

**Mental Illness and Recovery: A Mental Health Support Worker's  
Perspective.**

**Paulo Bisogno**

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**Primary Supervisor: Associate Professor Kate Diesfeld**

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## **Attestation of Authorship**

“I, Paulo Bisogno, 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 acknowledgements), nor 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.”

Signed: \_\_\_\_\_

Dated: 23 December 2009

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## **Abstract**

This research investigated what mental health supporter workers (MHSWs) in New Zealand understood recovery to be. Furthermore, MHSWs were asked how they foster recovery in the work place and their understanding of the role of autonomy in the recovery process.

Eight MHSWs were interviewed, using semi-structured interviews, about how they can support service users in their recovery. They were volunteers working for a recovery-oriented non-government organisation (NGO). The participants varied in the number of years work experience in mental health and number of years working for the organisation.

Two common themes that became evident from the discussions with MHSWs were first; the importance of service users defining what recovery is to them, and how they recover. Second, MHSWs indicated that part of the recovery process entails service users re/gaining ascendancy over aspects of their life. MHSWs facilitate service users' recovery at work by providing a platform for their recovery to take place. Moreover, MHSWs understood autonomy to be both a facilitator and a barrier to service users' recovery, and that service users' readiness for autonomy was a key indicator as to whether autonomy would act as a barrier or facilitator to their recovery.

MHSWs have indicated that they are more successful in advancing service users' recovery when their own values are congruent to the recovery philosophy. This has implications with recruiting and training staff as competent agents of recovery. Thus MHSWs will be able to perform both simple and complex tasks related to aiding and supporting the recovery journey of service users. Furthermore MHSWs that are well resourced, work with and have the abovementioned skills will ensure that they are competent agents of recovery.

# Chapter One

## The Concept of Recovery

The discourse of recovery has gained prominence in mental health over the past 15 years; starting in the early 1990's with the consumer movement, and closely followed by those working in the field of mental health (Anthony, 1991, 1993; Deegan, 1988; Harding, Brooks, Ashikage, Strauss, & Breier, 1987; Meehan, King, Beavis & Robinson, 2008). Within this discourse, the concept and definition of recovery remains fluid and diverse. There is growing consensus of what recovery 'is not' as opposed to what 'it is'. For example, Meehan, et al. (2008) noted that recovery does not imply "cure". In addition, Lunt (2002) alludes to the fact that recovery is not about a person striving to regain their premorbid lifestyle. Earlier, Deegan (1988) contended that recovery is not a "one size fits all" phenomena. Recovery is also not a linear process, Onken, Craig, Ridgway, Ralph & Cook, (2007), rather, it is a process of small incremental steps with relapses along the way. Similarly, Ralph (2004) postulated a 'spiral model' in that recovery is a process of moving up and down the spiral ladder of well being in a circular fashion. Deegan (1998), in describing this course, said:

"Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again" (p.15).

Recovery may be viewed from many perspectives and is multi-layered, starting with the individual (micro level) and rising to systemic levels such as recovery-orientated services. Although recovery is complex, the overarching conclusion is that recovery involves the process of change and these changes can be multiple and diverse or may come in small, indiscernible steps (Onken, et al., 2007). Andresen, Oades and Caputi (2003) noted that recovery may include an existential struggle of trying to make sense of the mental illness experience, and possibly, deriving a new sense of purpose and identity as a person moves beyond the effects of the illness. Part of moving beyond the illness, which is an important prerequisite to beginning the recovery process, is the need to come to terms with the illness; or, as Young and Ensing (1999) stated, overcoming "stuckness" which prepares a person for the arduous task ahead.



According to Deegan (2003), it is essential that people with a mental illness see themselves in their entirety and not, as for example, a schizophrenic; which is a necessary distinction to make in the context of recovery. Deegan refers to the need for people to distance themselves from psychiatric labels. This process of distancing themselves from their illness allows people to incorporate or bring back other important aspects of their lives, such as developing their talents and pursuing their dreams, which in turn may act as a catalyst in initiating their recovery journey. This, distancing themselves from their psychiatric label, may feed into the need for people to become actively involved in their recovery, or as Tooth, Kalyanasundaram, Glover and Momenzadah (2003) described it, becoming ‘active agents’ in their lives. Being an active agent enables the person to move from the passive “sick role’ mentality, to developing the determination to get better; while not allowing the illness to dominate their lives. Likewise, Noordsy, Torrey, Mueser, Mead, O’Keefe, and Fox (2002) speak about recovery in terms of taking personal responsibility and that taking personal responsibility was a fundamental shift in service users’ attitudes to their well being, resulting in adopting a more proactive stance towards their recovery.

Although recovery emphasises growth, transformation of self and self-actualisation, that are important to many, Dickerson (2006) stressed that, for some it is not. For some recovery may involve more mundane needs such as finding safe accommodation or appropriate employment. Furthermore, Roe, Rudnick and Gill (2007) in their research, posed the question, “Could the expectation of universal recovery promote extra stigma?” (p. 172). They postulated that those who do not consider themselves as “in recovery,” or who are not seen by others as “being in recovery,” may be stigmatised twice: first, by society for having a mental illness; and second, by the mental health fraternity or their peers, because of their failure to be in recovery or striving to achieve their potential. However, the vision of recovery as noted by Farkas, Gagne, Anthony and Chamberlin (2005) is grounded in the belief that people can rise above the catastrophe of a severe mental illness and live meaningful lives in the community.

### **Recovery and Autonomy**

The recovery process is a complex multi dimensional phenomenon of which autonomy is a fundamental component (Anthony 1991; Deegan 2003). Engelhardt (2001) noted the ambiguity of autonomy and believed that the different contexts in which autonomy

operates, determines its meanings. He further refers to autonomy as “self-rule” when grounded in the context of accountability (p.286). Harnett and Greaney (2008) viewed autonomy in the broader sense as relating to “self-governance” and “self-determination” (p.3). Moreover, according to Engelhardt, autonomy is associated with a person’s capacity to predict or pre-determine the outcome of decisions they make within the context of being granted the freedom to choose. Furthermore, Engelhardt resonates with Harnett and Greaney in that he noted autonomy may also be viewed in the context of self-determination. However, Engelhardt, also associated autonomy with a core recovery value, in that one is able to act in the interest of one’s own wants, fears, preferences, and welfare. Additionally, Rothman (2001) related autonomy in the health setting to the movement of patient rights, particularly with regards to treatment and informed consent.

Researchers from America and Britain have researched the relationship between service empowerment and recovery and asserted that services users’ feedback was paramount in determining the effects of service empowerment on recovery (Crane-Ross, Lutz & Roth, 2006). The consequence of this form of practice enables the balance of power between the health professional and the service user to shift; thus allowing the service user greater say over treatment decisions. In this setting, the service user autonomy was associated with the right to appropriate information that enabled service user to make informed decisions especially, in terms of becoming aware of the iatrogenic effects of treatment.

However, others expressed caution for the need to find a balance in the service user to practitioner power ratio, so that service users can articulate their wants and health needs while the practitioner is able to fulfil those responsibilities entrusted to them (Goodyear-Smith & Buetow, (2001). Interestingly, what contributed to the doctor service user-centred shift in the medical field resembled the sentiments from the recovery movement, in that doctors began to recognise that their service users know their own bodies and have personal preferences (Goodyear-Smith & Buetow, 2001).

Empowerment is closely associated with the concept of autonomy; therefore, recovery-oriented services should incorporate empowerment of service users as a desirable overall objective (Crane-Ross, et al. 2006). Crane-Ross, et al. (2006) concluded that empowerment can be defined in many ways; but stressed that one constant theme within most definitions, is the involvement of service users in decisions about their treatment and

recovery. In addition, Crane-Ross et al. saw the relevance of establishing collaborative relationships as a key process to services users' empowerment and recovery and a core competency that health workers should have in providing operative care. According to Coffey (2003) service users value autonomy in relationships and therefore the granting and taking away of autonomy may improve service users' outcomes. However, Coffey cautioned that people with severe mental illness are reluctant to follow autonomous paths without the support of staff and suggested that it helps service users' recovery when health workers are firm and directive.

Promoting autonomy in mental health is challenging given that service user's decision-making competency can vacillate (Harnett & Greaney 2008). This is challenging not only for service users, but for MHSWs, who, because of their continuous contact with service users, are more exposed to ethical dilemmas associated with autonomy in mental health than other health professionals (Gibson 1993). Saadah (2002) noted that in relation to recovery, service users', autonomy should not be fixed and could change at various stages of rehabilitation. Likewise, Cardol, De Jong and Ward (2002) recommended that service users' autonomy should not be rigidly measured against competency but also be granted in accordance with service users' preferences. In this way service users' recovery may be enhanced through employment, going to the cinema, meeting people, and finding a place to live.

### **Recovery-Orientated Systems and Services**

While changes in attitudes and beliefs of individuals came as a result of the recovery movement, traditional mental health systems struggled to adjust to the demands of these changes (Kelly & Gamble, 2005). Farkas, Ashcraft and Anthony (2008) asserted that simply retraining staff to accommodate an organisation's transition to recovery-oriented services is not enough. To transform successfully, organisations must also adjust the organisational culture and commitment through the organisation's mission, policies, procedures, activities, record keeping and so on. Pascaris, Shields and Wolf (2008) noted that current organisational cultures could act as barriers to the introduction of new systems because the new systems do not fit into the established modes of operation. Furthermore, because recovery differs from person to person, mental health practitioners have difficulty comprehending this and thus delivering appropriate services (Meehan, et al. 2008). Davidson, O'Connell, Tondora, Stryron

and Kangas (2006) asserted that professionals wanting to adopt the recovery approach must make the fundamental shift from working from their own perspective, to the service user's perspective. These authors claim that, "The issue is not what role recovery plays in treatment but what role treatment plays in recovery" (p. 643).

O'Connell, Tondora, Croog, Evans and Davidson (2005) noted that many mental health systems in America have had a desire to become recovery-oriented service providers, however, were unsure about the process. Jacobson and Curtis (2000) asserted that the practice of service providers in labelling existing programs with recovery-oriented names, without incorporating recovery values, indicated the lack of understanding of the recovery concept. According to Davidson, et al., (2007) recovery-orientated care was defined as care that, "identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive sense of membership in the community" (p. 26). Two recommendations are: redesigning services to incorporate recovery principles; and increasing availability of evidence-based recovery (Torrey, Rapp, Van Tosh, McNabb & Ralph, 2005).

