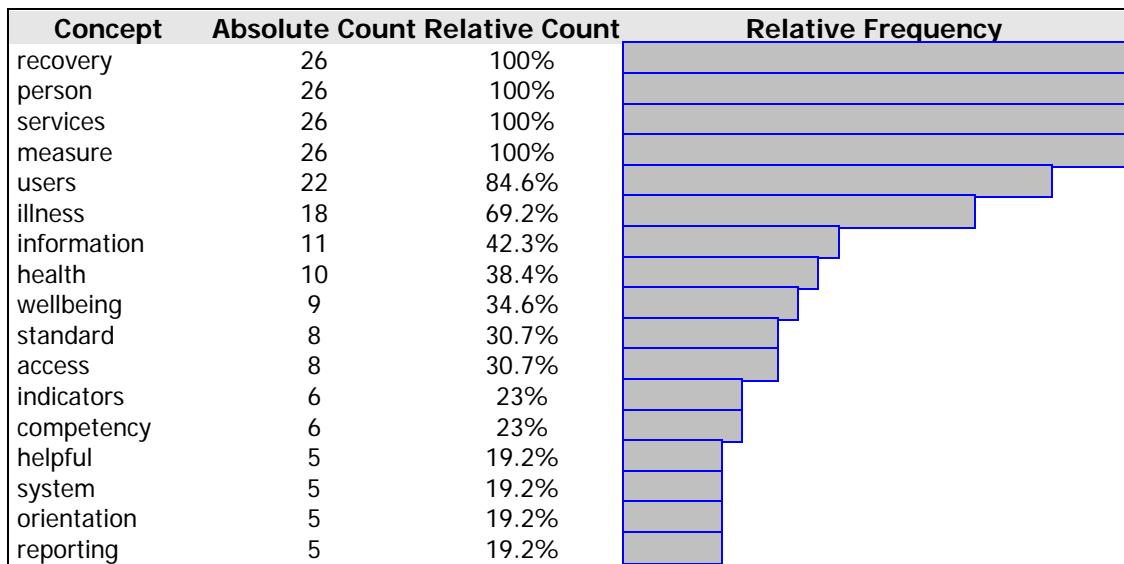


Table 3: Leximancer extraction of most frequently used concepts in interviews with Policy Makers.

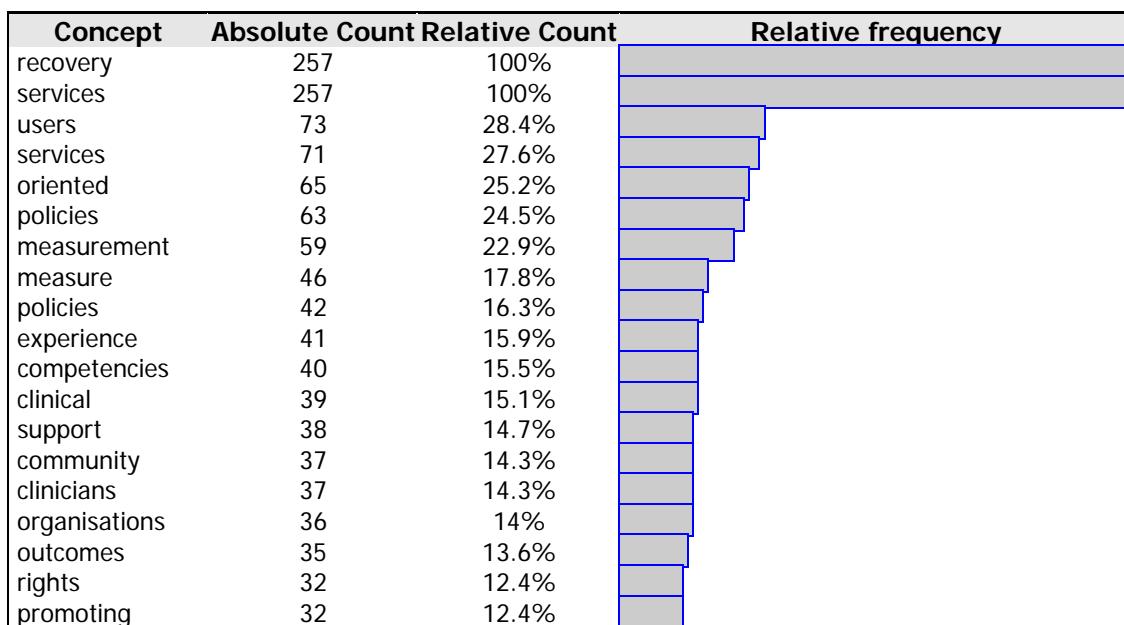


Table 4: Leximancer extraction of most frequently used concepts in interviews with participants who have both Policy making and Consumer Advocate backgrounds (P/CA)

Concept	Absolute Count	Relative Count	Relative frequency
recovery	206	100%	
people	206	100%	
services	206	100%	
service	101	49%	
mental	79	38.3%	
health	65	31.5%	
consumer	60	29.1%	
users	54	26.2%	
person	54	26.2%	
services	49	23.7%	
measurement	47	22.8%	
policy	42	20.3%	
measure	39	18.9%	
experience	38	18.4%	
should	37	17.9%	
competencies	37	17.9%	
clinicians	34	16.5%	
support	33	16%	

Table 5: Leximancer extraction of most frequently used concepts across all interviews and focus groups, combined.

Concept	Absolute Count	Relative Count	Relative frequency
recovery	353	100%	
orientation	353	100%	
illness	353	100%	
services	353	100%	
user	219	62%	
support	106	30%	
should	105	29.7%	
helpful	95	26.9%	
policies	95	26.9%	
understanding	89	25.2%	
measurement	83	23.5%	
experience	82	23.2%	
competencies	78	22%	
measure	66	18.6%	
rights	61	17.2%	
organisations	59	16.7%	
definition	57	16.1%	
promoting	57	16.1%	

‘Support’ was a frequent concept in all dataset and subgroups, except consumer advisors without policy experience. This is largely due to CA’s narratives being grounded

in the lived experiences, as reflected in their focus on the concept ‘helpful’. By contrast, policy makers and P/CA participants had a more conceptualised focus on ‘support’ – both to individuals seeking recovery and to services that try to facilitate it. Both of these approaches to answering research questions are represented in the overall dataset, as both ‘support’ and ‘helpful’ concepts were identified by Leximancer as important (Table 5).

The following additional findings emerged from examining Tables 2, 3, 4, and 5. Predictably, ‘policies’ was not a central concept among consumer advisors who have no policy background, but was a key concept in discussions of all the other participants. The concept of ‘competencies’ was prominent in all participant sub-groups, but this is due to the research questions asked (Appendix B) rather than because the concept was spontaneously invoked by participants. The concept of ‘rights’ was important in policymaker narratives and in the overall dataset, but was *not* among most frequently used concepts in CA and P/CA accounts. Directive ‘should’ was an important organising concept in the overall dataset (Table 5) and closer inspection revealed that it was strongly linked to the set of codes the author labelled “how things need to be” (Appendix C, part 2). With regard to measurement related themes, CAs spoke of ‘standard’, ‘indicators’, and ‘information’ which are all concepts consistent with assessment of process (Table 2). The concept of ‘outcomes’ was more central to policymakers’ responses (Table 3).

‘Health’ and ‘wellbeing’ were key concepts for CA participants (Table 2) but not for policymakers. By contrast, the concept of ‘experience’ was prominent in PM accounts (Table 3) but not in consumer advisor narratives. Multi-role participants reconciled the two perspectives in that both ‘health’ and ‘experience’ concepts are central to their accounts (Table 4). This finding is consistent with the author’s observation that CAs more frequently referred in their responses to personal experiences, while policymakers tended to speak with higher level of abstraction. P/CA participants provided a high level synthesis between the two perspectives by explicitly linking their examples from personal experiences to organising concepts and to theory/philosophy.

Further in support of the hypothesis on the differences in abstraction, ‘illness’ frequently mentioned concept in CA interviews and in overall dataset, but not in policymaker or P/CA narratives. Young’s (1982) work suggests that the highly personal, culturally shaped, and holistic ‘experience’ of madness is validated through a sense of physical reality that is implicit in medical, disease-like understanding of the experience. It

is possible that CA participants, who grounded their responses in personal experience, addressed perceived stigma by speaking of mental ‘illness’ experience as objective medical-like state. By contrast, policymakers and P/CA participants did not need to do this if through higher level of abstraction they were able to speak of the integrated cultural ‘experience’ of madness that was shared by many other than themselves.

Leximancer conceptual maps were created to explore thematic groupings of the concepts used by consumer advisors, policy makers, and multi-role participants, as well as in the combined dataset as a whole. The resulting maps are presented in Figures 2, 3, 4, and 5 over the next couple of pages. On these maps, the concepts are indicated as grayscale words, while organising themes are represented as coloured circles with coloured theme labels. The contrast or brightness of the map features is indicative of their relative frequency or centrality, whereas nearness on the map suggests contextual similarity or relationships between the features (Smith, 2002).

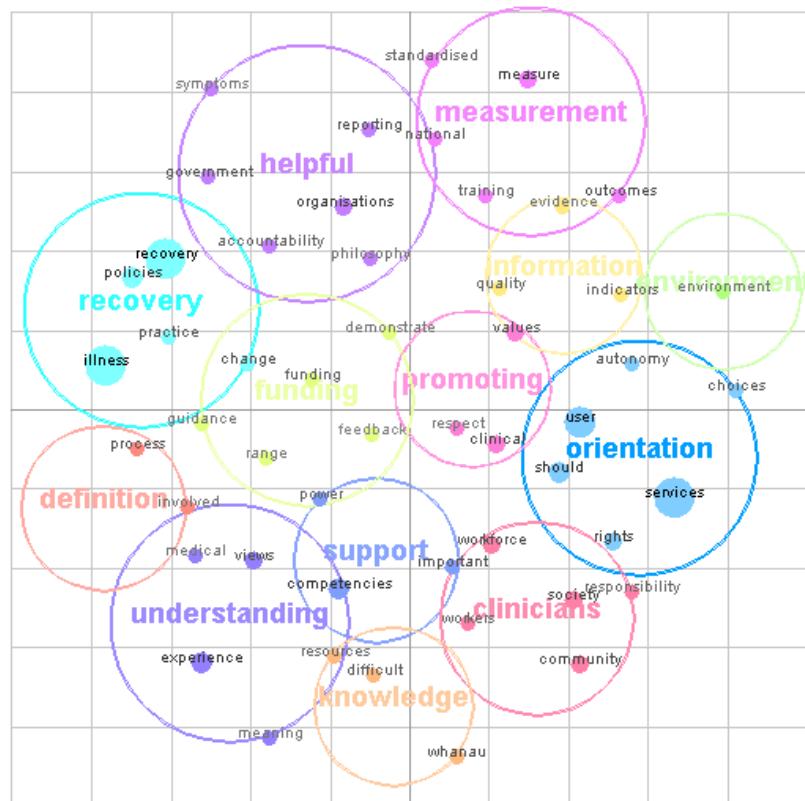


Figure 2: Leximancer map of the dataset as a whole, with *all* interviews and focus groups combined. Map settings: theme size 33%, number of points 100 %.

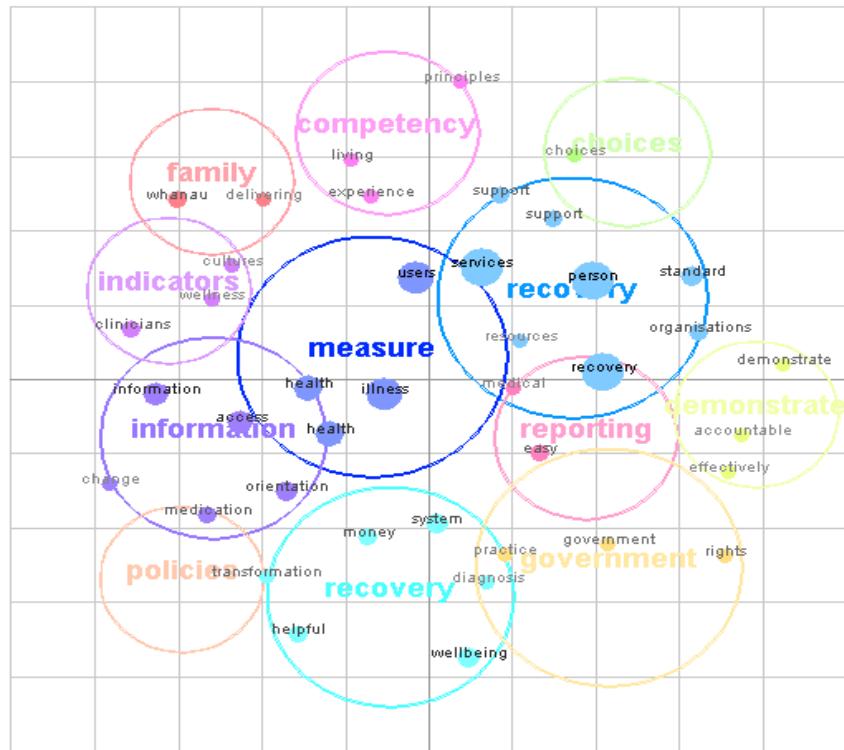


Figure 3: Leximancer map of the interviews with Consumer Advisors only. Map settings: theme size 37%, number of points 100 %.

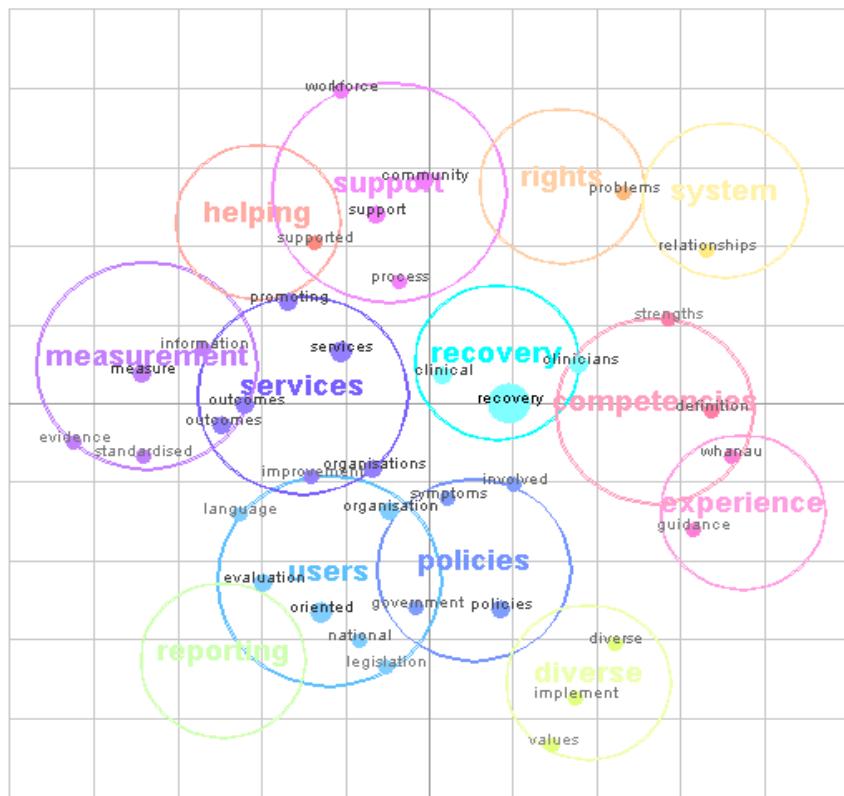


Figure 4: Leximancer map of the interviews with Policy Maker respondents only. Map settings: theme size 31%, number of points 100 %.

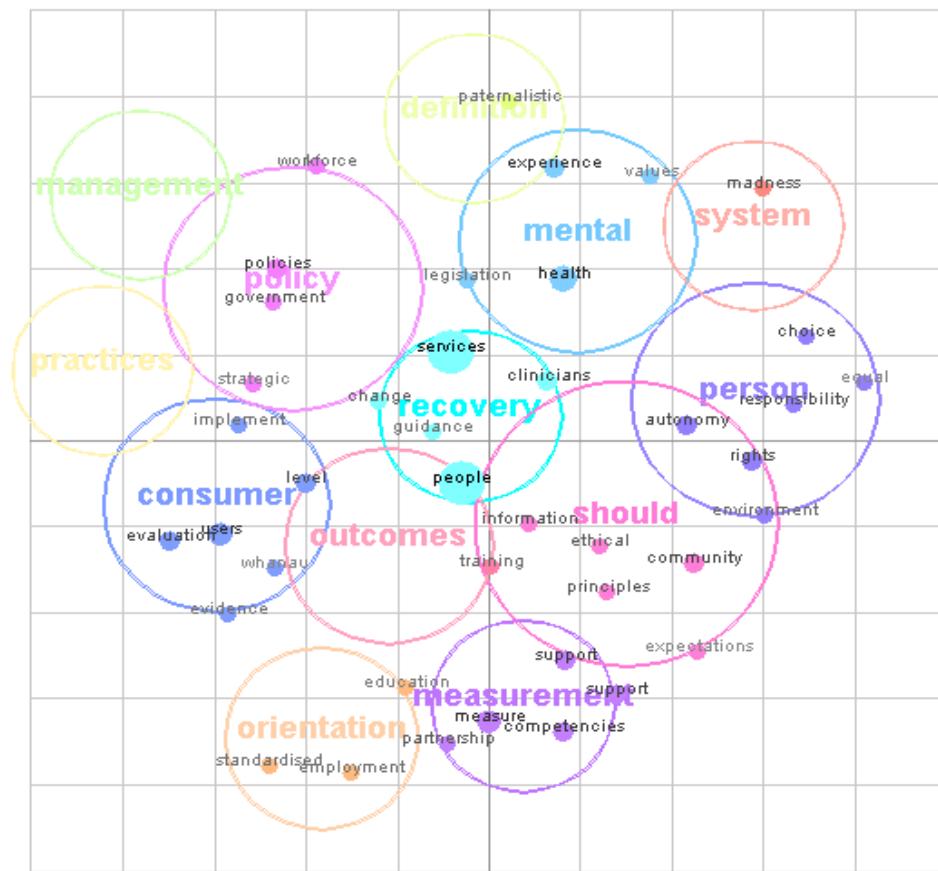


Figure 5: Leximancer map of the interviews with participants who have both Policy and Consumer Advocacy backgrounds (P/CA). Map settings: theme size 34%, number of points 100%.

In interpreting Leximancer conceptual maps it is important to bear in mind that thematic groupings are suggestive of the underlying organising concepts in text, not merely the presence or absence of keywords (Roy, 2005). Upon synthesising the information from the four maps above, it became evident that research participants generally organised their responses around four broad areas. Firstly, considerable attention has been paid to personal understandings of recovery and associated concepts, as exemplified by organising themes ‘recovery’, ‘experience’, ‘understanding’ and ‘definition’ that were present in some form in all interviews and focus groups. Secondly, participants addressed themes pertaining to helping environments, mostly in terms of how they experience them presently or based on past experiences. On the maps, this is illustrated through thematic groupings such as ‘services’, ‘clinicians’, ‘support’, ‘system’, ‘practices’ and ‘environment’. Third broad thematic direction was about factors related to

implementing recovery philosophy in practice. Themes associated with that focus are labelled on the maps as ‘should’, ‘policies’, ‘reporting’, ‘competencies’, ‘rights’, diversity ('diverse'), ‘promoting’, ‘helpful’/‘helping’, ‘choices’, ‘orientation’, ‘family’, and ‘funding’. The theme ‘competency’ was largely introduced by the research questions themselves and refers to competencies in terms of professional skills rather than mental capacity.

Finally, the fourth thematic grouping was around the questions of measurement, which was the key focus of the study. The themes associated with that issue are labelled on the conceptual maps above as ‘measure’/‘measurement’, ‘reporting’, ‘demonstrate’, ‘indicators’, ‘outcomes’ and ‘information’. It is crucial to remember that Leximancer evidence indicates only the frequency and centrality of a particular theme, not its direction. For example, the presence of the theme ‘policy’ on the map does not provide information about whether participants discussed policies in a positive or in a dismissive way. Instead, it only means that ‘policy’ was a prominent organising theme in their responses. Further Leximancer inquiry and manual analysis rendered the following information about how the issue of measurement was approached by different participants.

Leximancer ‘thesaurus’ feature allows seeing which concepts were most strongly associated with concept of ‘measure’ or ‘measurement’ in participants’ discourses. Subgroup comparisons revealed noticeable differences between policymaker and consumer advisor subgroups only. On the next page, Table 6 shows Leximancer thesaurus for the theme ‘measure’ for both CA and PM groups. From it one can see that policymakers placed greater emphasis on the issue of standardisation than did consumer advocates. Importantly, for policymakers discussion of ‘measure’ was strongly related to concepts of outcomes, and ‘functional’ [outcomes/indicators]. By contrast, consumer advisors spoke of measurement in the context of ‘qualitative’, ‘facilitation’, comparison, and ‘indicators’ concepts. Both groups linked measurement to ‘performance’/‘performing’, which indicates the measurement focus on service/system level rather than on individual recovery status.

Table 6: Leximancer extraction of ten concepts most related to the theme 'measure', for CA and PM participants, separately. Concepts are presented in order of relative frequency.

Consumer Advisors	Policymakers
Measure	Measure
Measured	Assessment
Measure_	Standardised
Evaluated	Measures
Qualitative	Outcomes
Standardised	Measurement
Facilitation	Functional
Performance	Performing
Compare	Instrument
Indicators	Conducive

Findings from manual analysis

One of the unexpected findings of the study was the extent to which all participants took care to contextualise the concept of recovery in either lived experience or philosophical discourses on mental health discourses, or in both. The questions that were targeted to finding whether policy definition of recovery was acceptable to diverse stakeholders brought instead a much richer discussion than originally intended. The code-by-participant summary in Appendix C aspires only to capture the breadth of the topics covered, but does not do justice to the eloquence and expressivity of participants' ideas. Extraction from Appendix C is presented in Table 7 on the next page to set context for later ideas as expressed in participants' own words.

Table 7: Thematic codes, by participant, related to defining recovery.

	CA background (no policy)						Both CA and policy backgrounds (P/CA)			Policy background (no CA)	
	Presently in CA role						Presently in policy/leadership				
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Recovery has many meanings		✓	✓	✓		✓		✓	✓	✓	✓
Tensions between different stakeholders' definitions, or "Whose meanings are they?"		✓	✓	✓			✓				✓
Recovery is about...											
Autonomy/self-determination	✓				✓	✓		✓	✓		✓
Acceptance of experience	✓	✓	✓		✓	✓					✓
Citizenship	✓	✓	✓						✓		✓
Connectedness/Relationships		✓	✓			✓	✓	✓		✓	✓
Hope	✓	✓	✓	✓							✓
Enhanced wellbeing		✓	✓								
Respectful treatment/R-conducive environment		✓	✓		✓				✓		
Finding meaning/sense/learning from experience	✓						✓	✓		✓	✓
Same latitude in rights as everyone else	✓	✓	✓						✓		
Empowerment	✓										
Mastery (of the experience etc)	✓		✓		✓	✓		✓			✓
Rights as well as responsibilities	✓	✓	✓	✓	✓		✓		✓		
Choices	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Person is the agent of own recovery (subjectivity/uniqueness principle)	✓	✓	✓	✓			✓	✓	✓		✓
Hiccups/relapse is part of the recovery				✓		✓		✓			
The process as well as end state				✓	✓	✓				✓	

How participants understood 'recovery'

Throughout the consultation process and across all participant groups the author witnessed a sense of discontent about the ways mental illness and recovery are thought of by society in general and helping professions in particular. A number of themes fed into

that understanding. Perhaps the most striking theme was about ‘madness’ as a legitimate and deeply human experience which is on a continuum with, rather than opposite of, health, wellbeing, and ‘normality’. More often than not, medical model representations of mental illness were described as pathologising and contradictory to recovery philosophy. The following excerpts from interviews may be long but they elaborate eloquently the views that were common to many of the respondents.

From the interview with Mary (P/CA):

<Mary> that's really what peoples' fundamental beliefs are_ about what we call madness or mental illness_ and_ and if you come from a biomedical set of beliefs_ you'll_ you'll view it as pathological_ as a distortion_ as a _ as an aberration that needs to be corrected_ and then if you come from an ignorant community perspective you'll_ you'll think oh that's weird and strange and I'm scared of that stuff_ and in a sense they both come from the same root_ those beliefs_ in a way_ although the system beliefs are much more sophisticated and sort of nicely worded_ but in that_ in that_ that root is actually_ the belief that madness is not a legitimate human experience okay_ and until _ the mental health system people_ and the people in the community_ and the _ we ourselves start to see this as a *legitimate* human experience_ that we can derive meaning and value from_ it doesn't mean to say it's a *nice* experience ‘cos for most people it's very distressing and overwhelming_ but you know there have been other experiences in life we have that are very distressing and overwhelming and_ you know_ and I often use the analogy of_ well_ if you've been in a battle field _ that's probably a pretty distressing and overwhelming experience_ if_ you know_ you've lost your family in a plane accident_ that_ that would be pretty distressing and overwhelming_ but the difference between those two experiences and madness is that society_ we give medals to soldiers_ we don't always understand them but we give them medals_ we have great sympathy for people in grief and we make allowances for them_ but what do we do with people who are in a state of madness? [...]yeah cross the road_ and so until we stop crossing the road as a community_ I think that our attempts to get recovery and all those other things in place are going to be very uphill struggles

(Appendix D, pp. 140-141)

Sue (CA) was another key respondent to speak on the issue of mental illness as a legitimate human experience. She reflected the opinion of many participants other than herself in speaking of the positive as well as negative aspects of the experience:

if people are unwell they are not [indicates inverted commas] living well in the presence or absence_ I think it is living as well as possible in the presence of illness_ the good thing about it [policy] though besides from that criticism is that it is some concept of valuing the experience of mental illness that sometimes it is not all bad_ people can learn a lot from their experience from mental illness and people around them can too as long as they are well supported and nurtured and nourished and informed [...] it is portrayed as something outside the common human experience when it is not_ it is my feeling or understanding that madness is intensely human and it is just human feelings and it is just experiences that have gone on deeper lower longer than other people routinely experience_ but if madness is presented as just broken down instead of labels into peoples experiences and ways that they are struggling to deal with things that have happened to them_ then I think Joe Bloggs out in the community will get it a lot more

(Appendix D, p.30)

There were also concerns, especially among consumer advocates, about the type of language commonly used in discussing mental ill health and recovery. Often these concerns tied in with the above references to fundamental beliefs about mental illness. However, just as often the matters of language were linked to discourses on knowledge and power (Foucault, 1967; Laing, 1982; Martinez, 2005). Language clearly mattered. Tommy showed strong preference for the empowering language of ‘experiencing’ mental illness versus ‘suffering’ it. John Smith similarly stressed the preference for the more holistic notion of ‘experience’ that prevents the person from living the life they want and contrasted it to the notion of ‘illness’ that is a reference to a medical model of madness- as-deficit. Sue critiqued the word ‘recovery’ for invoking the medical model and the implication that madness is something that people need to recover from and therefore not a legitimate human experience.

In discussing what recovery *was* about, there were striking similarities to Māori models of health even though the context of discussions was not specifically about that cultural group. Te Whare Tapa Wha model was explicitly mentioned by four people from consumer advocacy backgrounds in attempting to define their personal understandings of recovery and recovery-oriented care. Jacobus' words are an example:

you see because I prefer the Te Whare Tapa Wha which is four sides to the Maori food house which is deals with the spiritual_ umm psychological _ mental _ and physical wellbeing _ so when you talk about recovery to me you're talking about recovery in a holistic sense_ pertaining to four sides to a person's character or being _ okay so that's my understanding

(Appendix D, p.96)

John Smith concurs with Jacobus and links this idea with earlier discussion on beliefs and values about mental illness:

<JS> I'm getting at a redefinition of mental illness as a human experience which may not necessarily be __ a deficit_ or a lack__ you know what I'm saying?

<L> yeah_ yeah I think I do

<JS> yeah so I'm getting at the whole illness biomedical model widening it more

<L> where would you want to widen it?

<JS> to the more holistic Whare Tapa Wha type of stuff where__ mental distress isn't necessarily an illness but _ it could be just an experience that isn't that_ that helpful _ [<L> yeah okay] and it's actually stopping you enjoying your life and stuff but it's not necessarily a pathological illness

[...] <L> so what definition of recovery would be useful as__ a benchmark I suppose?

<JS> uh__ the closest I think is the life worth living

(Appendix D, pp.4 & 6)

On the language of policies

The policy definition of recovery could not satisfy all. However, the criticisms were few and mostly about the language used rather than at content or perceived intent of recovery policies. In terms of awareness of recovery policies, participants frequently

mentioned Te Tahuhu (Minister of Health, 2005), Te Kokiri (Minister of Health, 2006), strategic plans of local District Health Boards, and documents such as Let's Get Real (Ministry of Health, 2008) and Recovery Competencies for New Zealand Mental Health Workers (O'Hagan, 2001). However, some consumer advocates were not aware of specific policies, and could only comment on policy choice of definition based on the phrasing used in the interview questions (Appendix B).