New service delivery systems based on the recovery philosophy are grounded in the belief that people with a mental illness can recover (Anthony, 2000). The recovery philosophy that underpins recovery-orientated services operates on the assumption that recovery can occur spontaneously without professional help. However, if help is needed, it should be provided by people who believe in recovery (Anthony, 2000). Furthermore, a recovery-orientated service accepts that agency and options are fundamental to the recovery process and that recovery must address the consequences of having a mental illness (Anthony, 2000). There is currently a need for mental health service systems and policies to incorporate these assumptions in order to facilitate the move to more recovery-orientated services (Gagne, White & Anthony, 2007).

Anthony (1993) referred to a recovery-orientated mental health system as a combination of services that not only treat a person's illness with its focus on symptom relief; but also addresses the consequences of a mental illness that results in dysfunction, disability, and disadvantage. In the 1990s, the community support system (CSS) was initiated in a number of states and counties, in America. This is a system of critical services vital to assist people with mental illnesses (Anthony, 2000). Anthony (1993) used the CCS model as a

foundation to identify the essential services of a recovery-orientated system. These services include: (1) Treatment - focusing on relieving symptoms and distress; (2) crises intervention - focusing on managing and attending to critical or high risk problems; (3) case management - focusing on accessing services, that service users request or require; (4) rehabilitation - focusing on developing skills and providing the supports necessary to achieve service users' goals; (5) enrichment - focusing on engaging service users in self-development activities; (6) rights protection - focusing on advocating the rights of service users; (7) basic support - focusing on ensuring that service users' basic needs are met; (8) self-help - focusing on empowering service users to take care of themselves; and (9) wellness/prevention - focusing on endorsing healthy lifestyles. Although service users may not need to access all these services at one time, their availability caters for a population that have complex and multiple needs and wants (Anthony, 2000).

Torrey and Wyzik (2000) noted that mental health consumers want services to create an environment that facilitates recovery. According to these authors, consumers are saying that recovery is based on moving beyond hopelessness, powerlessness, and an illness dominated psyche. Thus services that promote hope, empower service users to be responsible for their health, and support service users in pursuing their interests, are likely to promote recovery. Changes to mental health systems and service delivery must incorporate the wellness approach (Swarbrick, 2006), which is holistic and multi-dimensional and encompasses a person's physical, emotional, intellectual, social, environmental, and spiritual needs.

In 2005 O'Connell, et al. conducted a comprehensive review of literature from service users and service providers to identify those recovery principles that endorse a recovery-oriented environment. They concluded that a recovery-oriented environment is one that encourages certain characteristics, like individuality, whilst campaigning against discrimination and the negative perceptions of mental illnesses. At the same time, it is strength based, uses a language that accentuates the positive and, provides a range of treatment and rehabilitation and support. A recovery-oriented environment also allows for risk-taking and; encourages service users' participation, together with their family members and other natural supports, in running services. Additionally it empowers service users to advocate for themselves, reconnects service users with communities and helps service users pursue valued roles, interests and other meaningful activities.

Farkas, Gagne, Anthony and Chamberlin (2005) proposed the recovery-orientated mental health program or ROMHP. A ROMHP model is comprised of program structures such as organisation vision, policies, procedures, record keeping, and quality assurance that reflect recovery values. Similarly, the selecting, training and supervising of staff are informed by core recovery values. According to Farkas, et al. person orientation, person involvement, self-determination / choice, and growth potential are four key values that are essential to a ROMHP.

Person orientated implies that there is more to individuals than their illness and that, in addition to their roles of service users; they may have other roles such as fathers, mothers, students, or sportsmen. It also implies that people who have a mental illness have interests, talents, aspirations and desires that are consistent with those of the general population (Farkas et al., 2005).

According to Majumder, Walls and Fullmer (as cited in Farkas et al., 2005) when service users are personally involved in the planning and delivering of services, then outcomes improve. Person involvement means service users have a say in what happens in their lives.

David and Strauss' research (as cited in Farkas et al., 2005) claimed that when service users feel they are being forced to comply to treatment plans, it has the effect of "diminishing, rather than strengthening the self" (p. 146). When service users have little opportunity for self-determination or choice in their lives, the input from mental health workers or the mental health system may not result in the outcome intended. Service users should be granted the right and control over all aspects of their recovery, such as their treatment plans, their recovery goals, and when to engage or disengage in services.

Recovery-oriented systems ought to uphold the value of hope for all service users engaged in services. Staff must carry the belief that all service users have potential to grow and they should engender that hope and belief with service users (Torrey & Wyzik, 2000).

Davidson, Tondora, O'Connell, Kirk, Jr., Rockholz, and Evans (2007), proposed a model of recovery-oriented care that ensures service users have easy access to services that guarantees continuity of care, and that offers programs, which are individualised, and

strengths based. Service programs are designed to remove obstacles to recovery and seek to identify resources and services in the community that can sustain and support people with severe and persistent illness, living in society.

The process of transforming existing mental health systems to recovery-oriented mental health systems is arduous and complex (Kelly & Gamble, 2005). Changes must occur on multiple levels. First, to ensure that recovery-oriented mental health services are promoted by government agencies and guided by health policy and practice (O'Connell et al., 2005). Second, service providers are committed to the overall industry transformation initiated by government strategies by aligning themselves with recovery-oriented services based on recovery values (Torrey & Wyzik 2000). Furthermore, staff are trained in and equipped with the recovery competencies that will enable a workforce to deliver a service that promotes recovery (Coursey et al., 2000).

Moreover, while there is increasing pressure on service providers to ensure services are more recovery orientated, how this is operationalised and practiced, especially at a MHSW level poses a number of challenges (Meehan et al., 2008). MHSWs are well positioned to facilitate and implement these changes because much of their work time is spent with service users. Therefore, the researcher believes that the input of MHSWs will be fundamental in assisting the transition towards a recovery-based environment for mental health services.

Accordingly, Lehman (2000) makes the poignant remark that the implementation of recovery based services demands a shift in attitudes by service users, service providers and society. What will accelerate the process is the understanding and recognition that the service user's life and well being is at stake and that the service user needs to be in control of this.

### **Mental Health Workforce**

Repper (2000) deduced, from her study, that mental health nurses need to fulfil multiple roles and be able to offer multiple perspectives to meet the needs and desires of service users; a description that aptly depicts the role of MHSWs. Similarly, Aubry, Flynn, Gerber and Dostaler (2005) concluded that community support workers have a challenging role that requires the combination of individual traits, skills and knowledge. Further, it has

been suggested by Aubry, et al. that support workers would benefit from aligning personal attributes that include, but are not limited to, being aware of individuals and their differences in a manner that is perceptive and considerate, having a strong work ethic, and upholding client rights in all areas. Similarly, Coursey et al. (2000) contended that support workers should hold specialised knowledge to assist people with psychiatric disabilities, as well as be a team player, be professional and maintain confidentiality of service users.

Bradley, Hickey, Kramer and Garralda (2009) build upon the professional competencies suggested by the abovementioned authors, and have further suggested that it is pertinent that mental health workers possess interpersonal qualities; for example, being approachable, able to adapt to new ways of working and work independently. Furthermore when a mental health worker has specialised knowledge, understands the organisational systems and is well resourced in being able to uphold the recovery values, better individualised care can be provided (Lester & Gask, 2006).

The Mental Health Commission's vision, for 2015, for mental health workers is that two core values will be creativity and being well trained. Further values that mental health workers should possess are an understanding, ability, expertise and aptitude that enable them to become proficient in connecting and working with people with mental illness as well as their families (Mental Health Commission, 2007). Mental health workers will further have the ability to network and access resources across a variety of agencies and be accomplished working with diverse communities and cross culturally (Mental Health Commission, 2007). The question arises; does the Mental Health Commission (and individual organisations) have the political scope and power as well as resources to implement the proposal?

Although many countries have various mental health support work occupations, New Zealand is a forerunner in recognising the need for a specialised MHSW (Mental Health Commission, 2007). Further evidence of New Zealand's commitment to this innovation is the formation of the National Certificate in Mental Health (Support Work), which provides an entry level into the industry and covers fundamental mental health together with recovery-orientated training (Mental Health Commission, 2007).

The Mental Health Commission (2001) has developed a set of competencies for New Zealand mental health workers, based on the recovery approach. Details of these 'recovery



competencies' are available to all mental health workers through government published documents as well as being incorporated in mental health support courses (Lawrence, 2004).

Cowan (2008) proposed that aspects of the MHSW's role is about supporting people with a mental illness in their daily living and encouraging them to learn how to make decisions which will help with their recovery. This involves connecting the person with their family and the wider community, whilst simultaneously pursuing goals in education, employment and various community activities. Moreover, the MHSW's role is about supporting service users to name and define their experience of mental illness during their process of recovery. To summarise, these features of the role of the mental health support worker encapsulate the overarching primary role, which is to facilitate service users' recovery.

## Chapter Two: Methodology

A humanistic phenomenological approach, which is well suited for exploring individual perspectives and experiences (Yardley, 2000), will be the guiding philosophy underpinning this study. Drew stated that phenomenological research uncovers the deepest meanings associated with human health illnesses and is an effective method in gaining the necessary insight for sensitive and meaningful practice (as cited in Donalek, 2004).

The topic, which is, reflections of what mental health support workers (MHSWs) understand recovery from a mental illness to be, will draw on the participants' personal experiences through intensive semi-structured interviews. In addition, the research will also explore how MHSWs foster the recovery process of service users. Peters, Abu-Saad, Vydelingum and Murphy (2002) stated that research that is exploratory, that lends itself to answering questions that concern, "meanings, experience, patterns, relationships, and values" (p. 1055), and which intend to generate hypothesis, are best addressed by qualitative methods, as is in this research.