Most participants expressed general agreement with the policy definition of recovery in terms of "living well in the presence or absence of mental illness and the losses that can be associated with it" (Minister of Health, 2006, p. 79). One of the few points of contention, however, was about living *well*. Sue's (CA) comments tap into some of the concerns about policy wording:

I don't particularly like their definition because I know many people myself included who when I am unwell I am certainly not living *well* [laughs] so I struggle with that bit of it_ so when I am unwell and having better choices more knowledge and having my wishes better understood by the people who are working with me [...] recovery is being presented as when you never get_ well_ you never get unwell and I think when you are really really acutely unwell you are not in recovery at that moment but if the processes are around you are supportive of you_ you will get well more quickly and you will be more empowered [...] I have a lot of concerns about how recovery is being packaged in New Zealand an probably around the world [...] people who are in paid service user position saying God I cannot afford to get unwell because they're supposed to be a champion for recovery_ it should never be used like that as this sort of impossible destination

(Appendix D, pp. 25-26)

Jim provided an important link between Sue's criticism of a word 'well' in the definition of recovery, and concern shared by a few participants that tangata whaiora are being treated differently by the society and helping professions than those who do not have the diagnosis of mental illness. Jim was also a key respondent in articulating the view that the role of mental health services should be to facilitate people's autonomy or ability to "live the life they want", rather than to promote 'recovery':

the term recovery has in a sense been around too long and adopted too many shades of meaning _ and so the use of it is problematic _ because what people mean when they say it can be extremely variable_ and those meanings can range from something quite specific to nothing at all (Appendix D, p.43) [...] if we say why do people use mental health services? _ well to recover from their mental illness_ what does recover from a mental illness mean? what about people who don't recover who just stay mad?_ and by looking at autonomy as the outcome rather than recovery that puts aside the issue of symptomology and clinical concepts and such like because whether you are deemed clinically mentally ill or not is not the issue_ the issue is are you able to live a life you find meaningful and worthwhile?_ and the Blueprint captures it in some extent with the phrase_ um living well in the presence or absence of symptoms of mental illness or whatever you want to call it _ I think living well takes it too far because to go into health service let's say_ your background is not very good_ so you go into mental health services having gone nuts and_ you have got no money_ you are living on the street and you have got mental illness_ but having no money and living on the street not having a job *preceded* the mental illness_ well that means the only way the service can be successful is to make you live *well*_ and *a* the service *can't* _ they cant determine how you live although they often try _ only the person can determine that_ but the person should have the same_ if you like right to fail_ so in other words to be *required* to live well because you are being labelled mentally ill_ why should you be required to live well? there are people who are not mentally ill are not required to live well_ they are required to carry out the responsibilities of citizenship_ but whether they live well or not is entirely up to them_ so that is why I prefer the idea of sufficient autonomy to pursue the life you want _ the life you find meaningful and worthwhile_ whether you *achieve* it or not is another matter (Appendix D, p. 44) [...] coming back to the same rights and responsibilities of citizenship as everybody else removes that discrimination_ and says that mad people have as much right to_ as much *latitude* to live their life as anybody else

(Appendix D, p. 45)

In line with Jim's point, restriction in rights and different expectations of ability to hold responsibilities of citizenship were often mentioned as barriers to recovery. Consumer advocate Tommy comments on the content of recovery education that he provides for service users:

we look at their [consumers] rights as well as their responsibilities_ and what_ you know_ what they're entitled to__ and_ it's about having the service user or tangata whaiora_ having the voice coming out of their mouth_ not somebody doing it for them like at Henry Bennett where the decisions were made_ this is about the individual being able to make good decisions that they're happy for_ you know_ that they can live with themselves and_ you know_ people_ like yourself you could probably make a mistake and no-one would judge it_ but somebody with a mental illness_ if they make a mistake_ well they're the biggest idiot out

(Appendix D, p.74).

Alistair validated the premise that people's answers to the research questions would be influenced by their respective roles in the sector. When asked about whether services would understand the guiding principles for promoting recovery of service users from reading national policies, Alistair, who is involved in policy making, commented:

“[laughing] It's like asking a nun whether she can make a comment on a married relationship_ of course they can” (Appendix D, p.127). Yet, almost every person in this project's sample has had a personal experience of recovery. It was plain from their accounts that such experience brings about a unique sensitivity, or expertise, that may not be attainable from theory learning alone. Therefore the follow up question was asked on whether or not policies provided a similarly clear picture of what recovery-oriented services should look like to someone who did *not* have that lived experience. Many found that recovery policies and competencies were prone to misinterpretation, unless service providers have had a lived experience or were otherwise grounded in recovery philosophy to begin with. Sue's (CA) response is consistent with other participants' opinions:

I don't think it is easy because they are inheriting something that has come from top down and they have been told you have to support recovery_ and they have also been told by service users that this is unique and individual_ how can

you marry those? you know _ when you have got directives from your funders to deliver recovery and you don't actually know what recovery looks like and you have some awareness that you cannot define recovery for people whose recovery it is __ I think it is really it is not intuitive __ I think it actually is dangerous for it to be intuitive I think it needs to be really spelt out

(Appendix D, p. 31)

What should recovery-oriented services look like?

The focus of the present study was on the state of implementation of recovery ideas in New Zealand mental health sector. One of the questions the study posed was whether interpretive flexibility of the national recovery policies came at expense of restricted usefulness in providing a clear guiding vision of what recovery-oriented services should look like. Therefore, participants were asked policies provided sufficient clarity for implementation of recovery philosophy at the service level, and how this may be accomplished. By and large, the participants thought that the direction for implementing recovery philosophy was apparent:

<Mary> (P/CA): well I think the subjective__ the subjective element is vague __ I don't_ I think you can be reasonably specific about how the people should behave or how systems should be_ yeah

(Appendix D, p. 136)

<Jasmine> (CA): it's quite plain to me what is required

(Appendix D, p.106)

<John Smith> (P/CA): it's simple_ it's__ fundamental_ but it requires a shift in thinking_ which_ and I don't want to be *too* prescriptive but it needs to be service user led__ it's a whole shift in paradigm [...]there's a fundamental shift with the service that's consumer led because__ well_ the idea that recovery__ is possible_ it's just__ it just goes without saying it's not something you have to learn (Appendix D, p.8) [...] and it's the same in any like minded group__ there's stuff that goes without saying__ because it doesn't *need* to be said you know
<L> do you think that having that shared experience of mental illness__ makes people like minded necessarily?

<JS> oh no there's still the diverse opinions as in any other group__ but the idea of challenging recovery__ *can't* exist coz it's contradiction_ in terms_ if you're working in service user led organisation you can't say recovery is impossible_ because you're living proof that it is__ you know?

(Appendix D, p.9)

A number of participants spoke of helping professionals as being generally ‘protective’, risk averse, and making too many decisions on behalf of service users, all of which were seen as barriers to recovery. The following excerpt from an Auckland focus group is an example of that. When talking about the meaning of ‘recovery’, Ted remarks:

when we're talking about recovery I also talk about_ acknowledge the journey and the conditions in order to do that [<Elspeth> mhm] [...] the conditions to *enable* you to recover [<Tiger> yeah]__ and those are from use of mental health services__ you see I was in a mental health service that didn't really allow you to do that [<Tiger> mhm] because they organise your life for you_ what day_ day you did something_ did gardening group on Monday and walking group on Tuesday

(Appendix D, p.60)

Participants commonly expressed discontent about power dynamics in mental health services being skewed in favor of professional dominance. According to John Smith (P/CA): “*so often what's termed the consultation of partnership is often really just power imbalance but given a gloss*” (Appendix D, p. 15). Yet participants’ sentiments were *not* anti-psychiatry. On the contrary, many voiced an expectation that in extreme or altered mental states the helping professionals would ‘step in’ to ensure that person’s autonomy will not be negatively affected in the long term by their actions while they are unwell. However, many stressed that compulsory treatment should become an exception rather than the rule. When it is needed, however, participants expressed desire for a clear and respectful communication with the service user and wanted clinicians to make references to person’s advance directive or similar expressions of what they would have wanted if their mental state was not altered. Sue’s comment is an example:

if I am very suicidal I don't want to do it really_ I will get better again and be glad that I was not successful or be disappointed and that is the scary thing is that you want_ I want all service users to have autonomy and self determination and rights_ I also want some protection and it is good for clinicians to be really honest about it and say there are *some* times where I will have to take a protective role for you and trust that when things are easy for you_ you will be glad of that

(Appendix D, p.29)

All participants consistently emphasised the need for service user leadership and involvement at all levels of service development, evaluation, and improvement. Consistent with that emphasis, both participant groups discussed *processes* that generally facilitate implementation of recovery philosophy, but the information about specific ‘content’ of service delivery came largely from consumer advisors (Appendix C). This has a bearing on interpreting the findings about what recovery-oriented services should look like.

Detailed analysis of characteristics of recovery-oriented environments is beyond the scope of this particular report. However, the consultation data pertaining to that field of inquiry can be seen in Appendix C, and additional reports may ensue from further analysis of the interview transcripts should a need for this information be expressed by interested parties.

The current state of implementation

The following quotes from Mary and Jim (P/CA) set a stage for discussing state of recovery implementation in New Zealand mental health sector:

<Mary> we've got a policy split I think_ in that we've got quite good policies about_ around recovery and service user leadership_ and you know_ getting a broader range of services_ now the trouble is this policy is never really translated much on the ground_ but it's still sound policy

(Appendix D, p.138)

<Jim> what the DHBs come up with_ and how they operationalise it [recovery orientation] is [Jim shakes head] _ is a mess_ [...] let me go back a bit_ the translation of policy_ so you get something like the Second National Mental

Health Plan which is quite a good document_ high level um _ coherent _ quite well grounded ethically that sort of thing _ there is a translation process that moves from a national document to become something that informs the District Health Board_ now that translation _ because it is a high level_ a set of high level generalisations there is a lot of room to translate it into all sorts of things _ um so sort of at a planning level_ the DHBs things are going to change_ high level stuff is going to turn into something a little bit different because of the way the planners see it_ then services will be purchased either in the NGO sector or from the provider arm of the DHBs_ and what is purchased wont be quite what _ like the funder will have an idea_ we want *this*_ and what they will get won't exactly be that_ you know there will be a few changes made _ in the negotiation the comes into it and all that_ so you have moved another step away_ then the service providers take their idea_ which is contained in the contract about what they are going to do_ and translate it into reality_ and then things change yet again_ because having you know put in a lot of proposals _ negotiating contracts and then translated the contracts_ there is always something when you come down to the ground floor or to the coal face_ oh that was a good theory but we are going to have to do it like this_ so it is a little different and that is at a management level_ then you instruct your workforce to go out and do this thing _ now there is evidence that says that what the workforce does can very often have very little to do with what the management wants them to do_ and I will give you an example_ [where] philosophically it [practice] was almost the polar opposite of what management intended them to do_ the management in essence were attempting to promote the autonomy of people who use the service_ the staff were nice people and were looking after these old people _ which of course increased their dependence_ um reduced their autonomy

(Appendix D, pp. 46-47)

Considerable distrust of current MHS' practices was expressed by all participants, regardless of their backgrounds. Their responses ranged from skepticism about benevolent intent by services at all to more analytic accounts that considered systemic barriers to implementation. Yet the underlying message was clear – participants unanimously

conveyed that New Zealand mental health services are on the whole *not* recovery-oriented at present. Sue speaks for a many in commenting:

what they do is they get those documents [policies] and they see what is signalled and they think how can we retain our funding it is not about redelivering it is just about repackaging or retaining funding for services it is not about drastically changing them

(Appendix D, p.26)

Table 8 on the next page is an extraction from Appendix C codes by participant table, included to illustrate participants' perceptions regarding the presence of recovery ethos in New Zealand mental health sector.

Table 8: Codes related to current recovery-orientation of New Zealand mental health services.

	CA background (no policy)						Both CA and policy background			Policy background	
	Presently a CA						Presently in policy/leadership role				
	To m	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Clinicians are sceptical about recovery concept	✓							✓			X
Services decide what's good for people, which is 'disempowering' and a barrier to recovery		✓		✓	✓	✓		✓	✓	✓	
Lip service/tokenism is common	✓	✓	✓	✓			✓	✓	✓		
Paper implementation is common, services "talk the talk without walking the walk", faking	✓	✓	✓	✓		✓	✓			✓	
Recovery practices are only so in name but not in reality	✓			✓	✓	✓		✓	✓	✓	
Policies are <i>not</i> implemented in practice	✓	✓	✓	✓			✓	✓	✓		
Consumer advisors in MHS have tokenistic power							✓		✓		
Services focus disproportionately focus on clinical recovery dimensions, and not others	✓	✓	✓		✓		✓	✓			✓
Services need to be more recovery oriented	✓	✓	✓		✓						✓
Most MH services do not promote recovery	✓	✓	✓		✓	✓		✓		✓	
Services do not address social determinants and consequences of mental illness		✓	✓					✓			✓
Service pursue/guard their own agenda/interests	✓	✓	✓	✓			✓	✓			
Institutions have closed but institutional practice persists	✓	✓	✓		✓	✓	✓			✓	✓
Family/whanau perspectives are poorly integrated (recovery competency 10)		✓	✓	✓			✓				✓
Services are problem focused not solution/strength focused		✓	✓		✓	✓				✓	
Consumer workforce are employed for experience of illness not for skill or ability	✓			✓					✓	✓	
Recovery competency 9 (service user movement) is not well applied or is problematic	✓			✓							
Recovery competency 2 (resourcefulness) is poorly applied or misunderstood			✓	✓							✓
Rec competency 3 (Diverse views) is misunderstood or poorly applied	✓	✓	✓	✓			✓				
Community inclusion is understood by services as geographic location, not as social inclusion	✓	✓	✓		✓	✓	✓		✓	✓	
Risk averseness by services is a barrier to recovery		✓	✓		✓					✓	✓
MH professionals do not advocate for patients		✓	✓								

Although the above table by no means captures the richness of the data obtained, the detailed focus on the shortcomings of current service delivery is outside the scope of the present report. Should the reader be interested in those types of narratives, they are invited to peruse part two of the Appendix C. One may notice that not all recovery competencies are mentioned in that table. This is because the coding was data driven, and unless participants explicitly mentioned a theme, it was not recorded.

The following implementation factors were mentioned by a number of participants as prominent in the New Zealand health system. The relative frequency of implementation themes can be seen in parts two and three of Appendix C. According to participants' experience, recovery policies, however sound, are used for funding applications but not to guide practice. However, there is no systematic reporting, neither bottom up or top down, about how recovery-oriented services are. The majority of participants perceived this to be a significant problem. Conversation with Mary reflects it to some extent:

<Mary> I don't think there's any real reporting on recovery

<L> Do you think that's an issue?

<Mary> oh that's a huge issue__ yeah

<L> okay_ why? [<Mary> because] _ what makes it an issue?

<Mary> well I think if you've got a policy you need a loop_ you need a feedback loop__ because if you've just got a policy sitting up there and stuff going on down here__ and you don't have a feedback loop__ you just don't know what's going on in terms of that policy_ yeah [<L> yeah]_ so yeah I think it's bad_ but you see there_ there__

<L> what's the worst that can happen if you don't know?

<Mary> oh it just withers_ the policy just withers on the vine really_ [<L> okay]__ it never _ nothing ever _ it doesn't take hold and in fact _ I think recovery is in a worse position than it was_ you know_ maybe 3 of 4 years ago

<L> why?

<Mary> I think there's been a loss of leadership in mental health at the national level [<L> okay]_ and I think there's been a bit of a backlash against recovery_ and I think it was demonstrated in that report_ that Auckland report_ that was one of the_ the one that you know about__ the Te Whetu_ you know the one_[<L> yeah]_ and I think the recession too has probably_ even though it hasn't had

much of an economic effect on services _ it certainly has a psychological effect _ I think it sort of shuts people down a bit and stops them innovating in public services __ they get scared to do anything

(Appendix D, pp. 144-145)

The perceived losses in consumer leadership and lack of visibility of exemplary services were seen by a few participants as under-utilising the power of role modeling and of ‘selling’ recovery philosophy to service providers. When asked whether policies provided sufficient guidance on implementing recovery philosophy, Tiger responded: “No _ ‘cos the guidance is written rather than role modelled [Ted nods] _and guidance needs to be role modelled through training and leadership of mental health services” (Appendix D, p. 67).

Participants suggested that lack of evaluation contributed to lip service or tokenism on the part of services, paper implementation, and recovery practices being mis-applied to the point of remaining recovery practices only in name but not in effect or principle. No participants expressed concerns about deliberate misuse of the recovery principles. However, the phrase of “road to hell is paved with good intentions” was mentioned by a number of participants in regard to poor application of recovery values by New Zealand mental health workers of various professional affiliations.

Organisational culture factors and workforce resistance to change were also seen as key barriers to implementation. John Smith (CA) and Jim (P/CA) comment:

<John Smith> if you’re like a consumer advisor working in a DHB __ you want to work in a recovery way but often the policies and practices stop you doing that [...] DHB’s a business like any other well it’s state owned enterprise _ funded back to the government on deficit_ yeah you know I guess I’m saying the organisational policies not just district health board_ you have to work within them_ from talking to consumer advisors for instance_ it’s the single most stressful part of the job__ having to work within those policies and practices

(Appendix D, pp 11-12)

<Jim> you look around at the old hands and you do what they do_ and often if you don’t do what they do they will actually try and make you do what they do_ and if they can’t make you do what they do they will make it so unpleasant that you will

probably quit_ and acute units have that sort of thing_ that dynamic happens over and over and over_ not so bad in the community

(Appendix D, p.48)

Lack of alignment in demands on service was frequently mentioned by participants as a barrier to recovery implementation as well. This was especially in context of funding contingencies, inter-sectorial coordination issues, as well as the conflict between recovery philosophy and the social/legal pressures for containment of mentally ill people. Mary comments:

I think that there is a lot of pressure on mental health services to pursue their control agenda _ the control agenda that's been handed down through the community via the politicians and the legislation [...] there's a community demand that people who are a danger _ you know _ who are deemed to be a danger to themselves or others are contained within _ a mental _ you know a psychiatric ward or something

(Appendix D, p. 139).

Service infrastructure and lack of centralised support for guiding change were also seen as barriers to implementing recovery approaches. A comment by John Smith is one example:

knowing how to provide a service in partnership with them [different cultures] is difficult_ but it relates back to what we were talking about earlier_ if you've got_ if you've got policies that just set up an infrastructure_ you don't have to_ know about it_ you let *them* do it and you just provide the mechanism for them to run themselves

(Appendix D, p.13)

According to policymaker participants, unless the services are already motivated to adopt recovery approach, there is presently very little to induce them to change their paradigm of care from biomedical models to more holistic or recovery oriented frameworks. Alistair works in a role that makes his opinion on the subject very dependable. Below is an excerpt from our conversation:

<L> What is the motivation for current services to adopt recovery?

<A> Not a lot [chuckles and shakes his head]

<L> I mean is there a carrot and a stick type situation_ in any way or?___ What's going on? I mean_ why *would* they? It's extra effort

<A> Look that's a very very good question I think_ I mean our_ our approach is not_ is a little bit stick_ you know [...] it's not a big one___ it's probably a feather duster really_ but the fact that the Commission is coming in and asking these questions_ does make people think about it

(Appendix D, p.131)

Implementation priorities

Research participants suggested the following mechanisms for implementing recovery policies and promoting recovery-orientation of New Zealand mental health sector. Most consumer advisors and some policy makers felt the need for clearer national guidance on what services would look like if they were creating opportunities for service user recovery. Elspeth, for example, says "*I think there should be better guidance on how you can demonstrate it* [recovery focus]" and Tiger agrees: "*It has to be guided better doesn't it?*" (Appendix D. p.67). However, rather than having top down directives, a clear preference was indicated for examples of what services are doing well and which areas of service delivery need improvement. Acknowledging service providers who delivered recovery-oriented care was mentioned as important, particularly by consumer advisors. For example, Tommy expressed disappointment about times when his extra effort in promoting recovery of his clients does not get "captured" or acknowledged:

<Tommy> [...] that to me tells me that our service has done something_ cos our networking skills have worked_ you know? But in saying that_ that does not get documented unless I put it in with my narrative at the end of the month_ with my stats okay___ if I remember I will put it in there as a narrative_ but otherwise that actually goes_ gets dropped

(Appendix D, p.90)

The need, the "essential need", as Ted puts it, "for consumer involvement in all aspects of service development and evaluation" (Appendix D, p. 71) was seen as a priority by most participants, as far as implementing recovery approach was concerned. That involved addressing the issues of service-user workforce, including the presently tokenistic

power of consumer advocates in the DHBs and employing consumer advocates based on experience of mental illness rather than based on skill or ability to advocate effectively (Appendix C, parts 2 and 3). Access to service user leadership views, and service user led evaluation opportunities, were mentioned as useful but under-used mechanisms in implementing recovery approaches. For example, Sue says about services: “*they need to know _ have access to what service user leaders are saying about their service or other services about models or visions of what healthy mental health services look like*” (Appendix D, p.35).

Alignment of demands on services was also seen as important. This included discussions on aligning mental health legislation and funding contingencies with recovery goals. Another point of alignment was about training of helping professionals. Auckland focus group participants suggested that NZQA Quality Assurance Framework should be parallel with recovery implementation goals. However, the conflicting demands on services were not seen as restricted to formal systemic types. Addressing stigma and discrimination associated with mental illness, and therefore reducing the community pressure on the services to ‘manage and contain’ were described as important in creating the environment that facilitated recovery. Like Minds Like Mine anti-discrimination campaign was commended by many as effective in breaking down discrimination, addressing negative values about mental illness, and making the consumer voice heard. Overall, there was a strong sense from the consultation that instituting positive and effective implementation *supports* was perceived to be as important to participants as addressing existing barriers to implementation. Effective supports may be especially crucial in rural or isolated communities:

<Tommy> when you’re talking about a little town like say Te Kuiti or Taumarunui_ they are out in the wamp wamps and their nurses only come up to have_ to have a team meeting once a week__ so during the rest of that week_ they’re on their own down in their little town_ they’re doing what they think_ or what they perhaps *know _* works

(Appendix D, p.75)

Should recovery orientation of services be monitored?

Participants of Auckland CA/PM focus group suggested that “recovery-oriented approach is *the* foundation of a good mental health service” and that it has to be the primary criterion for evaluating the services, superseding other evaluation agenda (Appendix D, p. 71). Other participants were of a similar mind in linking the recovery approach to service effectiveness and best practice. The following quotes from Alistair (PM) and Tommy (CA) are two examples from many:

<Tommy> Sometimes like you'll get a damn good clinician you know_ and other times you get some that are really you know_ just there for the job basically_ okay_ you know_ just there to collect their pay packet_ but_ the ones that *get it*_ the presence or the absence_ you watch_ I bet you they have a less relapse rate_ I *bet* you they do_ the ones that *get it*_ cos you know_ they've probably got that empathy with and they're are able to understand and relate better

(Appendix D, p.83)

<Alistair> I personally I think_ ah_ that if you take a recovery approach_ it's going to be a much more satisfying approach_ ultimately

<L> To the clinician?

<A> Well to everybody [okay]_ it would be more satisfying for consumers_ it will be much more satisfying for clinicians as well_ and my_ you see this is where I start to get into my kind of utopian visions [laughs] because I actually think that recovery services are more effective than_ ah than other services_ and funny enough there's_ not very_ you know_ sort of scientifically robust evidence but it's funny because um_ there are some services that we would say ah have a fairly strong recovery approach and they are doing very well

(Appendix D, p. 132)

Promoting recovery, and author is using that word as a blanket term to refer to participants' understandings of it, was clearly a desirable goal for New Zealand mental health services according to this consultation project. Recovery approach was variously linked to effectiveness, good practice, service user needs, and to de-pathologising experience of mental distress. It was therefore not surprising that many participants thought services should be audited in some way for adherence to recovery approach. Table

9 summarises the value bases that were most relevant to the study participants when talking about assessment of services for recovery focus. At this stage of the report, the focus is on general value of reporting against recovery, not on the merits of any particular approach to assessment. An important finding was that participants speak of reporting against recovery in terms of a feedback loop. That is, they saw the value in services reporting to authorities, but also mentioned the importance of top down closing of the information loop back to the service providers and users. To Tommy, who is a service provider himself, the value of feedback lies in potential to improve own service: “*if there was something I wasn't doing that I should be doing_ that it would be picked up then and I could look at it and improve my quality of service as well*” (Appendix D, p. 87). To Jacobus and Jasmine (CAs), closing the information loop may be more about faith in services:

<Jacobus> I mean shouldn't we_ the government have some kind of responsibility [<Jasmine> yeah] units put in place or a governing authority for all to be answerable to_ to say whether or not what they are using is working_ whether the system is working_ that the mental health services provide a good service

(Appendix D, p.107)

Table 9: Thematic codes, by participant, related to why services should be assessed for adherence to recovery approach.

	CA background (no policy)						Both CA and policy backgrounds				Policy background (no CA)	
	Presently in CA role						Presently in policy					
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali	
Accountability	✓	✓	✓	✓		✓					✓	
Transparency	✓	✓	✓	✓	✓					✓		
Consistency of services across communities	✓				✓	✓		✓				
Demonstrating/proof that services are really working in recovery ways	✓	✓	✓	✓	✓		✓			✓		
Informed choice for consumers	✓	✓		✓	✓		✓			✓		
Evidence-based practice	✓		✓	✓			✓					
Benchmarking (within services and across sector)				✓	✓		✓			✓		
"Deserving" public money/allocating funding	✓	✓	✓	✓			✓					
Monitoring facilitates change/implementation			✓		✓	✓		✓	X	✓	✓	
Consumer leadership and advocacy in service development, and improvement	✓	✓		✓	✓		✓			✓	✓	
Effectiveness of services	✓		✓		✓		✓			✓		
Quality improvement/feedback loop	✓		✓		✓			✓		✓	✓	
Affirming services that work in recovery way	✓				✓		✓			✓		

Evaluation of services against recovery principles was seen by many as a remedy for the lack of faith in mental health services, but it was also perceived as a powerful implementation mechanism in its own right. Ted observes:

<Ted> you could have a policy that all notes must be written collaboratively now that may actually encourage recovery because you're encouraging something so there's an overall value that that's a good thing among individual clinicians some will say that's really that's changed their practice and they're much more recovery focused others see it as just ticking the box but in the round it's probably a positive thing that you make that compulsory [...] the process of actually having to tick these boxes can change the

values in the long term [<Tiger> mhm] _ then people start wondering oh why do we have to do this? [<Elspeth> yeah]_ there must be a reason we have to do this __ it's the same with restraint and seclusion we reduce them out__ if we make people fill in the form which explains why they've got to and what they did to avoid doing it_ you are going to reduce the use of it

(Appendix D, pp. 65-66)

What indicates service adherence to recovery approach?

Coming back to the original research question of *how* recovery orientation may be measured, there was no unanimous straightforward answer other than rejection of *clinical* outcome measurements as reflection on service adherence to recovery approach. Consumer advocate Tommy from Waikato speaks for more than himself in saying:

<Tommy> that's a real hard one__ because I mean what one service thinks they might be doing really good guns_ another service may look at it and think oh geez_ I could do that a hell of a lot better __ I do believe yeah_ that they should be held to some sort of standard [okay] but how it's monitored I really don't know__ I mean people relapse for different reasons_ it could be the environment_ it could be drugs and alcohol_ it could be the wrong medications_ the wrong supports_ you know_ they're not with their own people or_ you know

(Appendix D, p.90)

In general, participants indicated preference for some sort of standardisation in evaluating service adherence to recovery approach (Appendix C). Consumer advisor participants, in particular, expressed that the recovery practice criteria/standards should be the same across the different services in the sector and across services in different communities. This is partly related to the high value they placed on relative comparison of different services for purposes such as informed choice for consumers and allocating funding to services that provide best opportunities for service user recovery. However, consumer advocate Sue also raised an issue, related to the original research premise, that standardisation may negatively affect diversity of services and worldviews they represent.

A number of participants mentioned that the organisations they work for or those in their professional network are in the process of developing a measure tapping into

organisational recovery orientation. One of the participants said that on recognising how many organisations were developing their own measures, Te Pou halted the development of a common tool for the sector in lieu of supporting organisations to develop their own by providing *indicators* for evaluating recovery orientation (The author was not able to either confirm or refute that as a fact from perusing the Te Pou website). Sue and Alistair were particularly supportive of the idea that services should have some flexibility about how they meet those recovery indicators. However, other participants were opposed to the idea, preferring instead a more rigorous standardisation. The author believes that this lack of consensus among stakeholders regarding acceptable limits of interpretive flexibility of measurement is in itself an important finding.

Although most participants agreed that *clinical* outcomes of service users did not reflect recovery-orientation of a service, there was a lack of consensus about whether or not outcome measurement is consistent with recovery philosophy in principle. On one hand, a few participants valued outcomes as an indicator of recovery-promoting environments. Examples of statements to that effect include, but are not limited to these ones by Jacobus (CA) and Mary (P/CA):

<Mary> _ if you knew how many people were employed and you know_ maybe having children_ or in stable partnerships_ or in stable housing of their choice_ I mean to me they're just measures of recovery_ so if you're interested in recovery_ that's it_ I mean that's it in terms of _ I mean that's sort of more _ I mean people might say that's pretty outcome based_ but it is_ but I think we want_ we want outcomes [<L> okay] _ we don't want to be stuck in services for the rest of our lives

(Appendix D, p. 146)

<Jacobus> in order to assess that service you talk to the clients_ [<L> okay] and they are serving this certain number of clients_ what are they doing with those clients? Just by talking to the clients_ are they being healed? Are they being restored? And the proof is in the tasting of the pudding_ you can tell by talking to them _ just assessing where *they* are at [...] I believe that a good thing will express itself [...] I think overall if it benefits society and it benefits people_ you gonna see the results of it_

(Appendix D, p.109)

On the other hand, conversations with the same participants often indicated relative preference for *process* evaluation over outcome measurement. Jim, for example, first spoke of Quality of Life survey results as indicative of how recovery focused helping environments are. However, he then warned the author that for individual clients the Quality of Life (WHOQoL Group, 1995) score may initially become lower in recovery-promoting environments. This he attributed to the fact that, with increased self-esteem and confidence, the Quality of Life indicators become more important to the user or that their aspirations become higher than they may have been in a less empowered state. And so Jim concluded:

<Jim> [...] looking at the organisation itself and what it is *doing* rather than the outcomes from the people who are using it [...] I guess when I think about it I believe that if you create the right environment good things will follow_ so you don't have to measure whether the good followed to see if the environment is right __ you focus on the environment _

<L> so do you think it would be useful to start asking questions about what the environment is like? try to measure the recovery orientation_ as a blanket term for whether that environment is conducive to promoting autonomy and respect_ you know things like that?