According to Vivar, McQueen, Whyte and Armayor (2007) qualitative research seeks to make sense of human experiences and as such is inherently interpretive. More specifically, Fossey, Harvey, Mcdermott and Davidson (2002) stated that qualitative methodologies are particularly appropriate for understanding people's subjective experiences of health and disease and their interaction within a health care environment. They emphasized that qualitative research is effective in uncovering knowledge of poorly understood, or complex, areas of treatment such as in mental health. Vishnevsky and Beanlands (2004) asserted that qualitative research seeks to study phenomena holistically and in its natural setting. Polit, Beck, and Hungler emphasized that researchers in the naturalistic tradition highlight the intrinsic complexities of humans, their potential to mould and create their own experiences, and the idea that truth is an amalgamation of realities (as cited in Vishnevsky & Beanlands, 2004). Likewise, the goal of qualitative research as noted by Polit, Beck, and Hungler, is to uncover 'truth' as it has been constructed by the research participants, which is done by exploring how the phenomenon is uniquely experienced by the individual (as cited in Vishnevsky & Beanlands, 2004).

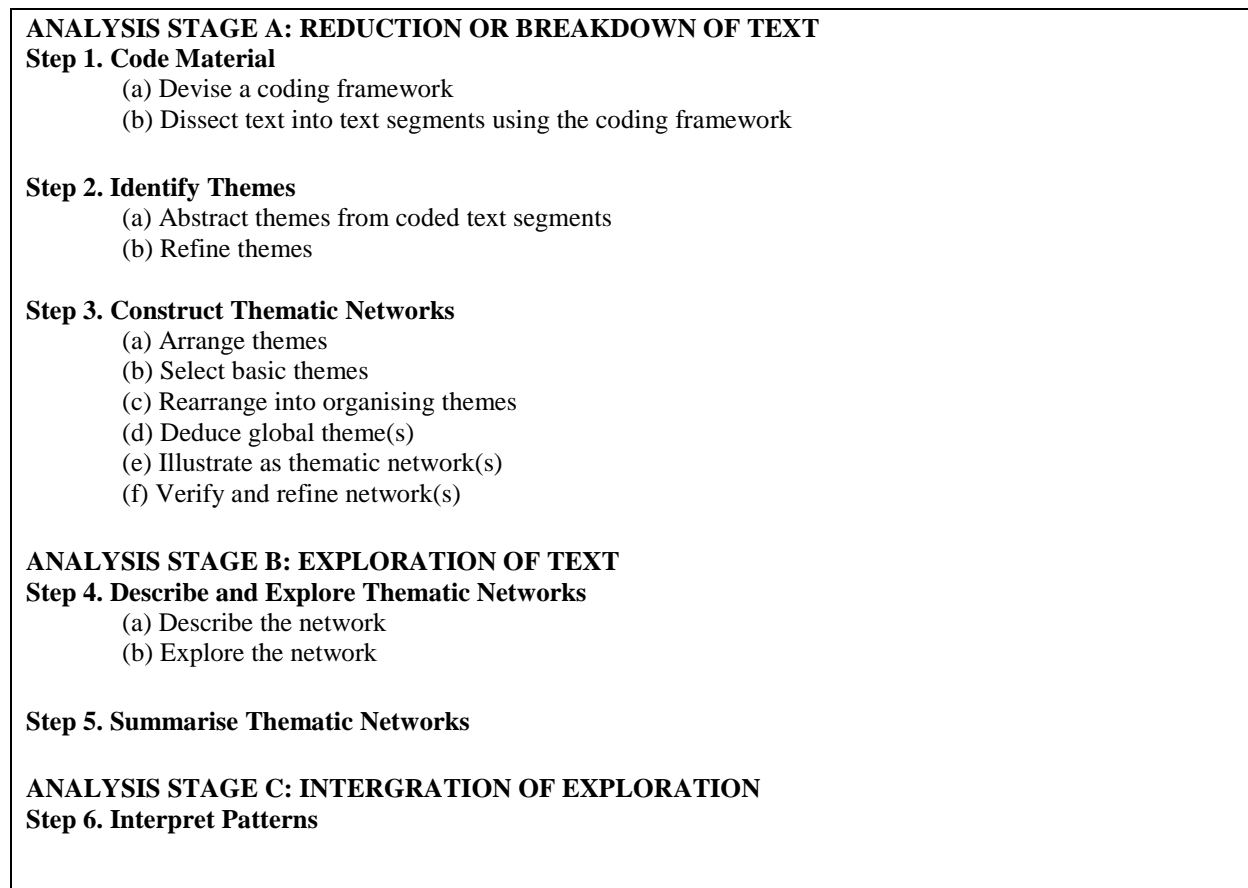
This study uses thematic analysis, and in particular, thematic networks (Attride-Stirling, 2001) to analysis data material derived from qualitative semi-structured interviews. According to Attride-Stirling (2001), “if qualitative research is to yield meaningful and useful results, it is imperative that the material under scrutiny is analysed in a methodical manner...” (p. 386). Therefore, thematic networks analysis will be applied in this research because of its highly structured and methodical approach to data analysis. This technique, according to Attride-Stirling:

*provides practical and effective procedures for conducting an analysis; it enables a methodical systematisation of textual data, facilitates the disclosure of each step in the analytical process, aids the organisation of an analysis and its presentation, and allows a sensitive, insightful and rich exploration of a text’s overt structures and underlying patterns* (p. 386).

Roulston (2001) stated that thematic analysis is popular amongst qualitative researchers for analysing data in the social sciences by enabling people to talk about their lives and experiences. However, Briggs (1986) cautioned that when researchers see interview data as simply statements, comments and descriptions, then what is said is seen as a reflection of what is “out there” rather than an interpretation of what has been jointly produced by the researcher and the participant. In fact, Briggs stated that the single most prominent flaw linked to the use of qualitative interviews is the superficial manner in which most analysis of interview data are conducted. In addition, Roulston adds that thematic analysis that does not move from descriptive to interpretative and ignores the principle of reflexivity associated with social science research, will produce a “naïve and possibly 'romantic' reading of data generated in research interviews” (p. 280). However, Patton (as cited in Vivar, McQueen, Whyte & Armayor, 2007) argued that the interactive nature of qualitative research could also be a strength given that the primary research instrument is the researcher themselves.

In response to the challenges of reflexivity and commonsense description of data interpretation, previously highlighted by Roulston (2001) and Briggs (1986), this research project will follow the rigouress step-by-step format proposed by Attride-Stirling (2001) associated with thematic networks analysis. These steps are outlined in Figure 1.

*Figure 1: Steps in analyses employing thematic networks*



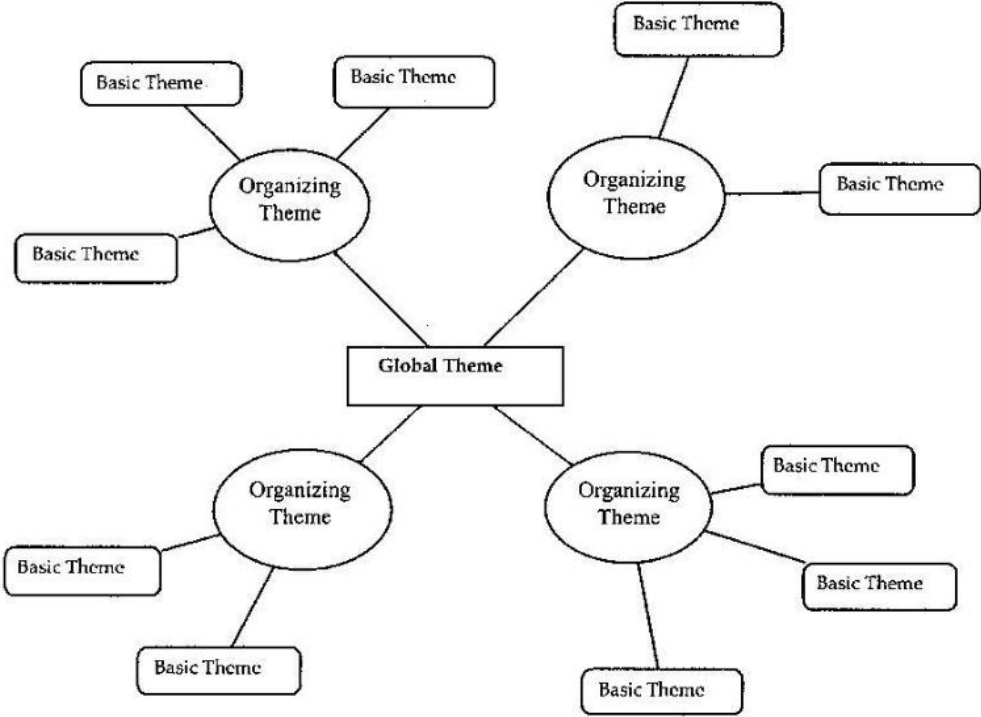
In step one, interview data is reduced through the use of a coding framework. This is done initially by devising a coding framework that will indicate which material to focus on. The research questions and recurrent issues arising from the interviews will guide the coding framework. Once a coded framework has been established the interview text will be dissected and inserted into text segments using the coded framework.

Step two involves identifying and refining themes from the coded text segments. Themes are constituted by their pertinence to the research questions and by the number of congruent statements made by each of the participants. This is done by first going through the text segments, abstracting pertinent information and then refining identified themes that succinctly summarise the text.

Having identified the themes, in step three, the thematic networks are constructed by grouping related themes together (See Figure 2). The themes originating from the text segments are referred to as basic themes. Some of the basic themes will be grouped together to form a cluster of themes, which will be connected to an organising theme. Organising

themes summarise the cluster of themes. Finally, once basic and organising themes are formulated, global themes are abstracted which represent the core principle idea that encapsulates the main points in the text.

Figure 2: Structure of a thematic network



Step four begins the analysis. Networks are described then explored and used as an aid in interpreting the original text of the interview material. By rereading the data material through the lenses of the thematic networks, further analysis and greater understanding will be achieved.

In step five, the thematic networks are summarised by highlighting the main themes and patterns that have emerged from the exploration phase. The final step integrates the deductions and summaries of the networks in relation to the research question and the theoretical interests underpinning the research.

To summarise, steps one to three constitutes the breakdown or reduction of the interview text; step four and five covers the exploration of the interview text and in the final step the integration of the exploration from the previous steps are made explicit.