<J> I think that is better actually than looking at outcomes _ because you could_ you've always got the problems with outcome with attributions__ people could be doing all right but in spite of the service

(Appendix D, p. 55)

On the whole, there was a strong agreement among research participants that evaluating environment, or process, of service delivery would be useful in assessing recovery orientation. Conversely, there was a lack of consensus about the value of outcome measurement. Key objections to outcome measurement were related to a) high face validity of outcome measures making them more prone to faking or 'gaming' by service providers, and b) attribution was considered problematic in measures of client outcomes.

The most popular solution to process/outcome debate was evaluating services based on a combination of quantitative outcome information and qualitative process information. Another possible solution was asking service users to develop an outcome measure that reflected factors important to them, and then make their own attribution about whether the service helped them achieve those goals. Whatever solution was offered, almost all participants emphasised that the information about recovery orientation of services should be collected from people who use those services.

In conclusion, all participants were asked to suggest a few questions that may be helpful in assessing recovery-orientation of *a* mental health service. The list of their suggestions follows below. According to participants' understandings, the parameters assessed by these questions are not presently addressed in New Zealand mental health services evaluations. The list may be of value to future developers of recovery orientation measurements. Alternatively, they may affirm practices of organisations who already ask these questions about their own service delivery.

Questions that need to be answered by service users:

- ◆ did this service help you achieve the life you wanted?
- ◆ what would you like to see included [in the service]?
- ◆ What could the service do better?
- ◆ Is the information provided to you by service clear/can you understand?
- ◆ What are the exits from service? Do you know them?
- ◆ Do you know how to make a complaint/suggestion about how the service runs?
- ◆ (from a full list of services offered by organisation) What options are you aware of?
- ◆ Did the service provider tell you about resources outside their own organisation? In the community? Which options are you aware of?
- ◆ Are some services/options offered more regularly to you than others?

Questions to the service providers:

- ◆ How do you make the decision whether to refer? who does the referring?
- ◆ In a professional relationship, where does the power lie?

- ◆ Who decides what is to be achieved? And who decides when it has been achieved?
- ◆ Whose choice is time and place of the meeting, its intensity and duration?
- ◆ What range of services is provided? What is the uptake to those services? How regularly are different options offered to people?
- ◆ How aware are service users of diverse choices? Are some choices offered more regularly, or at expense of others?
- ◆ Does the service refer people outside its own organisation/professional niche?
- ◆ What training do staff receive in recovery processes?

Questions that tap into quantitative information:

- ◆ How many people using MHSs are employed? (employment is an indicator of recovery)
- ◆ How many people are in stable housing of their choice?
- ◆ How many people are in relationships/have children?
- ◆ How many people are disabled by their experience? How many are using benefits due to psychological disorder?

DISCUSSION

One of the unexpected findings from this research was how extensively participants elaborated on what ‘recovery’ means to them. The questions that were posed to explore whether policy was an agreeable starting point for implementation of recovery approach rendered surprisingly thorough and philosophically grounded discussions about what recovery is and is not. For many participants, the concept of recovery could not be divorced from the complex interaction between an individual seeking recovery and the wider socio-political context they exist in. The author was surprised to hear participants describe their understandings of mental illness and recovery from it in ways that were remarkably consistent with ideas expressed in works of such thinkers as Foucault (1967) and Laing (1982). Without going into in depth explications, the following are key similarities between participants’ descriptions of recovery and the works of these social philosophers.

The way participants described experience of mental illness and recovery is very similar to the experience of ‘metanoia’ described by R.D. Laing (1982; Mullan, 1995). That is, participants described mental illness as often unpleasant, but a legitimate, deeply human, and informative experience. Consequently, thinking of recovery in terms of return to ‘normality’ or simple return to pre-morbid condition was seen as inappropriate because doing so entails hidden losses, and devalues the meaning and learning gained by going through the experience. This is not to romanticise and minimise ‘madness’, but to humanise it and to encourage empathy, which were seen by participants as important preconditions for recovery. Sue commented that “*people can learn a lot from their experience of mental illness and people around them can too as long as they are well supported and nurtured and nourished and informed*” (Appendix D, p.30)

According to a number of respondents, recovery occurs when people are treated respectfully and are supported to focus on their strengths and competencies instead of are emphasised instead their problems. This was contrasted to being ‘cared for’, ‘looked after’, ‘contained’ or ‘maintained’. Similarly, being denied, overtly or implicitly, autonomy and the rights and responsibilities of citizenship because of the experience of mental illness were perceived by participants as barriers to recovery. In general, participants described recovery in terms of achieving social connectedness and being a valued and valuable

member of the community with the same rights and social responsibilities as everyone else. In line with this, the role of supportive environment was emphasised to a greater degree by the study participants than it appears to be promoted in the international literature on the subject (Bellack, 2006; Onken et al., 2007; President's New Freedom Commission on Mental Health, 2003; World Health Organisation, 2005). The convergence of participant opinions in emphasising social determinants and consequences of mental illness and recovery may be a sampling artefact. However, it is also possible that this finding reflects a true difference between New Zealand and overseas stakeholders in terms of understanding relative contributions of the individual and their context to achieving the goal of 'recovery'.

Although there was a general consensus that compulsory treatment should be used only in exceptional circumstances, there was also a clear expectation that mental health services would step in to look after the person's best interests should they be in extreme mental state that poses danger to themselves or others. An important distinction was about how the service user's 'best interest' is determined. Many stressed the importance of clear communication between service providers and users. In particular, the need to respect the wishes of services users was emphasised. Recording service users' own goals in documents such as advance directives, strengths profiles (Rapp & Goscha, 2006), and Wellness Recovery Action Plans (Copeland, 2000) prior to onset of extreme episode was seen as one way of achieving that.

A number of participants saw mental health services as environments that, by design, should create favourable conditions for service user recovery. This is consistent with New Zealand and international literature that suggests that the new overarching goal of mental health systems should be to support recovery (Jacobson & Curtis, 2000; Minister of Health, 2005; Mountain & Shah, 2008; *Our Lives in 2014*, 2004). Yet, none of the study respondents believed that New Zealand MHSs are, as a rule, recovery oriented at present. Instead, their descriptions were mostly of services that are biomedically focused, often paternalistic, and inducing dependency rather than hope for the future. Even though a few consumer advocate participants did not know what the service user movement was, their narratives of service experiences were remarkably similar to local and overseas consumer movement stories (Deegan, 2003; Mead & Copeland, 2000).

Nevertheless, participants' responses were *not* anti-psychiatry. This lends support to international authors who claim that recovery focus should not be conflated with anti-psychiatry, although it often is taken this way (Meehan et al., 2008; O'Brien et al., 2001). Many participants acknowledged that organisational and systemic factors negatively affect individual clinicians' ability to practice in recovery oriented ways. These factors are similar to those described in the implementation research reviewed earlier in this report, and include workforce inertia, lack of supporting infrastructure, conflicting demands and so forth. A few policymaker participants suggested that adopting the recovery approach would be more satisfying to both consumers and service providers, but that professional roles would need to be re-negotiated at a system level to remove clinicians from a "biological cul-de-sac", as Mary put it (Appendix D, p. 139).

Some participants indicated that recovery paradigm was not equally acceptable to all MHS stakeholders, which is also a recurrent theme in recovery research (Cowan, 2008; Cunningham et al., 2005; Meehan et al., 2008). Only two or three people attributed this lack of acceptance to professional helpers vying for paradigm dominance, while others suggested that the way recovery was "packaged" in New Zealand and overseas did not lend the concept to easy implementation by diverse stakeholders. For example, Jim suggested that "recovery adopted too many shades of meaning" (Appendix D, p. 43) for it to be useful in guiding practice. This is not dissimilar to point made by Roe, Rudnick and Gill (2007) about recovery paradigm becoming too broad to be meaningful, and that it is losing the boundaries that distinguish it from other models of care. However, other than the nuances of wording, policy definition of recovery as "*living well in the presence or absence of mental illness and the losses that can be associated with it associated with it*" (Minister of Health, 2006) was acceptable to the vast majority of the study participants. This may be due to the fact that most of the participants have a shared perspective gained through a personal experience of recovery. That is, the research sample does not represent distinct stakeholder groups and therefore their perspectives were not as difficult to reconcile as literature seems to suggest is common in the mental health sector (Bellack, 2006; Borg & Kristiansen, 2004; Brown et al., 2008).

As mentioned earlier, participants generally agreed with the policy directive that mental health services should practice recovery approaches but did not think that these approaches were at the time of data collection implemented by the majority of New

Zealand mental health sector. This was a predictable finding, since the gaps in policy implementation processes were identified from the outset of the study. A number of barriers to implementing recovery practices were cited by participants. The perceived stakeholder tensions in defining what recovery means were alluded to by a few participants. On a related but separate note, most participants did not think that key health system documents provided sufficient guidance on what recovery oriented services should look like. As Tiger put it “*to avoid the shades of grey you need to make it as black and white as possible really*” (Appendix D, p. 67).

Also, most of the participants expressed that lip service or paper implementation of recovery approaches is common in New Zealand MHSs. Policy maker participants acknowledged that at present there are insufficient motivators for services to undergo authentic change. Participants cited that this was partly because recovery orientation of services is not systematically evaluated. To the best of participants’ understandings, neither are there tangible consequences associated with ability of services to demonstrate that they are recovery focused. Participants with management experience shared that the service contracts may signal funders’ expectation of a recovery approach, but the funding is not contingent on service’s ability to demonstrate they are delivering it. Participants unanimously perceived this as a problem, thus confirming the research premise that implementation issues in New Zealand warrant further attention and research.

Participants saw potential measurements of organisational recovery orientation as a worthwhile avenue to explore. From the many uses of measurement that are cited in the research literature, research participants tended to focus on a few key objectives. Firstly, measurement was cited as instrumental in promoting accountability to public funders and transparency about service operations. This transparency was perceived as essential in building faith in services and in giving power to service users, who could then make informed decisions about using particular services. Using service evaluations to empower service users was not a theme the author encountered in any of the implementation or service evaluation literature reviewed. It was, nevertheless, a common theme among consumer advocates who participated in the present project.

Measuring organisational recovery orientation was seen by some as an important change mechanism that in its own right affects the change of values. Earlier quote from Ted is an example of that opinion when he talks about paperwork making service

providers ‘stop and think’ about their practices and reasons for them. On the other hand, policymaker participants expressed doubts about the value of measurement for measurement sake. Jim expressed this thought as “*having more and more rules and having more and more ways to try and enforce them doesn’t do it __ you actually have to get people to um _ to connect the good intentions of the people with a guiding moral principle*” (Appendix D, p. 53). Alistair also commented that “*it’s something that people take on themselves_ and whenever anybody waves a big stick there’s always going to be_ well I would say the majority of people will resist it*” (Appendix D, p. 131).

In light of the above, it seems crucial that any measure that attempts to assess organisational recovery orientation is of high value to services themselves, as well as to overseeing agencies, and to service users. This value may be derived from other measurement uses cited by participants. Providing services with evaluation-based feedback was seen by a number of participants as a potent quality improvement and change mechanism. However, such feedback needed to cover both areas in need of improvement as well as practices that the service is doing well. Participants obviously valued the reinforcement and social learning potential of evaluation in expressing that measuring organisational recovery orientation would affirm services that already practice recovery approaches and will provide guidance by exemplary leadership to organisations who do not yet practice in recovery ways. Waikato consumer advocate Tommy also expressed that an oversight of service delivery, if perceived by providers to be promoting quality improvement rather than disciplinary action, may induce more conservative MHSs to try a new recovery approach. Overall, there was a recurrent theme among participants that New Zealand MHSs need greater support and positive infrastructure if recovery policies are to be translated into practice.

From the outset, two approaches to measuring organisational adherence to recovery philosophy were reviewed: outcome measurement and evaluation of the processes of service delivery. It was proposed that client outcomes may be less useful as indicators of organisational recovery orientation because of the potential inconsistency with recovery principles and because outcome attribution is problematic. Both of these hypotheses were supported as feasible by the data collected. The commonly expressed opinion that individual should have the “right to fail” and “personal agency” in driving recovery process make outcome measurement problematic as the sole measurement of service

adherence to recovery approaches. Most participants thought that clinical outcomes were not a measure of recovery orientation of services, and a few were conflicted about whether outcome measurement in any form is consistent with recovery principles. Other assumed a less dramatic stance in expressing that service should demonstrate positive trends in achieving outcomes important to service users, which may or may not be include clinical outcomes. However, the consensus that measuring the process of service delivery is useful was unanimous. Thus, the findings of the present consultation project suggest that evaluating the process of service delivery is a priority, although it may also be valuable to supplement process information with consumer-driven outcome measures.

The costs associated with developing a measure of organisational recovery orientation were not mentioned as a consideration by any of the stakeholders consulted. However, a degree of top down standardisation was still perceived as useful. The key consideration in choosing a stance on standardisation issue seemed to be the balance between desire for national consistency in service delivery on one hand, and desire for more innovative and flexible services on the other. There was great variability in the degree of standardisation participants perceived as striking an optimal balance between these two considerations. Some participants wished to see the same recovery orientation questions being asked of all service in the country, to enable meaningful comparisons. Others suggested that a standard set of recovery indicators should be developed, but that services need to have flexibility on how these indicators may be demonstrated. This lack of agreement between participants does not necessarily reflect irreconcilable differences. Rather, a more structured approach to consensus building than this study could provide may be called for (Hermann, 2005).

Because there was little agreement among participants on the subject of standardisation, it is not possible to discuss which of the evaluation approaches presented in Appendix A may be most promising for use in the New Zealand context. A more structured consultation with a diverse range of stakeholders may be necessary to determine which specific evaluation model would be of most value.

Strengths and Limitations

The epistemological notions of objectivity and researcher as neutral observer are as a rule foreign to qualitative research (Fischer, 2006; Hesse-Biber & Leavy, 2006).

Regardless of dedication to be driven by data rather than by own theories, the researcher inevitably influences the outcome of the study. They do so by deciding on the focus of the research and the questions to be asked, by prompting participants, by selecting from a rich textual material the fragments that count as relevant in answering research question, and in many other ways (Pawson, 1996; Ritchie & Lewis, 2003). This is the limitation of *all* qualitative social research and so it applies to the present project as well. The strategies described in the methods section somewhat minimised, but did not eliminate, the impact of researcher subjectivity.

Overall, the main limitation of the study is that only one person analysed all of the data, with only a limited parallel process with research supervisors. Also, only 11 people of two stakeholder categories were interviewed. The use of software-assisted analysis technique was helpful in giving leads and suggestions about key themes. However, Leximancer does not reflect the cause and effect relationships, nor does it give meaning to what is being said. It was the job of the author to organise and interpret the whole of information obtained and to reflect on commonalities and differences of participants' perspectives. Inevitably, this is done through lens of author's own experiences and perspectives. Alistair was aware of this even at the data collection stage:

<A> have you got a hypothesis?

<L> no we're trying to keep an open mind to see what people say__ so I'm consulting at the moment_ policymakers [mhm] and consumer advisors [yeah]_ just to see what their_ opinions are [yes] on the matter and trying to keep an open mind and not come with any pre-determined ideas_ yeah

<A> but you must have some ideas? [...] I don't mind by the way

(Appendix D, p.120)

Multiple authors suggest that the key to reducing the impact of this shortcoming is acknowledging it by putting researcher's theory and agenda in clear view of both participants and of the potential research readers (Fischer, 2006; Hesse-Biber & Leavy, 2006; Horwitz & Schied, 1999; Kamberelis & Dimitriades, 2005; Pawson, 1996). To achieve this, at the outset of every interview the participants were introduced to the research and the researcher's background. The reader can now draw their own conclusions about whether the process was sufficiently transparent, by referring to Appendix D.

As is true for most qualitative studies, claims of data representativeness are limited to sample consulted. This, in conjunction with relatively small sample size, prevents confident extrapolation of findings across other New Zealand consumer advocate and policymaker stakeholders. The representativeness of data *within* the sample is relatively strong. All but two participants have reviewed and edited the interview transcripts prior to data analysis in order to ensure faithfulness of textual representation to their actual views.

The participants who took part in the study had many levels of overlapping experiences, thus blurring the distinction between consumer advocates and policymakers as research categories. This limited the ability to answer one of the research questions. Namely, whether there were clear differences between the views of the two stakeholder groups. However, the researcher stands by the original choice of requesting that participants select all the experiential categories that apply instead of choosing only one role for describing their background. Doing the latter would be artificial and less transparent. Also, it would have created difficulties for participants if they had to rank their many and varied life experiences in order of importance. This is exemplified by Mary, who said: "*I've always been hard to categorise*" (Appendix D, p.137). Finally, there is the original reasoning for that methodological decision. Participants with multiple or overlapping experiences are valuable in providing bridging perspectives to reconcile views of different stakeholders. In a larger scale inquiry, such as what this research has been originally designed as, it is expected that overlapping experiences should not prevent comparisons between stakeholder groups. From the author's past research experience, overlapping experiences do not always prevent between-group comparisons even in samples comparable in size to the present research (Voronova, 2008). Therefore, limited ability to compare between stakeholder groups is more likely to be the artefact of the sampling than it is of procedural decision. The experience of this project should not deter other researchers from letting participants select multiple roles to describe their experience.

This project was conducted as a feasibility study for a larger scale inquiry and should be understood as such. Research design and methods in general worked out as expected. The only surprise was instability of Leximancer analysis. The software-extracted figures and tables presented in this report have been tested for stability by running the analysis several times for each task. The relative prominence of key themes changed somewhat

between different runs of the analysis even though key concepts, themes, and relationships between them remained much the same. To be used in this report, Leximancer maps and tables had to remain ‘stable’ in three consecutive runs of the analysis. This was a time consuming process. Other researchers may look into seeking to better understand the reasons for instability of Leximancer analysis and thus avoid it, or else use a different software package.

Conclusions

The findings of this research lend support to the idea that it is useful to assess recovery orientation of mental health services (MHS). There was strong overall opinion among participants that it would be optimal for all MHSs in New Zealand to be evaluated against a standard set of indicators by external agencies. The basic functions of such evaluation included promoting accountability and transparency for funders, quality improvement within services, consumers being able to make informed decisions about which services to use, as well as improving public trust in mental health services and encouraging systemic change in the direction of the recovery approaches. These uses of the evaluation are consistent with international findings of the benefits of evaluation. The key reservation expressed by participants related to likelihood that services would be resistant to adopting any new measure, and would see it mainly as an additional paperwork burden. Therefore, it is important to consult stakeholders in New Zealand mental health sector to ensure that any measure of recovery orientation that is introduced is of value to them and has tangible implications for practice.

Process focused evaluation approaches were seen as more useful than outcome measurements in terms of demonstrating recovery orientation of services. However, only one participant completely rejected the outcome data as a reflection of service performance. Most participants suggested that *clinical* outcomes, such as those collected by HoNOS suite of measures, do not reflect how recovery oriented a service is. However, consumer-assessed outcome measures, proposed by MH-SMART initiative, may provide useful information that ties in with the recovery focus if information collected was to be identified by service users themselves as relevant to their recovery. Outcomes related to social inclusion, education, employment, and empowerment were seen as potentially most

important. By contrast, the use of service user satisfaction surveys was seen by a few participants as not consistent with recovery philosophy.

There was a strong emphasis on service user leadership in the development, evaluation, and improvement of services. With regard to measurement, participants were in consensus that information on recovery-orientation of service should be collected primarily from service users. Some allowed that auxiliary information may be gathered from other sources, but all agreed that it should relate back to the identified service user needs rather than be driven by top-down processes such as policies.

The following implementation priorities were shared by participants. Alignment of other demands on MHSs with the recovery approach was seen as important, particularly with regard to funding accountability and mental health legislation. Participants expressed that providing services with clear guidelines of what recovery oriented practice should look like was crucial, and emphasised the need of leadership and role modelling by exemplary services. Closing the policy-practice feedback loop was perceived as vital to successfully implementing recovery philosophy and improving the quality and consistency of mental health service delivery in New Zealand. However, these research findings are best conceptualised as suggestive but not conclusive due to the small scale of the consultation they are based on. A larger scale inquiry is warranted to reach stronger conclusions.

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Appendix A

Table comparing measures of recovery orientation

[Please fold out the next page]

Note: if printing, the next page requires A3 size paper

Measures included in the table and sources of information:

REE/DREEM – Recovery Enhancing Environment measure, also known as
Developing Recovery Enhancing Environment Measure (Allott, Clark, &
Slade, 2006; Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005)

AACP ROSE – American Association of Community Psychiatrists Recovery
Oriented Services Evaluation (Campbell-Orde et al., 2005)

RSA – Recovery Self Assessment (Campbell-Orde et al., 2005; O'Connell,
Tondora, Croog, Evans, & Davidson, 2005; Salyers, Tsai, & Stultz, 2007)

SRI - Scottish Recovery Indicator, is based on an earlier instrument known as
Recovery Oriented Practices Index, and is described and available at
www.scottishrecoveryindicator.net

IROSS - Indicators of Recovery-Orientated Service System are described and
available at <http://www.pmhca.org/docs/ACallForChange.pdf>

RPFS – Recovery Promotion Fidelity Scale (Armstrong & Steffen, 2009)

ROSI – Recovery Oriented Systems Indicators measure (Campbell-Orde et al.,
2005)

O'Hagan – Systematic Recovery Framework, is described and available at
<http://www.maryohagan.com/mental-health-recovery.html>

	REE/DREEM	AACP ROSE	RSA	SRI	IROSS	RPFS	ROSI	O'Hagan
Domains Assessed	1. Demographics 2. Stage of recovery 3. Importance ratings on elements of recovery 4. program performance indicators 5. special needs 6.organisational climate 7. recovery markers 8.consumer feedback	1. Administration 2. Treatment 3. Supports 4. Organisational culture	1. Life Goals 2. Involvement 3. Diversity of treatment options 4. Choice 5. Individually tailored services	1. Meeting basic needs 2. Personalised services and choice 3. Strengths based approach 4. Comprehensive service 5. Service user involvement/participation 6. Social inclusion and community integration 7. Advance planning 8. Recovery focus	1. Validated personhood 2. Person centered decision-making & choice 3. Connection -- community integration, social relationships 4. Basic life resources 5. Self-care, wellness, & finding meaning 6. Rights & informed consent 7. Peer support/ self-help 8. Participation, voice, governance & advocacy 9. Treatment services 10. Worker availability, attitude and competency 11. Addressing coercive practices 12. Outcome evaluation& accountability	1.Collaboration 2. Participation and acceptance 3. Self-determination and peer support, 5. Quality improvement 6. Staff development	<u>Self-report survey:</u> Person cenered decision making and choice, invalidated personhood, self care and wellness, basic life resources, meaningful activities and roles, peer advocacy, staff treatment knowledge, access <u>Admin profile:</u> peer support, choice, staffing ratios, system culture/orientation, consumer inclusion in governance, coercion	1. Beliefs about madness 2. Purpose and values of services 3. People involved in services 4. Elements of services 5. Deliveries to families and individuals 6. Deliveries to populations 7. Inter-sectorial integration and cooperation 8. Systemic framework (incl. legislation, policy and funding alignment, service user oversight, and development)
Filled by:	Consumers Providers Service managers Families Advocates	✓ — — — —	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓	Data consists of all of the following: 1. Interviews with consumers 2. Interviews with providers 3. Care plans 4. Service info, policies & procedures	✓ ✓ ✓ — —	? ? ? ? ?	✓ — (administrative profile) — —
Number of items	166 including 20 special needs items	46	36	19	A number of possible indicators for each domain. Indicators vary depending on level of assessment	12	42 items in consumer self-report survey, plus 23 items in administrative data profile	NA – qualitative report with reference to domains of Systematic Recovery Framework
Versions	1	1	1	1	3	1	1	N/A
Level of assessment	Organisation	Organisation	Organisation Service System	Organisation Service System	Individual Service	Organisation System/country	Organisation	Organisation Service
Services suitable for	Any adult service in mental health or addictions sector	Any adult service in mental health or addictions sector	Any adult service in mental health or addictions sector	Any service in mental health or addictions sector	Any service in mental health or addictions sector	Adult mental health	Any adult service in mental health or addictions sector	Any adult service in mental health or addictions sector
Formal testing	Yes. Although possible sample issues.	Not by 2005 – last available mention	Yes. Good psychometric qualities	Some. Qualitative validation.	Not as of 2009	Initial stages – face and content validity	Some. Further testing was contingent on funding as of 2005	Not as of 2009
Cultural validity: developed/tested for use in	REE- USA (limited testing with African American and Hispanic populations) DREEM- UK and Italian versions	USA	USA – tested with White, Black/African Americans, and Hispanic/Latino Americans	Developed and tested in Scotland	Limited information – cannot comment	Developed specifically for Hawai'i	Diverse USA populations	Evaluation service used by clients in New Zealand, Australia, Netherlands, Scotland, England & Canada
Consumer involvement in development?	Strong involvement at all stages of development + author has personal experience of recovery	Through informal feedback	Yes. Consumer-produced literature for review, + involved in expert review of original items + in focus groups on definition of recovery & its models	Yes. Need more info to estimate the degree of involvement	Yes. Need more info to estimate the degree of involvement.	Yes. Need more info to estimate the degree of involvement	Strong involvement at all stages of developmnt	Yes. Author has personal experience of recovery.
Availability for use	Copyrighted by P.A.Ridgeway – permission required prior to using	Copyrighted by AACP but can be used freely	Public domain. Not copyrighted. Permission recommended but not required.	Public domain. Available in electronic or pen and paper form.	To be established	To be established	Public domain. Permission recommended but not required	Services to be contracted from the author

Appendix B

Research Documentation

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18 May 2009

Ms Lola Ivanovski
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Dear Lola

Should recovery practices within mental health services be monitored? If so, how can organisational

recovery orientation be measured? A qualitative inquiry.

Investigators: Lola Ivanovski. Supervisor: Kate Diesfeld.

Ethics ref: NYT/09/03/030

Locations: Auckland region.

The above study has been given ethical approval by the Northern Y Regional Ethics Committee.

Approved Documents

- Participant Information Sheet and Consent Form dated 22 February 2009
- Invitation letter

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until **18 May 2010**. A final report is required at the end of the study and a form to assist with this is available at <http://www.ethicscommittees.health.govt.nz>. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

A handwritten signature in black ink, appearing to read "Amrita Kuruvilla".

Amrita Kuruvilla
Northern Y Ethics Committee Administrator

Email: amrita_kuruvilla@moh.govt.nz

TO WHOM IT MAY CONCERN

Talofa lava, my name is Hana Asi-Pakieto. I am a New Zealand born Samoan. Lola Ianovski has discussed with me her research project titled "Should recovery practices within mental health services be monitored? If so, how can organisational recovery orientation be measured? A qualitative inquiry".

I think Lola is competent to work with Pacific Island participants and she seems to understand the principles of sensitive enquiry very well. This research is vital to all Pacific Island communities in New Zealand as it has potential to improve service delivery in the Mental Health sector.

I have told Lola that I am available to provide cultural supervision if she has questions around working with Pacific Island people.

Yours Sincerely



Hana Asi-Pakieto

Kia ora my name is Ivan Pattison, I identify as being Maori, my iwi is Ngai Tuhoe and Ngarauru. I have discussed with Lola Ianovski her research project titled "*Should recovery practices within mental health services be monitored? If so, how can organisational recovery orientation be measured? A qualitative inquiry*". I believe this research question is very important and thus relevant to all Maori communities as well as to the wider New Zealand community. Because it raises important questions around the issue of recovery: for example, what is recovery for Maori? Are there differences between Maori ideas of recovery and the rest of New Zealand? This research, will question current practices put in place to assist mental health practitioners working alongside tangata whaiora.

I think the research methods Lola will employ are culturally sensitive towards Maori and thusly appropriate for this type of scientific enquiry. I think potential benefits for the Maori community, for mental health practitioners, and for New Zealanders in general, far outweigh the risks. I firmly believe that Lola will take all precautions necessary to ensure that this research will be conducted within culturally safe boundaries. In addition I have confidence in Lola's general competence to carry out this research.

I am willing to provide Lola with ongoing consultation in my capacity as the co-chairperson of the Mental Health Support Workers Association of New Zealand (SWANZ), pertaining to Maori related aspects of her research study.

Yours sincerely,



Ivan Pattison.

To Whom It May Concern,

My name is Rayji Sean Tsutsui. I belong to Te Arawa (iwi) and Ngati Whakaue (hapu). I am a medical doctor practicing at Auckland City Hospital.

Mrs. Ianovski and I held a pleasant discussion regarding her research project that she was about to embark on. In this discussion, she had highlighted some key issues that I believe were pertinent to involving the Maori.

In fact, in her previous research experiences, she held discussions with Maori health workers, which I felt she had learnt a vast amount from. Some of the overlapping themes in our conversation and her previous conversations were: developing friendly relationship with the client prior to research participation; Recognition and engaging Maori Mental health team; seek for advice by a Maori elder when further concerns arise.

Mrs. Ianovski has explained to me what her research aim to answer and I believe it is a relevant topic for Maori also. It will help clients by enabling mental health practitioners provide the consistency of care for Maori, which I believe is a key component of professionalism.

Maori community / mental health clients will benefit from this research project. In addition, I believe that the benefits of this research will outweigh the potential risks.

If required, I am more than happy to provide cultural supervision for Mrs. Ianovski should she have Maori related concerns during her data collection / interviews.

Regards

Dr. Rayji Sean Tsutsui

 2/3/09

To Whom It May Concern,

I am a doctor training in psychiatry. I met with Lola Ianovski to discuss her proposed research, titled “*Should recovery practices within mental health services be monitored? If so, how can organisational recovery orientation be measured? A qualitative inquiry.*” In my opinion this research promises to make important contributions to the concept of recovery, to mental health service delivery, and ultimately, and most importantly, to service users. The methods are appropriate for the research questions being asked, and procedures allow for sensitive enquiry with those of participants who may be vulnerable. I have also read a letter from Lola’s 2007 consultation with Lynne Cartwright and Liane Kiwakiwi Penney, and if Lola follows suggestions outlined there, her study is likely also to be culturally sensitive and appropriate. The benefits of such research seem to outweigh any potential risks, and furthermore I am happy to provide Lola with ongoing consultations and assistance during her research.