## **Chapter Three: Method**

### **Ethical Review**

This research project received ethics approval from AUT Ethics Committee (AUTEC) on 7 April 2009, ethics application number 09/03 (See Appendix A). In response to the ethics application two changes were proposed, one from AUTEC and one from the researcher. The ethics committee requested that the researcher be removed from the recruiting process because the researcher is a member of the organisation from where potential participants were being recruited. AUTEC suggested that an independent third party do the recruiting. AUTEC agreed, with the suggestion made by the researcher, that a clinical nurse from the clinical team, independent of the organisation, assumes the recruiting role.

The second change to the ethics proposal came from a recommendation by the researcher's supervisors to improve research reliability. This involved approaching a person who is knowledgeable on the topic of mental illness and recovery to analyse one or two transcripts and to compare his analysis of the interview data with the researcher's own analysis. The goal of this process was to check for consistency with data analysis or inter-analysis reliability. AUTEC requested that the person acting in this capacity sign a confidentiality agreement form (See Appendix B) approved by the committee.

### **Participant Selection**

This study adopted the process of purposeful recruitment of participants. Participation was voluntary. All participants were mental health support workers (MHSWs) from the same organisation (See Table 1). Participants' names were replaced by fictitious names to maintain confidentiality and to protect the privacy of the participants. The qualifying criterion for participant selection was based on: 1) the MHSW must have worked in a recovery-based environment for a minimum of one year in New Zealand and; 2) the MHSW must be proficient in the English language. Eight participants who met the criteria were approached, all agreed to participate. Six of the participants worked in supported accommodation and two worked in the mobile services. In supported accommodation MHSWs are responsible for a group of five to six service users living in a house. MHSWs that are connected to mobile services carry a caseload of three to five clients, and deliver services to service users living independently in the community.

*Table 1: Participants*

Name	Age	Number of years in mental health	Number of years with the organisation
Glen	43	1	1
Ken	53	13	4
Linda	37	2	2
James	36	2	2
Tom	70	5	3
Peter	51	5	1.5
Alec	41	6	1
Jill	51	8	8

Potential participants were identified through consultation between the researcher and the organisation's managers. Consistent with the recommendation by AUTECH to address possible conflicts of interest, the researcher was not personally involved in inviting potential participants to participate. A clinical nurse, not employed by the organisation, who was associated with each service, was assigned to approach the potential candidates to take part in the research project. The potential participants were given a week to decide whether they wish to participate, and were asked to inform the clinical nurse of their decision. The potential participants were, at the time of recruiting, given a copy of the participant information sheet (See Appendix C) as well as a copy of the research interview questions (See Appendix D). The candidates were asked to use the interview questions to help them think of examples based on their work experiences. They were also asked not to research the interview questions.

Once the clinical nurse had informed the researcher that a potential participant had agreed to participate, the researcher contacted the potential participant to arrange a time and a place for the interview to take place. At the start of each interview after the potential participant had indicated that he or she was satisfied with the introduction and all questions



about the study had been sufficiently answered, the potential participant then signed a consent form (See Appendix E).

The participants were offered, if required, up to three free counselling sessions at the AUT counselling service. Details about accessing the service were provided in the information sheet.

## **Setting**

### *The Organisation.*

The organisation that employs the MHSWs participating in the research is a non-government organisation (NGO), which is a charitable trust providing a range of recovery services to mental health service users. The trust also provides services for people affected by physical disability, dementia and drug and alcohol issues. The organisation, has over the years, expanded to provide expertise and services to a variety of people to accommodate: (1) high and complex mental illness; (2) severe physical disability; (3) dual diagnosis; (4) older adults; (5) maternal mental health; (6) post accident victims; and (7) specific cultural groups including Maori, Pacific, Asian and (8) specific needs groups.

### *Organisational Recovery Vision.*

The organisation believes that for recovery to take place it must centre its focus on the individual. The underlying beliefs that drive the organisational vision is founded on the understanding that:

- All people have the potential to live a meaningful life.
- All people should have access to the best services available to aid their recovery.
- Each service user is entitled to specialised services tailored to their unique circumstances.
- Services should address the person in their entirety, not just their deficiencies.
- Each service user will be cared for by the best-suited person to ensure the best service possible.

### *Services Offered.*

The organisation is dedicated to providing a range of recovery-oriented services. The organisation works closely with government, non-government and private organisations in offering these services which include: (1) residential support, from low to high needs; (2) community based support i.e. supporting people in their homes; (3) respite care; (4) information, advocacy and support services; (5) education and training; (6) employment and job schemes; (7) housing options; (8) community centres; (9) family/whanau services; (10) private mental health services; (11) forensic services; and (12) peer support services. Access to services, by service users, is done through the organisation or agency purchasing the service. Private referrals are done through the organisational head office.

### *The Organisation's Model of Recovery.*

The organisation's model of recovery was developed from extensive consultation with a range of people accessing the organisation's services. These people were asked questions about their illness, such as what caused their condition, what helped them get well, what caused relapses and how they stayed well. Their responses initiated the six-domain recovery model, now used by the organisation. These domains include:

1. Emotional Health – to do with individual purpose and esteem, coping mechanisms, and reconnecting with family and the wider community.
2. Spiritual/Cultural Health – acknowledging, recognising and connecting to one's core values and beliefs.
3. Clinical Health – encompasses treatment and medical interventions.
4. Economic Health – involves developing self-reliance.
5. Environmental Health – being able to choose where to live.
6. Physical Health – incorporates choosing a life style that enables good health.

### *The Organisation's Staff.*

The organisation employs a range of people with varying skills and qualifications. Due to the multiplicity of services offered, staff include: nurses, occupational therapists, psychologists, social workers and qualified support workers. The organisation provides extensive core and competence training for the staff. Part of the core training involves training staff and educating service users in the delivery and application of the organisation's recovery model.

### *Organisational Research Policy.*

The researcher received written permission from the organisation to do the research, in accordance with the organisational research policy (See Appendix F).

Information regarding the organisation discussed under this section (setting) has been taken from an organisational pamphlet and is available upon request from the researcher.

### **Pilot Study**

A pilot study was conducted to improve the quality and relevance of the interview questions to the research topic. According to Kvale and Brinkmann (2009), a good interview question should produce relevant knowledge and contribute to the interpersonal relationship between the interviewee and the researcher. Six candidates were approached to discuss with, and receive feedback and recommendations about, the interview questions. Three of the candidates were regarded as experts on either the research topic or on qualitative research. One candidate was an associated student who had previously researched a similar topic. Of the remaining two candidates, one was a MHSW and the other a manager within the organisation.

The following recommendations from the candidates that participated in the pilot study were put forward:

- Begin the interviews with rapport building conversation to settle the interviewee before beginning with the research questions. It was further recommended that the researcher move from the rapport building to the research questions without interrupting the flow of conversation.
- Start the interview with general questions about recovery and then gradually move to more specific recovery questions.
- Keep interviews fluid. In other words, if a later interview reveals important information from the interviewee, then return to previously interviewed participants for their feedback on the subject.
- Ask participants to share personal examples from their work experience in an attempt to increase depth of data collected from the interviewees.

The candidates' feedback was considered and changes were made to incorporate recommendations from the pilot study.

## **Interview**

Interviewees were offered the option of having the interview take place at either AUT or at their workplace. All interviews took place within the organisation workplace. The interviews lasted between 40 to 60 minutes. At the start of each interview the researcher asked participants whether they had any questions regarding the research or the participant information sheet. After the initial orientation and answering of questions, participants were asked to complete the consent form.

Qualitative semi-structured interviews were conducted starting with questions related to MHSW's understanding of recovery, then questions about the job of MHSWs and ending with an inquiry about the role of autonomy in recovery. Research questions were compiled from the recommendations from the pilot study. Interviews were audiotaped, and were later transcribed verbatim by external transcribers (See Appendix G).

## **Data Analysis**

All interviews were transcribed and analysed for thematic content using thematic analysis with the use of thematic networks. This was done by using thematic analysis to make explicit the themes relevant in the text and by bringing together the different themes into an organised structure with the aid of thematic networks (Attride-Stirling, 2001). In this way, raw data was separated into: (1) lowest-order premises of interview data, referred as basic themes; (2) groups of basic themes summarising higher abstracted data, referred to as organising themes; and (3) groups of organising themes encapsulating the main ideas of the interview data, referred to as global themes.

First the researcher established a basic theme by compiling a summary of the participants' responses that were relevant to the research question. Second, each of the participants' summaries was compared and colour coded by matching those responses shared by more than one participant. Third, matching colour codes from each of the participants' summaries were grouped together into organising themes. These three steps establishing the organising themes were repeated for each of the interview questions. Finally, grouping together those organising themes that summarise the principle themes related to the text as a whole, was identified as global themes. This process was then captured and represented graphically as a thematic network depicting the various themes in relation to each other.

During the process of developing the thematic networks the researcher gave copies of the transcriptions and discussed the methodology used for analysis to another researcher to verify inter-analysis reliability. This was done by allowing the person to analyse the interview data independently. Then the researcher met with the person to compare themes. The meeting revealed considerable consistency or matching between both the person and the researcher's themes. The person identified was used because of his work experience in mental health and his own doctoral research on recovery and mental illness. He was also asked to sign a confidentiality form to protect the identity of the research participants.

Basic themes that were identified from the participants' remarks were not discussed individually; however, organising themes were discussed and expanded on in the chapter discussing results. Finally, global themes representing the overarching core tenets of the interview data were discussed and expanded on in the discussion chapter.

## Chapter Four: Results

### Aim of the Study

The aim of the study is to research MHSW's understanding of recovery and how they can foster the recovery of service users in their work place. In addition, philosophical discussions related to the concept of autonomy, within the context of recovery, are briefly explored. The first five questions are related to MHSWs' views on recovery, questions six and seven, cover MHSWs' understanding of their role in fostering service users' recovery, and the finale two questions, relate to the role autonomy has in the recovery process. MHSWs' comments will be discussed under these headings.