Yours sincerely,



Dr. Dhamidhu Eratne
Psychiatry Registrar
Auckland Hospital



TO: Whom it may concern
FROM: Robert Hogg
DATE: 4th March 2009
SUBJECT: Cultural consultant for Lola Ianoovski

Ka tangi te Tītī, ka tangi te Kākā, ka tangi hoki ahau
Tihei Mauri Ora
Ko Tarawera te Maunga
Ko Tarawera te Moana
Ko Mātātua te Waka
Anei tetahi mokopuna no te Iwi nui tonu, a Tuhoe
E maumahara e nga mate, haere, haere, hoki atu ra
Ka huri nga mihi ki nga hau e wha
No reira, tena koutou, tena koutou, tena koutou katoa.

This letter is to confirm that I accept the responsibility of acting as a Cultural Supervisor for Lola Ianoovski. My function will be to provide ongoing advise throughout the duration of her research project with matters related to working with Māori participants and general Māori issues. If you have any furrther questions, please do not hesitate to contact me.

A handwritten signature in black ink, appearing to read "R Hogg".

Robert Hogg
Senior Lecturer
School of Sport and Recreation
Equity Academic Leader
Faculty of Health and Environmental Sciences

AUT School of Sport and Recreation
Private Bag 92006, Auckland 1020

Tel: (09) 921 9999 x 7220
Email: robert.hogg@aut.ac.nz

Indicative questions for interviews and focus groups:

1. Are you familiar with the concept of “recovery” in terms of mental health? How do you understand/define it?
2. New Zealand government policy such as Blueprint for Mental Health Services defines recovery as ‘living well in the presence or absence of mental illness’ and says it is a journey as much as a destination. What are your thoughts on that definition?
3. Are you aware of the policies on recovery?
4. What are the key ideas in recovery?
5. For the next question try to think of recovery in terms of official New Zealand definition of living well in the presence or absence of illness. Is this policy definition of recovery clear enough to be used as a goal? What are the good things about this definition in terms of implementing it? What are the difficult things about implementing this idea of recovery?
6. How easy/intuitive do you think it is for organisations to promote recovery of their service users? Do policies provide sufficient guidance in achieving this?
7. Which of these official recovery competencies, would you say are most achievable? Which do you think are less achievable or difficult to implement?
8. Can you think of a situation where any of these recovery competencies could be misinterpreted or misused in practice?
9. In your understanding/experience, do New Zealand mental health services providers report to someone about whether or not they actually promote recovery of service users?
YES: what sort of information do you believe gets reported to show that the service is recovery-oriented? Do you think this type of information is appropriate and sufficient to gauge recovery orientation? What other types of information would be useful to put into these reports? Who do you think receives and assesses these reports? Is this an appropriate agency to report to?
NO: Do you think this is an issue?
10. Do you think one could measure whether a service is conducive to promoting recovery of people who use it? Do you think it should be measured?
11. Would it be useful to have a standard measurement tool to check if recovery approaches are appropriately implemented/used by mental health service providers?
12. For the next part of our interview, lets take official policy recovery competencies here (the visual aid) as something we want tested on organisational level. If you had your input into what goes into this recovery measure we spoke about before, what sort of question would you ask about an organisation to test each of those recovery competencies?

Thank you so much for sharing your views with me. We are now at the end of our interview and I have no more questions. Do you have any final comments yourself before we finish?

RECOVERY COMPETENCIES

1. Understanding of recovery principles and experiences in the Aotearoa/NZ and international contexts

- demonstrating ability to apply Treaty of Waitangi to recovery
- understanding the philosophical foundations of recovery approach
- demonstrating knowledge of and empathy with service user recovery stories or experiences
- understanding of the principles, processes, and environments that support recovery

2. Recognising and supporting the personal resourcefulness of people with mental illness

- Knowledge of human resilience and strength, and knowledge how to facilitate it
- Ability to support service users to deal constructively with trauma, crisis, and with keeping themselves well
- Ability to support service users to experience positive self-image, hope and motivation
- Ability to support service users to live the lifestyle and the culture of their choice

3. Understanding and accommodating the diverse views on mental illness, treatments, services and recovery

- Demonstrating knowledge of the major ways of understanding mental illness
- Demonstrating knowledge of major types of treatments and therapies and of their contribution to recovery
- Ability to facilitate service users to make informed choices for recovery
- Demonstrate knowledge of innovative recovery-oriented service delivery approaches

4. Mental health workers have the self-awareness and skills to communicate respectfully and develop good relationships with service users

- Demonstrating self-awareness of their life experience and culture
- Demonstrating communication styles that show respect for service users and their families/whanau
- Managing relationships so they will facilitate recovery

5. Understanding and actively protecting service users' rights

- Demonstrating knowledge of human rights principles and issues
- Demonstrating knowledge of service users' rights within mental health services and elsewhere
- Demonstrating the ability to promote and fulfil service users' rights

6. Understanding discrimination and social exclusion, its impact on service users and how to reduce it

- Demonstrating knowledge of discrimination and social exclusion issues
- Demonstrating an understanding of discrimination and exclusion by the wider community

- Demonstrating an understanding of discrimination by the health workforce
- Demonstrating an understanding of other kinds of discrimination and how they interact with discrimination on the grounds of mental illness
- Demonstrating familiarity with different approaches to reducing discrimination

7. Acknowledging the different cultures of Aotearoa/NZ and knowing how to provide a service in partnership with them

- Demonstrating an awareness of cultural diversity
- Demonstrating knowledge of Maori protocols and models of care
- Demonstrating knowledge of European-derived cultures
- Demonstrating knowledge of Pacific Islands cultures
- Demonstrating knowledge of Asian cultures

8. Having comprehensive knowledge of community services and resources and actively supporting service users to use them

- Demonstrating the ability to facilitate access to, and good use of, mental health services
- Demonstrating ability to facilitate access to, and good use of, other government sectors
- Demonstrating ability to facilitate access to, and good use of, community resources & services

9. Having knowledge of the service user movement and being able to support their participation in services

- Demonstrating knowledge of the principles and activities of the service user movement
- Demonstrating knowledge of the range of service user participations and principles, and of policy behind it
- Demonstrating understanding of the different methods of service user participation
- Demonstrating the ability to apply knowledge of service user participation to different groups and settings

10. Having knowledge of family/whanau perspectives and being able to support their participation in services

- Demonstrating knowledge of the range of family participation and the principles and policies behind it
- Demonstrating knowledge of the methods of family participation
- Demonstrating the ability to apply knowledge of family participation to different groups and settings
- Demonstrating awareness of the experiences of families and their potential to support recovery

Hello! Kia Ora! Malo! Neih hou! Namaste! Bula! Kia orana! Privet!

My name is Lola and I am interested in the recovery models of mental health services. Where do mental health services report about how well they promote recovery of service users? And what information is reported? What gets omitted? Is it important that recovery practices are monitored across all the diverse mental health service organisations in New Zealand? If so, how can we measure how well organisations promote recovery of their service users?

You may or may not know the answers to these questions, but I would like to hear your opinion.

If interested, please contact me on 021 1013494 or on lola.ianovski@gmail.com and I will send you an information pack further describing what is involved and how you can take part in this research. To participate, you need to be at least 16 years of age, and feel that you represent at least one of the following groups:

- Mental health policy makers/developers
- Mental health services management
- Mental health clinicians (including doctors, nurses, case workers etc)
- Consumers of mental health services (in the present or in the recent past)
- Consumer advocates/advisors
- Family/whanau members of people with mental ill health and members of the general public

This research is part of my Masters degree qualification. Your participation is entirely voluntary, and if at any time you choose to withdraw from the study, the information you provided will not be used, and no adverse consequences will follow. Please consider this invitation, and do not hesitate to be in touch if you have any questions.

Thank you,

Lola Ianovski

Participant Information Sheet



Date Information Sheet Produced: 22nd of February 2009

Project Title: *Should recovery practices within mental health services be monitored? If so, how can organisational recovery orientation be measured? A qualitative inquiry.*

An Invitation

Hello! Kia Ora! Malo! Neih hou! Namaste! Bula! Kia orana!

My name is Lola and I wish to examine the extent to which recovery philosophy is understood and practiced by the Mental Health Services in New Zealand. Is it important that recovery practices in mental health service organisations in New Zealand reflect national recovery policies? If so how might we measure this?

You may or may not know the answers to these questions, but it is your opinion that I seek. You will not have to give any more information than you are comfortable in giving.

To participate, you need to be at least 16 years of age, and considered a member of at least one of the following groups:

- Mental health policy makers/developers
- Mental health services management
- Mental health clinicians (including doctors, nurses, case workers etc)
- Consumers of mental health services (in the present or in the recent past)
- Consumer advocates/advisors
- Family/whanau members of people with mental ill health and members of the general public

Your participation is entirely voluntary. If at any time after beginning questioning you choose to withdraw from the study, the information you provided will not be used, and will be destroyed. No adverse consequences will follow if you choose to withdraw, either. Please consider this information sheet as an invitation to participate in the study. Do not hesitate to be in touch if you have any questions. Your participation would be most helpful.

What is the purpose of this research?

This research is part of my Masters Degree qualification. The results of the research will help better understand how recommended recovery approaches are used in our mental health system, and how we might go about measuring this effectively.

How was I chosen for this invitation?

If you belong to one or more groups of people described above – you are warmly invited to take part in this study. Please note, however, that you cannot participate in this research if you are receiving acute mental health services when this study becomes operational and information is being collected.

What will happen in this research?

I would like to collect information by conducting group interviews where possible. If for some reason you prefer to be interviewed individually instead of being part of the group that can also be arranged. Please let me know about your preference. If you choose to participate in a group interview, please note that all members of that group will come from only one participant category e.g. service users will only be interviewed with other service users, without presence of clinicians or management etc. Of course, if you choose to bring a support person with you who belongs to another group than yourself, that is alright as well, but in that case the interview will be with you only (not in a group).

We will start the interview with a round of introductions. I will use my real name, but I would ask for you to use some 'stage name' you prefer instead of your real name. I ask this to protect your confidentiality. Be as creative as you like!

During the interview I will introduce the topic and will ask you to brainstorm around it. This is a consultation process, so rather than asking specific narrow questions, I will want to hear your thoughts on the topic overall. It is entirely up to you how you choose to respond to each of the issues raised, every response is important. We will begin by talking about mental health recovery in general, then progress to talk about how could one measure the degree to which a mental health service promotes recovery of its consumers.

Every interview will be videotaped in order to later transcribe data into text. No video material will be used in the final report.

Once the tapes are converted into text, I will ask you to read the transcript and make sure that your comments are accurately recorded. At this stage, you will be able to delete some of your comments you may not be comfortable with, to change your 'name', or to clarify those of your statements that you feel need it.

What are the discomforts and risks?

Sharing ideas and thoughts about recovery supports with others may not always be easy. You do not need to discuss issues you do not feel comfortable in discussing. The process will not involve any physical, psychological or emotional risks not already faced in everyday life.

How will these discomforts and risks be alleviated?

You may tell me if you do not feel comfortable, physically or psychologically, during the interview and we may end the interview. Remember in the group setting your chosen 'stage name' is intended to protect your confidentiality. Also keep in mind that you are free to withdraw at any time if you do not feel comfortable participating in the group discussion. Should you need it as a result of participating in this research, a free counselling or debriefing session can be arranged for you through AUT health services.

What are the benefits?

Your benefits include getting your views on recovery and on related policies expressed and heard and to learn about how others like you feel about the subject. And the wider community may benefit from improved mental health services

How will my privacy be protected?

You will not have to identify yourself by your real name during the interview nor in group discussion. Your legal name will only be needed on your consent form. Only my supervisors and I will have access to that information. Those documents will be stored securely and separately from data collected in order to prevent identifying you personally.

What are the costs of participating in this research?

The interview will take approximately an hour and a half of your time and it will take place where it is convenient for both you and researcher. It could be a community centre, or some other quiet public place. Please consider where you would like to meet, taking into account travelling time and costs.

What opportunity do I have to consider this invitation?

Please confirm your interest by mid September 2009 by contacting Lola (see contact details below)

How do I agree to participate in this research?

Please fill in the consent form if you wish to participate in this research. Please give this form to Lola with you when you meet her for your individual or group interview.

Will I receive feedback on the results of this research?

Yes, if you are interested. Please provide Lola with your contact details if you wish to receive feedback and a debriefing summary will be sent to you. You are also welcome to attend any presentations that result from this research, and will be able to access the full text of the final report from the Mental Health Foundation library in Auckland, or electronically from AUT library.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors. Their contact information is available below.

Whom do I contact for further information about this research?

Researcher Contact Details:

Lola Ianovski

Phone 021 101 3494 or email: lola.ianovski@gmail.com

Project Supervisor Contact Details:

Associate Professor Kate Diesfeld

Faculty of Health & Environmental Sciences - Akoranga Campus

Auckland University of Technology

Private Bag 92006 Auckland 1142

(09) 921 9999 ext. 7799 or email: kate.diesfeld@aut.ac.nz

Dr. D. Rex Billington

Faculty of Health & Environmental Sciences - Akoranga Campus

Auckland University of Technology

Private Bag 92006 Auckland 1142
(09) 921 9999 ext. 7894 or email: rbilling@aut.ac.nz

Health and Disability Advocates can be contacted via following numbers if you have questions about your rights, or if you have an unresolved issue regarding this research:

North Shore (09) 4419001
West Auckland (09) 8388068
South Auckland (09) 2739549

Approved by the Northern Y Ethics Committee on the 18th of May, 2009, Reference number NTY/09/03/030.

Note: Participants should retain a copy of this form

Consent Form



Project title: **Should recovery practices within mental health services be monitored? If so, how can organisational recovery orientation be measured? A qualitative inquiry.**

Researcher: **Lola Ianovski (BHSc(Hons), Masters candidate)**

Project Supervisors: **Associate Professor Kate Diesfeld and Dr Rex Billington**

- I have read and understood the information provided about this research project in the Information Sheet dated 22nd of February 2009.
- I have had an opportunity to ask questions and to have them answered. I am satisfied with the answers I have been given.
- I understand that the interviews will be video taped and transcribed by the researcher.
- I understand that no material that could personally identify me will be used in the final report.
- I understand that, although confidentiality is encouraged, it can not be guaranteed in group interviews.
- I understand that I may withdraw myself or any information that I have provided for this project at any time before the final report is written, without being disadvantaged in any way.
- I know I do not have to give reasons for leaving the research.
- If I withdraw, I understand that all relevant information I provided including videos, interview transcripts, or parts thereof, will be destroyed.
- I am over 16 years of age.
- I am not currently receiving treatment in an acute mental health service.
- I agree to take part in this research.

-
- I prefer to participate in (please tick one): individual interview group interview
 - I agree to edit the transcripts of the interview I take part in (please tick one): Yes No
 - I wish to receive a copy of the report from the research (please tick one): Yes No

Participant's name:.....