Themes will be uncovered using the following research questions and discussed under the three sections mentioned above, related to each question:

1. What has worked well when working with service users in their recovery?
2. What has not worked well when working with service users in their recovery?
3. Based on your experience, what has been helpful for service user's recovery?
4. Based on your experience, what has been less helpful for service user's recovery?
5. How would you summarise the concept of recovery?
6. What is your understanding of your role as a support worker in the recovery process when working with service users?
7. What makes a good recovery mental health support worker?
8. Do you see autonomy as a barrier or a facilitator of recovery?
9. When autonomy is not used wisely, how do you negotiate the tension between autonomy and power sharing?

### MHSWs understanding of recovery

*Question One: What has worked well when working with service users in their recovery?*

In response to this question, three organising themes were identified: relationships, being service user centered and MHSW's optimistic and accepting attitude towards recovery.

Out of the three themes mentioned, relationships and being service user centered were the two more prominent themes.

### **Organising Theme One: The importance of relationships in aiding recovery**

Seven of the eight participants mentioned the importance of relationships when discussing what has worked well in aiding service users' recovery.

According to Ken, the establishment of relationships with service users are aided when MHSWs are understanding, non-judgemental and non-punitive. Ken feels these characteristics encourage service users to be more open and transparent about their lives. He related an incident in which the service user failed to wake up in time to attend his son's parent teacher meeting. Ken believed the way he addressed the issue was a turning point in their relationship.

*I just normalised [the incident] and said "well that is what we do sometimes... we do sleep in". I made sure there was no judgment calls from me and it was just an understanding... I told him if he learned from [this, then] they were very positive experiences in his life.*

Linda believed that making the effort to get to know the service user, and allowing time for the service user to get to know her was an important prerequisite to the commencement of therapeutic work. Linda said:

*Before I start trying to help them (service users)... they think, who is this person coming in, and if you do not have that connection, it can be quite difficult. I have found that they are more accepting and more open to me as a new person coming into their life and trying to help them... but they do not see that at first, they just see a new person, another one.*

Glen stated that his relationship-building was founded on humour and that humour builds rapport quickly and speeds up the connecting process with service users. He said that he uses humour not only to build rapport but also to sustain his relationships with service users.

*I think using humour... works really well. I believe it helps to build the rapport early and the earlier you can build the rapport it kinda makes it easier to work with them (service users) a lot sooner and [it] get[s] things happening. Then of course, once you have got the rapport built up, then you find out more of how, what [and] when is the best time to use humour and when not to use it.*

### **Organising Theme Two: MHSWs being service user centred**

Jill, Ken, James, Alec, Tom and Glen all felt that focussing on service users' needs, wants and dreams, have worked well for them in assisting service users' recovery. According to these MHSWs, aspects of being service user centred included: (1) matching key-workers and other relevant people to service users; (2) establishing collaborative practice; (3) focusing on what is meaningful to the service user; (4) walking alongside the service user; (5) adjusting their practice to suit the service user; and (6) respecting the service user's values and not imposing the MHSW's values.

Jill gave an example where a service user's recovery began to flourish when a new key-worker was assigned that was more aligned to the service user's needs than what was convenient for the service provider's staff. Jill believed that when assigning key-workers to service users, age, cultural background, work experience and gender that match the service user's needs should take precedence over the service provider's preference.

*One guy in particular, when he first came [to the service], I did not feel at the time, was matched to the person that he was given [as] the key-worker... so [I started] collaborating with him where the person was able to have a key-worker that matched him as opposed to one who was just given to him.*

Ken shared that what worked well for him was to focus on what was meaningful to the service user and what was important to him in his life. Ken focused on the service user's son as a motivator for the service user's recovery.

*[I] show[ed] him some quality value[able] ways of spending time with his son... he valued that because he'd see how much joy it brought to his son and himself. He wanted to connect with his son but he did not know how. I worked with those areas that I was able to find some meaningfulness in his life and it was a turning point.*



Tom highlighted the importance of MHSW's being flexible in their practice and adjusting their approach to suit service users.

*Knowing how to apply myself to different clients... I continue to learn and I continue to tweak [my approach].*

### **Organising Theme Three: MHSWs optimistic and accepting attitudes towards recovery**

James demonstrated this attitude by challenging his own belief system and cultural norms relating to recovery. He spoke about looking inward and questioning his own views about recovery. This process helped him believe that recovery is attainable.

*It was more about myself and challenging my belief system, challenging my cultural beliefs... we were taught as children when you are in the mental health system there is no way that you can go back [to] mainstream or you can be normalised. I just realised that... recovery has so many different strands... all this belief that recovery could not happen... I[t] opened my eyes... never were we taught that recovery is possible.*

James spoke about mental illness being a socially constructed phenomenon in his country of origin. He was taught that people have a mental illness because they are “cursed by demons”. It was only when he came to New Zealand that his belief system was challenged and he began to believe that people with a mental illness could recover. As James’ belief in recovery strengthened from his personal experiences of working in the field, he became more optimistic about service users reaching their recovery goals.

One element of attitude seemed to include the workers’ determination to grind through obstacles to accomplish service users’ priorities. Alec discussed a service user he worked with who came to New Zealand as a refugee from Africa and described a seemingly hopeless situation in that the service user had arrived with no identification documents, had no living parents or siblings and could not remember his place of birth. However, Alec was optimistic that if the service user was willing to work with him they could accomplish what they set their minds to do. Alec learnt that this service user wanted to do a course. Alec talked about the lengths he went to, in helping the service user acquire all the relevant application documents

needed. This involved numerous communications with the country in Africa, the New Zealand government and various agencies. Alec described the process of finding the service user's place of birth:

*So I took him to an internet café and with the help of the internet... I showed him all the places, which he can remember where he was born... Finally, he got the name of the place where he was born and I spoke to them. Then through a Justice of the Peace we made a declaration on a form from the Ministry of Internal Affairs and eventually he got that statement and he submitted that paper and many other documents from his sponsors and some other sources. It took nearly one year.*

When Alec learnt that the service user wanted to do a course, his response was, “I am willing to work with you, [and] I think we can do this together, we can sort this out”.

*Question Two: What has not worked well when working with service users in their recovery?*

In discussing what has not worked well in aiding service user's recovery, two themes arose: MHSW's failure to consult with service users and lack of professionalism. Lack of consultation with service users included decisions affecting their lives and the manner in which MHSWs interact with service users. The majority of the participants believed that the biggest factor impinging on service users' recovery is to exclude service users when making decisions about their lives.

**Organising Theme One: MHSWs failing to consult with service users about decisions affecting service users lives.**

According to Ken, what does not work well is when others tell service users how to recover. He has witnessed how MHSWs have tried to “prescribe and dictate” to service users what they should do. Ken remarked that he has heard MHSWs and other mental health professionals promise service users recovery, if they (service users) do what they are told to do. He believes that “dictating” to service users does not equip them with the skills and knowledge for independent living in the community.

Similarly, Jill believes it is hard for service users to recover when MHSWs follow their “own agenda”, meaning that it does not help when MHSWs force their own opinions and disregard the service user's input regarding their recovery. She said:

*If the person who works with them (service user) has their own agenda, that does not help, because then you are missing the whole point of the recovery, because they should have part and parcel of it. An example of that is someone saying to the client, “oh you know, I think this is good for you to do this, this and this”. That is an opinion, but it should not be something that is pushed on the client because they have to decide what they want to do and how we can best facilitate that.*

Alec, when discussing service users’ recovery plans, reinforced the tendency for recovery plans to fail, when service users are left out of the consulting process or when other people make decisions for them. He relayed an example where a number of his clients were asked by their physicians to adopt a healthier lifestyle through diet and exercise. When asked why some of the clients were successful and others not, he said that he could only assume that for some, healthy living was not important.

*Diet did not work for that client, I mean you know, it is hard to say... [For] some of the clients... it is not their first priority to become fit or healthy physically. They (service users) [are] not really worried about their physical fitness.*

It seems that failing to consult with service users about their recovery, is not only about excluding service users from the decision making process, but about MHSWs and other mental health professionals believing they know what is best or what works.

### **Organising Theme Two: MHSWs lack of professionalism when interacting with service users**

According to some participants, service users are sometimes treated unprofessionally by MHSWs. Participants identified: MHSWs’ emotions getting in the way of their practice, workers reacting when triggered by service users, and the way MHSWs occasionally talk to service users, including being abrupt and intentionally withholding information from service users, as examples of workers behaving unprofessionally towards service users.

Glen discussed an incident when he lost control of his emotions and over-reacted. He mentioned that he was having a difficult day and he took exception to something a service user had said. He believes simple strategies such as not taking what service users say personally and taking a moment to check, 'where he is at' before interacting with service users, will help him maintain his professionalism.

*I really need to be aware [of] leaving aside whatever happens before I see the client, just leaving it behind [when] I am with the client. I think definitely; as you are driving on your way to your client, just think about pushing those things aside, so that when you get to your client you can just get into character I suppose.*

James believes it is important that MHSWs are aware of how they interact with service users. MHSWs who are abrupt, such as declining a service user's request without an explanation, can trigger emotions and damage relationships.

*I have seen staff saying no straight away to the clients and saying no straight away would somehow trigger bad emotions... It was not explained to them. Then fights would erupt and arguments would erupt which created stressful relationships*

Conversely, MHSWs demonstrate their professionalism when they are respectful and open with their communication, which in turn invites dialogue between the worker and service user and leads to strengthening their relationship.

If a staff says "no" and goes through the process of explaining why it is a no, [it] has a different impact on the client. [But], when you put out a very negative no, straight away, it limits clients from asking more. It is about the interaction; the manner of delivery and it is about the relationship.

Alec encapsulates the sentiments of his peers, stating that, being professional is to remain calm when feeling frustrated or annoyed with a service user. He stated that it is important that MHSWs are careful with the language they use when interacting with service users.

*Question Three: Based on your experience, what has been helpful for service users' recovery?*

The participants felt that MHSWs who are concerned for the welfare of service users and working within the pace set by the service user is helpful for service users' recovery. For MHSWs, finding the recovery pace that suits the service user allows for the fact that service users differ in the manner, and rate, in which they recover. Moreover, this process is further enhanced when MHSWs show sincere love for the people they care for.

**Organising Theme One: MHSWs having a concerned for the welfare of service users in their care**

A number of participants said having concern for the welfare of service users in their care was valuable. Compassion and empathy were two characteristics identified as relevant by participants. These characteristics were manifested through MHSWs attitudes towards service users and how they treated them. Some participants showed their concerns for service users' welfare through 'love'. For example, having a love for service users helped MHSWs to be honest, sincere, and optimistic and assured that service users were treated with dignity. Tom expressed these sentiments in this way:

*I think one of the most important degrees, in this work, is you have to have a love of [the] people (service users), [and] a lot of understanding. You have to be able to interact with those people that you work with and show some degree of compassion. It is important to shake a client's hand. It is important for me to give them a hug.*

Peter said that MHSWs should always interact with service users in a loving manner and that loving service users does not "cost a cent". According to him, speaking to service users in a "peaceful" manner, or in other words, speaking with a soft voice, is an indication and a demonstration of MHSWs love for them.

Ken mentioned that his honesty comes from the "aroha" or love he has for the people in his care. He stressed that when MHSWs have a love for the service user and when that love is grounded in their practice, then things fall into place. Likewise, Alec believed that qualities such as compassion and empathy helped him to be, "positive, optimistic, dedicated and sincere" in his practice.

## **Organising Theme Two: MHSWs working at a pace that suits service users**

Within the organisation, service users have recovery plans and goals. Glen feels that at times MHSWs push service users to accomplish their goals, rather than, focusing on their relationship. He believes it is better to find a balance between encouraging service users to accomplish their goals while respecting their wishes regarding timelines. He describes the scenario in these words:

*I am focusing [on] relationship side, rather than pushing them (service user) towards their goal. Other colleagues would focus on the goal and reach that goal a lot faster than myself. I would not ignore the timelines but I just would not push too hard towards it. I suppose what makes a really good support worker is one who has that really good balance of knowing, how, where, [and] when, to push, how hard to push, when to hold back, [and] keep things really smooth.*

Glen was asked, “What helps him find the right balance between, when and when not to ‘push’ service users?” He said MHSWs should ask the service users about their progress and get feed back from them and MHSWs should follow the service user’s direction.

Ken said that what helps him when working with service users, on their recovery, is to recognise that, “everyone has their own time and moment to evolve...” and one cannot force the process. Likewise, Tom believes that, unlike machines that can be repaired quickly, people need time. He said:

*When you are working with machines, you can make a statement, to enable the repair of that machine to be carried out in such a way that the job is going to be done quickly [and] cheaply. When you work in the field of humanities, you cannot always apply that exercise. [The process] cannot be quick and [it] cannot be a quick fix.*

These comments from the participants stress that the rate at which service users recover is not determined by the MHSW, the service, or organisation that service users are affiliated to, but by the service users themselves. Often, the pace is set and agreed upon through consultation with service users and those in their care however, how that translates into daily application, ultimately lies with the service user.

Service users are expected to be treated with dignity and respect as outlined by the professional code of conduct of the organisation they belong to. However, MHSWs believe that when values associated with the professional code of conduct are driven intrinsically by an emotion such as love, it produces a MHSW that is genuine and sincere about their work.

*Question Four: Based on your experience, what has been less helpful for service users' recovery?*

When participants were asked to share their thoughts on what is not helpful for service users' recovery, one theme emerged. Participants shared that the failure to implement service users' recovery plans was due to systemic reasons. First, the system of assigning a MHSW to work personally with a service user causes MHSWs to inadvertently exclude supporting other service users in the service, and second, the nature of some recovery plans may require the input of gender specific staff.

#### **Organising Theme: MHSWs not implementing or following through with service users' recovery plans**

According to Linda and Jill, when MHSWs do not follow or fail to implement recovery plans in the workplace, it impedes service users' recovery. These participants work in supported accommodation in which a group of staff members are responsible for a number of residents living in a house. Jill has noticed that sometimes MHSWs focus exclusively on the service users they have been assigned to key-work at the expense of other service users. Jill further contends the point, that occasionally some recovery plans, that are formulated, are more suited for certain genders to implement.

Linda believes that MHSWs sometimes become so preoccupied with the service users that they are assigned to work closely with, that they ignore the other service users who are also under their care.

*Staff do not help in the process by not following the plans, by ignoring what they should be doing and not supporting them (service users). They (MHSW) may just not notice it (recovery plans) or they are so focussed on what they are doing that they forget about it. But they (MHSWs) are so driven to work on that one person (service users) that they are not diverting their thoughts to other people (service users). [They*

*are] not feeling like that it is their responsibility, that somebody else (MHSW) is allocated to that person (service user).*

Jill referred to a scenario in which a female service user's recovery plan included the checking and monitoring of some basic hygiene needs. Jill highlights the fact that for ethical reasons, parts of the service users plans are difficult to action with male staff on shift.

*I think that personally... a woman (MHSW) should actually address her (service user) needs in regards to going into their room because then it is safe for both the client and for the staff. If it is a man (MHSW)... in there comes ethical stuff as well, walking into a woman's room, you know, on their own (MHSW) could be unsafe... I (MHSW) come along sometimes and she looks quite unkempt, dishevelled, so that just suggests to me, you know, that the continuity of her care is not happening according to her plan.*

The two scenarios above illustrate some of the operational challenges facing MHSWs in their work. Linda highlights the fact that the key-working system encourages the tendency for workers to become consumed by their key-working role, for one service user. Jill makes the point that MHSWs, through no fault of their own, cannot at times implement recovery plans. In each case recovery plans, or parts thereof, are unlikely to be put into action which impacts on the service user's continuity of care and recovery.

*Question Five: How would you summarise the concept of recovery?*

The participants' remarks about recovery were summarised into two organising themes, with some overlapping of both themes from the comments of Ken and James. Glen, Alec and Tom emphasised the importance of service users defining what recovery means and how to recover. While Jill and Linda highlighted that recovery takes place when service users gain some ascendancy over their circumstances, in other words, they begin to take back or regain control over parts of their lives.



### **Organising Theme One: Recovery should be defined and determined by service users**

Glen feels that service users are recovering if they believe they are doing well; regardless of the progress they are making. Furthermore the service user, not the MHSW or the mental health system, should define progress.

*I think recovery is [when] a client gets into that space where they feel they are making progress. As long as the client feels like they are doing well, [it] is more important if it comes from them.*

Alec summed up recovery as a long process and that the service user determines the length of time it takes to recover. Likewise, Tom believed that recovery takes place when service users enjoy a quality of life, which they have determined. Tom said:

*They (service user) [set the standard] but we as a support worker would like to encourage them to the next step, but they set the benchmark. They say to themselves, "That is it for me, I am quite comfortable here"... Now, for that client, he or she has reached the step in life that they are comfortable. Another client, [may say], "I want to own my own business". The level of achievement is very much decided upon by the client.*

These comments from the participants signify the need for MHSWs, and those who work in mental health, to allow service users the freedom to indicate and express what recovery means to them and to follow the service users' direction regarding their recovery.

### **Organising Theme Two: Service users recover when they are able to regain control over aspects of their lives**

Ken said that service users are recovering when they develop the power to take back their lives, and are in a position to make choices for themselves, as well as establish meaningful roles in their lives. According to James, recovery is a journey of "small steps" in which service users learn to participate and function in their chosen environment.

*It is the small steps that count, [I worked with a service user who] was institutionalised and he did not know how to [catch a] ride [in] the bus. The first step*

*was taking him for a bus ride. The ultimate goal was for him to independently ride the bus and buy his own ticket, to [be able to] function in the environment that [he] needs to live in.*

Linda believes service users are recovering when they get back into a life where they feel happy and fulfilled. Furthermore, recovery, according to Jill involves every facet of a service user's life. Jill said it is about reintegrating into society and learning how to live in the community.

*Recovery is about every facet of a person's life and it is about helping them (service users) to understand that whatever it is, that they can do it. They have to get out into the community and try and make their life work.*

Ken, James, Linda and Jill's remarks stress the point that in order for recovery to happen, service users need to learn how to satisfy or successfully negotiate the demands of the environment they are in. According to these participants, service users recover when they learn how to participate and function effectively in certain activities such as catching a bus or fulfilling certain roles in society.

### **The role of the MHSW in facilitating recovery**

*Question Six: What is your understanding of your role as a support worker in the recovery process when working with service users?*

The participants' responses to the question regarding their role as support workers in aiding service users recovery, was varied and diverse. This highlights the complexities of the MHSW's role. The two central organizing themes to emerge in this question were: MHSWs spending time with service users, connecting with them and, assisting them with their needs together with equipping service users with the skills and/or supports that will enable them to succeed. Other themes that emerged were the importance of role modeling and MHSWs monitoring service users mental state, as well as, reporting service users' condition to various people such as organisational management and clinical personnel.

### **Organising Theme One: MHSWs spending time with service users, connecting with them and assisting with their needs**

The majority of the participants felt that getting to know service users by spending time with them and assisting them with their every day needs is one of the core roles of MHSWs. Alec explained how he attempts to achieve this,

*Identify the needs of the client, in terms of their recovery journey. Work alongside with them in everything, like shopping, cooking and the daily activities, be part of their lives. Like, for example, one of my clients, he was very interested in [doing] the forklift licence. So I encouraged him to do a course with me, just for him, I did the course with him. I spent two days, all two days with him.*

James, when discussing his role as a MHSW, makes the distinction between helping and supporting service users. He says helping is like pulling somebody out of the ditch and then walking away; whereas supporting according to James, means “walking alongside” the person and working things out together. James’ definition of support accentuates the MHSW’s role of taking time to get to know service users and learning how to best serve.

Jill reiterates this need for MHSWs to work closely with service users, being involved in their lives and doing what is necessary in supporting service users with their daily activities and aspirations.

*If someone (service user) wanted to do a course, you will facilitate the process. I think part of the role [of MHSWs] is making sure that they (service users) have what they need to succeed, whether it is taking them to or bringing them back from wherever they need to be.*

These participants’ comments identify that to be effective, MHSWs must engage with service users, work closely with them, get involved with and support service users in their daily needs and aspirations. In other words, for MHSWs to do their job they must be prepared to immerse themselves in service users lives.