Name/alias to be used in research

Participant's signature:..... Date :

Participant's Contact Details (for confirming your replies when videos are transcribed into text)

.....
*Approved by the Northern Y Regional Ethics Committee on 9th of April 2009, Reference number
NTY/09/03/030 Note: The Participant should retain a copy of this form.*

***The following information will be used for statistical analysis only, and will not be reported in any way
that can identify you personally:***

Age: _____ (years)

Gender: _____

Ethnicity: _____

Please tick as many statements as apply to you to indicate which groups of stakeholders you represent in this research:

- I am, or have been, involved in the development of health policy
- I have, or have recently had, a management role in a mental health service
- I have a clinical role/responsibility in a mental health service
- I have personal experience of mental illness and/or have used mental health services (past or present)
- A family member or a significant other in my life have mental illness or/and have used mental health services
- I have, or have recently had, a role of mental health service consumer advocate/advisor
- For the purposes of this research, I am a member of the general public
- I am an employer / I own a business in New Zealand

MEMORANDUM

To Lola Ianovski
CC
FROM Stella McFarlane
SUBJECT AUT Counselling services for research participants
DATE 25th February 2009

Dear Lola

As manager of AUT Health Counselling and Wellbeing, I would like to confirm that we are able to offer confidential counselling support for the participants in your AUT research project entitled: **Should recovery practices within mental health services be monitored? If so, how can organisational recovery orientation be measured? A qualitative inquiry**

The free counselling will be provided by our professional counsellors for a maximum of three sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Current AUT students and staff also have access to our counsellors as part of our normal service delivery.

Yours sincerely

Stella McFarlane
Manager
Health, Counselling and Wellbeing

Appendix C

Table of thematic codes across research participants

Key to reading the table:

CA Consumer Advocate/Advisor

✓ indicates participant explicitly mentioning the code as important

✗ indicates participant's disagreement with the statement reflected in the code

? indicates participant indecision, and/or participant providing potentially conflicting views with regard to the statement reflected in the code

Abbreviations of participant names:

Tom Tommy

Jas Jasmine

Jac Jacobus

Sue Sue

Ted Ted

Tig Tiger

JS John Smith

Mar Mary

Jim Jim

Els Elspeth

Ali Alistair

Part 1 (of 4)

Codes related to recovery: experience, definitions, and fit with other models

	CA background (no policy)						Both CA and policy backgrounds			Policy background (no CA)	
	Presently in CA role						Presently in policy				
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Recovery has many meanings		✓	✓	✓		✓		✓	✓	✓	✓
Tensions between different stakeholders' definitions, or Whose meanings are they?		✓	✓	✓			✓				✓
Recovery is a complex concept			✓						✓		
Recovery is a confused/problematic concept									✓		✓
Recovery as a concept is easy to get wrong				✓			✓				✓
Misunderstanding recovery can negatively affect service users			✓	✓	✓			✓			✓
Recovery is about....:											
Autonomy	✓			✓	✓		✓	✓	✓		✓
Acceptance of experience	✓	✓	✓		✓	✓				✓	
Citizenship	✓	✓	✓						✓		✓
Connectedness/Relationships		✓	✓			✓	✓	✓		✓	✓
Hope	✓	✓	✓	✓							✓
Enhanced wellbeing		✓	✓								
Respectful treatment/R-conducive environment		✓	✓		✓				✓		
Finding meaning/sense/learning from experience	✓					✓	✓			✓	✓
Same latitude in rights as everyone else	✓	✓	✓						✓		
Empowerment	✓										
Mastery (of the experience etc)	✓		✓		✓	✓		✓		✓	
Rights as well as responsibilities	✓	✓	✓	✓	✓		✓		✓		
Choices	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Person is the agent of own recovery (subjectivity/uniqueness principle)	✓	✓	✓	✓		✓	✓	✓			✓
Hiccups/relapse is part of the recovery				✓		✓			✓		
R. is a process as well as an end state				✓	✓	✓					✓
Recovery policies are valuable/useful/good	✓	?	?		✓	✓		✓	✓		✓
Policy definition of recovery is agreeable	✓	?		X	✓	✓	✓	✓	✓	✓	✓
There are problems with policy definition of recvry	X			✓						✓	
There are gaps in policy definition	X	✓	✓					✓			
Recovery is still a reference to madness as deficit				✓	✓			✓	✓		
Health/illness is a false dichotomy					✓			✓			
Madness is a legitimate human experience				✓	✓			✓	✓		
Madness has positives as well as negatives	✓			✓		✓	✓	✓	✓	✓	✓
Society's negative beliefs about madness are barriers to recovery		✓	✓	✓					✓		
Importance of community inclusion/acceptance		✓	✓					✓	✓		
Balance btw needs of society &individual rights				✓			✓		✓		✓
Medical models vs Recovery models	✓	✓	✓	✓			✓	✓			
Symptom reduction is a part of recovery	✓	✓	✓			✓	✓	✓			
Recovery can take place in the presence of symptoms		✓		✓			✓				
Recovery links to Maori models of health		✓	✓	✓			✓				
What language is used is crucial	✓						✓				

Part 2 (of 4)

Codes related to current state of recovery implementation and service delivery

	CA background (no policy)						Both CA and policy background		Policy background (no CA)		
	Presently a CA						Presently in policy role				
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Recovery-focused practice requires a radical shift in thinking/service delivery		✓	✓	✓			✓		✓		
Focus on recovery is about best practice	✓						✓				✓
Services cannot <i>make</i> people recover	✓		✓	✓	✓	✓	✓			✓	
Job of services is to create conditions for recovery	✓	✓	✓	✓	✓	✓		✓	X		
Recovery practices are <i>easy</i> to do	✓	✓					✓				
Recovery is confusing to service providers	✓			✓							✓
Clinicians are sceptical about recovery concept	✓							✓			X
Services are over-stretched for resources	✓	?	?	✓				✓	✓		
Services decide what's best for people, which is a barrier to recovery		✓		✓	✓	✓		✓	✓		
Policies are used to guide practice	✓	X	X	X	X	X			X		
Policies are "too waffly" to guide practice				✓						✓	
Policies are used for funding				✓						✓	
Funding is contingent on being recovery-oriented				✓			X		X		X
Services report how recovery oriented they are	X			X		X	✓	X	X	X	X
Lip service/tokenism is common	✓	✓	✓	✓			✓	✓	✓		
Paper implementation is common, services "talk the talk without walking the walk", faking	✓	✓	✓	✓		✓	✓				✓
Recovery practices in name but not in reality	✓			✓	✓	✓		✓	✓		✓
Policies are <i>not</i> implemented in practice	✓	✓	✓	✓			✓	✓	✓		
There is no support for implementing policies	✓			X	✓	✓		✓	✓		✓
The only mechanism for overseeing implementation of rec. philosophy is CAs										✓	
Consumer advisors have tokenistic power in MHSs							✓		✓		
Services focus disproportionately focus on clinical recovery dimensions, and not others	✓	✓	✓		✓		✓	✓			✓
Services need to be more recovery oriented	✓	✓	✓		✓						✓
Most MH services do not promote recovery	✓	✓	✓		✓	✓	✓			✓	
Services do not address social determinants and consequences of mental illness		✓	✓					✓			✓
Services disempower consumers by deciding "what's good for them"				✓	✓	✓		✓	✓		✓
Organisational factors prevent individual clinicians from practicing recovery approach	✓						✓	✓	✓		✓
"Road to hell is paved with good intentions"							✓	✓	✓		
Negative values about mental illness influence service delivery				✓				✓			
Service pursue/guard their own agenda/interests	✓	✓	✓	✓			✓	✓			
Institutions have closed but institutional practice persists	✓	✓	✓		✓	✓	✓			✓	✓
Family/whanau perspectives are poorly integrated		✓	✓	✓			✓				✓
Autonomy vs The Mental Health Act								✓			✓
Protecting people in extreme state is part of R.	✓	✓	✓	✓			✓				✓
Services are problem focused not solution/strength focused		✓	✓		✓	✓				✓	
Consumer workforce are employed for experience of illness not for skill or ability	✓			✓					✓	✓	

Codes related to current state of recovery implementation continue on next page

*...continued from previous page**Codes related to current state of recovery implementation and service delivery*

	CA background (no policy)						Both CA and policy background			Policy background (no CA)	
	Presently a CA						Presently in policy role				
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Recovery competency 9 (service user movement) is not well applied or is problematic	✓			✓							
Recovery competency 2 (resourcefulness) is misunderstood or poorly applied			✓	✓							✓
Rec competency 3 (Diverse views) is misunderstood or poorly applied	✓	✓	✓	✓			✓				
Community inclusion is understood by services as geographic community base, not socially	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Recovery values/demands are not aligned with other demands on services				✓				✓	✓		
"recovery competencies" provide good indication of how to promote recovery of service users	X							?	X		✓
Competencies are not behaviourally enough based							✓	✓	✓		
Manualised competencies are prone to misinterpretation unless providers are grounded in recovery philosophy or have lived experience	✓				✓		✓		✓	✓	
Workforce resistance to recovery concept	✓							✓			X
Workforce resistance to outcome measurement					✓						✓
Workforce resistance to change	✓							✓			✓
There is little motivation for services to adopt recovery approach											✓
Services self-assess recovery orientation if motivated	✓							✓	✓		✓
Community pressure for 'containment' /cf recovery	✓		✓					✓	✓		
Recovery rhetoric has lost its momentum								✓	✓		✓
MH professionals are stuck in narrow & rigid roles		✓	✓		✓	✓	✓			✓	
Lack of guidance by role modelling of services					✓	✓					
Lack of leadership in implementation of recovery	✓					✓		✓			
Services are excessively risk averse		✓	✓		✓					✓	✓
Mental illness is predominant in lower socioeconomic classes		✓	✓								
MH professionals do not advocate for patients		✓	✓								

Part 3 (of 4) <i>Codes related to "how things need to be"</i>	CA background (no policy)						Both CA and policy backgrounds			Policy background (no CA)	
	Presently in CA role						Presently in policy				
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Funding needs to be aligned with recovery focus				✓		✓	✓			✓	
Need to have clear indicators of what service would look like if it was recovery focused	✓	✓	✓	✓		✓				✓	✓
Services should be service user led whenever possible	✓		✓	✓	✓		✓				
Service users should be involved in workforce training and recruiting	✓			✓	✓						
Service user leadership should have real power	✓	✓	✓	✓	✓				✓		
Service users should be involved at all levels of service development and improvement			✓	✓	✓						
Services need to foster hope	✓	✓	✓	✓							
Services need to focus on strengths & empower	✓	✓	✓	✓	✓	✓		✓		✓	
Services should be more holistic (less biology focused)		✓	✓					✓			✓
Services should provide greater choices/range	✓	✓	✓		✓			✓			
Services should address a <i>variety</i> of recovery dimensions	✓	✓	✓								✓
Services have to explicitly communicate with service users the balance between social/whanau needs and their individual recovery needs/right				✓			✓				
Addressing stigma and discrimination is essential	✓	✓	✓	✓				✓			
Need examples of what services are doing well (not just what the problems are)	✓			✓	✓						
Need to know what services are doing wrong		✓	✓								
Need to have clear top-down directives about recovery	?		X	✓							
Service policies must link with national policies	✓										✓
Social determinants and consequences of mental illness should be addressed: housing, employment, education etc	✓	✓	✓					✓			✓
Services need support in implementing policy directives	✓			✓	✓	✓				✓	✓
Majority of services should adopt recovery approach	✓	✓	✓								✓
Policies need to be follow bottom up service user needs, not the other way around		✓	✓				✓	✓			✓
Policies and strategic plans should be written by service users		✓	✓				✓				
There should be greater inter-sectorial collaboration (networking, referrals out of service)	✓	✓	✓		✓	✓		✓		✓	
There should be reduced emphasis on compulsory treatment			✓		✓			✓	✓		
There should be more emphasis on empathy and acceptance, compassion	✓	✓	✓					✓			
Monitoring should have tangible contingencies	✓	✓			✓	✓			✓		✓
Recovery education is essential	✓	✓	✓			✓		✓			✓
Promote supports outside of services (community)	✓	✓	✓		✓	✓	✓				✓
Focus on prevention of mental disorders		✓	✓			✓					✓
Regular supervision of MH workers is crucial					✓	✓			✓	✓	

Part 4 (of 4) Codes related to measurement	CA background (no policy)						Both CA and policy backgrounds			Policy background (no CA)	
	Presently in CA role						Presently in policy				
	Tom	Jas	Jac	Sue	Ted	Tig	JS	Mar	Jim	Els	Ali
Tools assessing recovery focus are being developed in NZ				✓	✓	✓	✓			✓	✓
Services should be audited for recovery focus	✓	✓	✓	✓	✓			✓		✓	✓
Services can self-assess own recovery orientation	✓						✓	✓			✓
Measuring recovery orientation is difficult	✓	✓							✓		
Outcome measurement is consistent with recovery goals	?		✓	X	✓		✓	✓	X	✓	
Clinical outcomes are indicative of how recovery oriented the service is	X		X	X	X		X	?	X	X	
Measuring environment/process is useful	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Recovery orientation could be measured				✓			✓	✓			✓
Recovery orientation should be measured		✓	✓	✓	✓	✓	✓				✓
Need a mixture of qualitative and quantitative information	✓			✓	✓		✓	✓			✓
Measurement should be standardised	✓		✓	X	✓		✓			✓	✓
Same recovery criteria/standards for all services	✓	✓	✓	✓	✓		✓			✓	
Flexible demonstrating of how recovery indicators were achieved would be useful				✓		X				X	✓
Capturing diversity would be an issue				✓							
Faking/desirable responding would be an issue					✓		✓		✓		
Reporting against recovery is about...											
Accountability	✓	✓	✓	✓		✓					✓
Transparency	✓	✓	✓	✓	✓						✓
Consistency	✓				✓	✓		✓			
Demonstrating/proof that services are really working in recovery ways	✓	✓	✓	✓	✓		✓			✓	
Informed choice for consumers	✓	✓		✓	✓		✓			✓	
Evidence-based practice	✓		✓	✓			✓				
Benchmarking				✓	✓		✓				✓
"Deserving" public money/allocating funding	✓	✓	✓	✓			✓				
Monitoring facilitates change and/or policy implementation			✓		✓	✓		✓	X	✓	✓
Consumer leadership and advocacy in service development, and improvement	✓	✓		✓	✓		✓			✓	✓
Effectiveness of services	✓		✓		✓		✓				✓
Quality improvement/feedback loop	✓		✓		✓			✓		✓	✓
Affirming services that work in recovery way	✓				✓		✓			✓	
Information about recovery orientation of service should be collected from multiple sources							✓				✓
Information about recovery orientation of service should be collected <i>from</i> service users	✓		✓	✓	✓	✓	✓	✓		✓	✓
Information about recovery orientation of service should be collected <i>by</i> service users				✓							
Indicators of recovery should be consumer-driven and reflect consumer needs	✓			✓		✓	✓		✓		✓
Satisfaction surveys should <u>not</u> be used to measure recovery-orientation of services								✓	✓		
Ask service users what they attribute outcomes to (not assume outcomes are due to service)	✓							✓	✓		