## **Organising Theme Two: Equipping services users to succeed**

Ken believed this could be done by handing power back to service users and instilling hope by through highlighting their achievements. Linda also mentioned the importance of bringing to service users' attention their achievements; she said this helps service users build their confidence. She added that teaching service users how to stay well was another way that enables them to be successful. Tom spoke about the importance of creating happy memories for service users to fall back on and Jill extolled the virtues of networking and empowering service users.

In discussing ways to help equip service users to succeed, Ken spoke about the importance of instilling hope in service users lives. He makes the distinction between superficial hope and genuine hope. He does this by discussing with service users their recovery journey by comparing their past with their present situation.

*I say, [to the service user] "let us just stop for a moment and let us just look back three years ago when you actually entered our service"... At the end of the conversation [you are] saying, "I am feeling a lot better about myself than where I was in hospital". It is just reminding them from where they have come to where they are [today], and hopefully they can really remember where they have come from and how much they had improved.*

Jill describes the practice and philosophy she follows that she believes equips the service user, through the process of empowerment, to succeed.

*My role is not to do it for them, but it is to help them do it for themselves and walk alongside them while they're doing it. That encompasses the recovery model... that it is everything that they need whenever they need, but helping them to do it, themselves.*

In relation to networking, Jill talked about a particular service in the community that helps service users find employment or prepares them for the job market. The employment agency also provides ongoing support and correspondence with the service user's employer and with the organisation the service user is affiliated to. Other agencies in the community,

according to Jill, that provide valuable resources and services includes social clubs, educational centres, and peer support groups.

*Networking is a big part of recovery... If a person (service user) wanted a job, we have consultants [in the community] that we work with; if they are ready to go back to work, they can go down there, [they can also] do a course as well, about the job, the interview... They (consultants) also do the follow ups for the clients in regards to their progress and they liaise with us about their progress.*

These comments and examples by the participants draw attention to a fundamental aspect of recovery in that service users need to move beyond the effects of their illness and claim back their lives. This process may vary from service user to service user and essentially encompasses such aspects as MHSWs assisting service users to develop their talents, empowering them with pertinent skills and equipping them with the resources available in the community. According to the participants, when service users involve themselves in these skill-building processes and boost their support systems through networking, they enhance their ability to recover and to follow their life dreams.

*Question Seven: What makes a good recovery mental health support worker?*

Alec and James emphasised the importance of role modelling, while Linda and Glen reported that good MHSWs are flexible and/or adaptable in their approach.

### **Organising Theme One: MHSWs being role models for service users**

James said that he tries to be a role model to service users so that they can see that there are alternative ways to doing things in life. He shared that he had a formula he uses to gain the service user's trust. This formula involves disclosing aspects of his life in the hope that service users would respond by talking about their life. This process has a dual purpose, in that James hopes that the service user would see his life as one they would like to emulate and it helps James build rapport with service users.

*Be a role model to them (service users). When these people swear a lot in their environment, I try not to be like that, swear. I do not swear, so they see there [are] other options in life; there is more to life than this. I have a formula, what I do is, I*

*present myself as a role model. The first couple of times I will talk about my life with the hope of them trusting me and connecting the bridges. [This] is my family... this is my life and [they] too would open up?*

Alec believed role modelling is influential in changing service users' habits. He maintains that when MHSWs validate their advice, by evidence from their personal life, then service users are more likely to respond to their input.

*One of my clients runs out of food every week. I mentioned about my life... "Look I am spending a certain amount of money for the whole family, exactly the same amount you are spending just for you". "See I can give you the proof from the docket from the supermarket". He (service user) was amazed. He spent nearly 60 percent of the money that he used to use and there was plenty [of groceries].*

James and Alec's discussions about role modelling highlight the point that role modelling can have a powerful impact on services users' lives. Their comments indicate that role modelling helps service users gauge the genuineness of MHSWs when service users believe or see that workers practice what they preach. It can also accelerate the process of building trust when MHSWs disclose aspects of their lives, which they believe will have a positive impact on service users.

### **Organising Theme Two: MHSWs are flexible and/or adaptable in their approach**

Linda stated that she likes to keep an open mind when assisting service users in their recovery. She does not believe recovery should be prescribed. More specifically, she believes that what works should be determined by the service users themselves.

*I think in general I am a caring person and I listen and am quite open to suggestions. You know, it does not have to be one way it could be whatever works. Flexible, because it makes it so much easier when you realise that it does not have to be one set way. It can be what suits [the service user] because everybody is different and it might not work the same way with everybody.*

Glen recognised that service users are different and in order for him to build relationships with his clients he must be able to adapt his approach to what suits them.

*There are so many different types of clients that I think if you do not have that ability to adapt to the different clients, it just makes it a bit harder to build that relationship. I think that is really important, the ability, as far as getting things done... So I think if you adapt to your client with what they find more comfortable, more acceptable, then everything else becomes a lot easier.*

Glen's and Linda's comments highlight the notion that good MHSWs need to be flexible with their philosophical ideals of recovery and sufficiently malleable to accommodate the unique recovery circumstance of each service user.

### **Autonomy in relation to recovery**

*Question Eight: Do you see autonomy as a barrier or a facilitator of recovery?*

Some participants believed that the service users' readiness to receive autonomy would determine whether an increase of autonomy would be a barrier or a facilitator to their recovery. Autonomy can be a barrier to service users' recovery when autonomy is forced onto service users such as when they are compelled to change their environment. Further, when service users are given autonomy before they are ready for it, it can impede their recovery. The participants reported that autonomy acts as a facilitator to service users' recovery when service users indicated that they are ready for it, when it is introduced gradually into service users' lives, or when autonomy becomes part of service users lives and overall plans for the future.

### **Organising Theme One: Autonomy as a barrier to recovery**

Jill and Linda felt that if autonomy were forced on service users, it would become detrimental to their recovery. In this regard, Jill spoke about the reality, that at times, service users have little choice regarding the increase in their autonomy because they are sometimes asked to exit the service they are currently receiving to make way for patients coming out of hospital.

Ken reported that when service users are given autonomy, when they are not ready or prepared for it, then the increase of autonomy in their lives can be counter productive to recovery.

*When they (service users) come from an institution [and] for so many years they have had no power and it is handed to them. They are very brittle [and] vulnerable [and when] power is handed to them at the wrong time they really do not know the right way to work with it. I have seen a lot of people (service users) collapse or fall back [when] given [more autonomy] at the wrong time, because they were not ready for it and they were not ready to accept those responsibilities in their lives.*

When service users are given autonomy that is uninvited or when autonomy is given too early or too quickly after service users exit the hospital or institution, then according to the participants, autonomy becomes a hindrance to their recovery. Tom mentioned that autonomy is “a mechanism to enable independence” and is a difficult exercise to implement. He stressed that even though MHSWs placed a high value on independence, the service user may not and that, although autonomy has its place, it is not the be all and end all of recovery.

### **Organising Theme Two: Autonomy as a facilitator to recovery**

Tom and Glen reported that when service users consent to having more autonomy in their lives, then autonomy becomes more of a facilitator than a barrier to their recovery. In discussing the need for service users to consent to receiving an increase in autonomy, Tom said:

*I suppose for autonomy to have any relevance the client has to understand and to accept [that] it is a mechanism to enable independence, but the delivery of that message or the implementation has to be always with the client's consent because you know autonomy is such a final exercise.*

Alec discussed the value of gradually introducing autonomy into service users' lives. In this way, the service users can be monitored and coached or guided in learning how to use their autonomy to aid their recovery. Alec shared an example from his work:

*I am working with the client [and] I have been coaching him around his cooking and his shopping and the management of [his] budget and things. I have been doing that actually for the last four or five weeks and he is getting slowly into the autonomy. So gradually...I can easily see that at this point, this autonomy is really working well. [While I continue to] support him, a [few] more times [for a few] more weeks.*



Jill believed that service users would assimilate autonomy back into their lives better if the procedure of handing service users their autonomy is enmeshed in the MHSWs practice from the day service users enters the service.

### **Organising Theme Three: Autonomy controlled by external constraints**

MHSWs and service users often perceive autonomy controlled by external constraints as barriers to recovery. Sometimes the restriction placed on services users' autonomy is to protect the community or even the service users themselves. For example, conditions such as instructing service users to make themselves available for treatment or where service users must live, may initially act as a barrier in their lives. Yet ultimately, autonomy may provide the necessary platform or preparation for service users' recovery. Likewise service users' freedom to exercise autonomy may be limited by social and/or organisational policies that restrict what service users can or cannot do and stifle their opportunities to recover.

Peter reported that sometimes the level of autonomy a service user is allowed, is not determined by the service user or the MHSW but by conditions stipulated by the courts or from compulsory treatment orders.

*There are clients who are probably on section...or CTOs, compulsory treatment orders and [their] empowerment [is] given by [the] court and that has to be followed. We have no say on those sections...if they break the rules then probably that will affect their empowerment.*

James emphasised that there is no such thing as full autonomy and that there are always systemic or social barriers associated with the concept. He mentioned that when service users are given autonomy it usually comes with constraining parameters. For example, he said that service users are allowed to make decisions by themselves as long as it keeps the organisation safe or themselves safe and the funders happy.

These comments by the participants draw attention to the fact that the degree of autonomy that service users have or are allowed is a dynamic process, which requires careful judgement and negotiating between service users and those who are responsible for their care.

*Question Nine: When autonomy is not used wisely, how do you negotiate the tension between autonomy and power sharing?*

The participants' responses to this question varied from stating that autonomy may come with conditions, to the extremes of punishing the service user, and MHSWs increasing their support in facilitating service users' recovery.

### **Organising Theme One: Use of autonomy controlled externally**

James said that whenever service users are given autonomy, it always comes with conditions attached, which impacts on service users' recovery. He used the metaphor of the 'canoe' to illustrate his point in that service users may be given the freedom to paddle their canoe but the MHSW or the mental health system always keeps a hand on the rudder which ultimately guides the service user's recovery pathway.

*It is like the metaphor of the canoe, if you (MHSW) are a steerer at the back, you [allow] him (service user) to decide where to go, but you steer, you assist him in the direction. You steer in the direction of what is accentuated by the agency, so if you (service user) go away from the mission or vision of the agency, you pull him back that is how you exercise your control. You can row wherever you like but I am steering the direction of the boat and it is me who is steering... if they (service users) point to a direction where it is a bad spot, then you pull them back.*

James is saying that service users are allowed to paddle the recovery course they choose, as long the course is congruent with the MHSW or the mental health system. Tom likewise, talked about service users' autonomy and recovery being controlled by external constraints by the Mental Health Compulsory Assessment and Treatment Act or the law.

*If the client is not using their autonomy wisely, what do we do in that situation? It depends on the mental health status that that client is being cared for. If the status is one that creates certain conditions for that client that places a responsibility on the people that manage that client. However, if he is a voluntary client, that is a different set of rules again...The one that is compulsory [or a] restricted patient, he cannot go anywhere but the one that is voluntary, he has options open to him and management can only volunteer their assistance to that particular client unless he breaks the law.*

Tom and James' comments accentuate the reality that although service users have autonomy or are given autonomy that drives their recovery, service users may be expected to exercise their autonomy within the parameters prescribed by an external agency. This may mean that under certain conditions the consequences of the use of autonomy and the impact this has on service users' recovery, lies beyond the responsibility of MHSWs.

### **Organising Theme Two: MHSWs should work with and increase their support of service users recovery**

Linda reported that service users should be accountable for their actions but there should be some compromise or "middle ground" negotiated between the service user and MHSW regarding the use of autonomy in the recovery process. Linda said MHSWs should stay engaged with service users, negotiating a consensus between the use of service users' autonomy and them "owning up to their actions." She believed that because service users are the "experts" of their lives, a consultation process should be followed so that service users can explain their understanding of how autonomy works in their recovery.

Tom emphasised that when service users do not use their autonomy wisely it is because the mental health system has failed them. He mentioned that service users are placed in the community ill prepared and with inadequate support systems to assist and maintain their recovery. Tom said one way to negotiate the tension that arises is to increase the support for service users. He shared the example of a service user whose quality of life and use of autonomy improved when the visits from supporting staff increased from one to three visits a week.

*I am thinking about a particular client who was given independence and allowed back into the community. What happened was through no fault of his own and because of a set of circumstances, he tripped [up in the community]. The clinicians at the time felt that he should not have been allowed into the community because he was not ready to be independent. What failed was the follow up by a management team to care for him while he was out there. Six months after he had been hospitalized, he was released into the community again. And under pretty much the same conditions that he was put out there initially. What changed was their care for him went from one visit a week to three visits a week and that resulted in him managing his affairs a lot more efficiently than he would otherwise have done.*

Ken reported that when service users use autonomy unwisely he tries to “normalise” the situation. He believed that when MHSWs over react by punishing the service users, service users “close up” which forms a barrier to recovery. He shared an example of what he meant by “normalising”. He told a service user, who took leave without permission to visit his family, that wanting to visit his family was a natural desire to have and that recovery often involves the reconnecting with family. He told the service user that, in future, if he desires to visit his family, he should plan the trip with his care team; in that way, the outcome of the visit will be more positive and in line with his recovery goals.

Alec said it is the service user’s choice as to how they want to use their autonomy and MHSWs are limited to what they can do. He believed the best MHSWs can do under the circumstances is to offer support and help service users, if they want it, understand the connection with concept of agency in recovery.

### **Organising Theme Three: Punitive consequences should follow**

Peter believed that when service users abuse their autonomy, service users should be punished. He said that service users should be “reprimanded” and their privileges taken away which in turn can frustrate their recovery plans. In this situation, according to Peter, when service users’ privileges are rescinded, these privileges should be reintroduced gradually as the service user demonstrates his or her ability to use their autonomy responsibly, such as aligning their behaviour with their recovery goals.

*If they (service users) go to a shop and they should come back within an hour and they take two hours they should be questioned on their arrival... He (service user) might be reprimanded, like you cannot go for a week and then the second week he can be allowed again [to] see whether he [will] still comes back within an hour. [Then] the [restriction] not to go to the shop for a week can be lifted and he can be allowed to [go] again.*

Jill likewise said there should be consequences although she did acknowledge that failure is part of recovery. She was not sure what the consequences should be and she did not believe that “stripping” service users’ autonomy was a solution, which she said may curb service their recovery.

These comments by the participants underline the diversity of opinions and complexities surrounding the topic of autonomy in mental health. The question about what to do when service users do not use their autonomy wisely is influenced by a number of things which, based on the discussions from the participants, include: (a) the MHSW's personal value system; (b) the service user's personal value system; (c) systemic constraints of the mental health system; (d) social constraints; (e) legal constraints from the Mental Health Act; and (f) the Criminal Justice Act.

The participants' comments, together with the social and legal constraints that may impinge on service users' recovery, bring to light the complex interplay between service users' rights and the values systems they are exposed to and those that are operating in their lives.

## **Chapter Five: Discussion**

In this section, global themes derived from the previously discussed organising themes, associated with the three topics situated within the interview questions, are discussed. These three topics are discussed under the same headings used in the results section, namely: MHSWs understanding of recovery, the role of the MHSW in facilitating recovery, and autonomy in relation to recovery.

### **MHSWs understanding of recovery**

The comments from the participants about their understanding of recovery revealed the global theme that MHSWs and service users have distinct roles in the recovery process. An important component of the service user's role is to communicate to the MHSW what recovery means to them and how to recover, which reinforces Meeham et al's. (2008) assertion that recovery is self-defined and that the recovery experience can differ from person to person. Davidson, et al. (2007), noted that it is imperative that people, who are recovering, lead the way because it is up to them to define what recovery is and what it entails. In response to this, MHSWs stated that once service users begin to communicate this, their role is to help set the platform for the service user's recovery to take place. MHSWs also stated that service users recover when they gain some ascendancy in their lives through regaining previously lost roles or the establishing of new roles.

This global theme brings to light the different roles service users and MHSWs have in facilitating the recovery process. Anthony (1993) highlighted this distinction when he stated that recovery is what people with a mental illness do themselves and rehabilitation is what mental health workers do to facilitate recovery. Therefore as service users begin the recovery journey, MHSWs support this process by providing an environment that is conducive to recovery. What this means is that even though service users may enlist others to support them in their recovery, initially, they must have an idea of what their recovery involves. When facilitating service users' recovery, MHSWs should consult with service users about their recovery. Furthermore, any means of compulsion or telling service users how to recover (Spaniol, 2000), ignores the two fundamental recovery values of empowerment and self-determination (Torrey & Wyzik 2000).

*Global Theme: MHSWs and service users have distinctive roles in the recovery process*

MHSWs have stated that part of the service users' role in the recovery process is to regain aspects of their life. This encompasses service users reintroducing previously lost premorbid roles such as becoming a student or a parent again or taking on new roles, for example, becoming a peer support person. In this way service users begin to recognise that they are not defined by their diagnosis but by their place in society and that the illness is only part of who they are. Deegan (1993) refers to this as distancing oneself from one's psychiatric label. Through this process, service users realise that they too have hopes and dreams that they are entitled to, and that they should have the same opportunities as others in society. MHSWs can help service users regain lost roles by, for example, helping a service user reconnect with a spouse; or develop a new role, like helping a service user become a successful tenant.

The comments by MHSWs that recovery should be defined and determined by service users are consistent with the assertion by Meehan et al. (2008) that recovery is a uniquely personal experience. This highlights another role service users need to fulfil for recovery to take place. MHSWs have identified that it is necessary that they understand and allow service users the freedom to explore and vocalise what recovery means to them. However, if service users have difficulty doing this, it is important that MHSWs do not use this as a justification or an opportunity to superimpose their worldviews of recovery. Fardella (2008) purports to the collaborative practice of the recovery approach, which requires practitioners to have a reflective, transparent, unambiguous, and inclusive stance to their practice. Situations like this require the MHSW to remain neutral, open minded and ready to help service users map out their unique recovery pathway (Spaniol, 2000).

MHSWs stated that the role of setting the platform for service users' recovery to take place comprised of: (1) building relationships with service users; (2) having an optimistic and accepting attitude towards recovery; (3) being concerned for the welfare of service users in their care; and (4) implementing or following through with service users' recovery plans.

Recovery does not happen easily, it is hard work, and requires time. Deegan (1998) described recovery as a journey of set backs, regrouping and starting again. Therefore, MHSWs set the platform for recovery by establishing a solid relationship based on trust that

is authentic, which will create the foundation to sustain the arduous journey of recovery that service users must take.

MHSWs have stated that what assists them to develop a relationship with service users is when they make an effort to understand them, particularly in terms of their recovery. Further, the relationship is strengthened when MHSWs are non-judgmental and do not overreact in a negative way to service users' mistakes and setbacks. Other ways, according to MHSWs, that help MHSWs build relationships with service users is by spending time with service users; getting to know them and learning how best to support their recovery. Furthermore, MHSWs have expressed that humour helps them connect with service users and is a way of helping service users cope in situations that are stressful or overwhelming.

MHSWs have additionally suggested that another way they can build on the foundation of their relationships with service users was by believing that recovery is possible and that service users have the potential to recover. Similar sentiments were shared by Torrey and Wyzik (2000) who declared that all people with a mental illness have potential to grow. Sometimes, this translates to MHSWs carrying the hope for service users when they are feeling overwhelmed and lack the energy or drive to initiate their recovery because the task is too daunting (Henderson, 2004). Moreover, MHSWs strengthen their relationships with service users, by demonstrating their concern for the welfare of those in their care. The importance of authentic relationships is paramount to building strong bonds between MHSWs and service users. In this way, service users feel secure and the relationship can sustain the challenges associated with the recovery process.

Young and Ensing (1999) noted that recovery is not a simple procedure; it requires energy, enthusiasm and momentum. Service users easily become discouraged when faced with the daily laborious tasks of goal setting, implementing plans and other recovery related activities. Motivation and momentum are vital to service users 'sticking' to recovery plans. MHSWs can provide the impetus for recovery to happen by establishing an environment that will keep service users motivated. Continuity of care is imperative, therefore, when MHSWs do not, or are unable to follow through on service users' plans, motivation and momentum is replaced by inertia, disrupting recovery plans and leaving service users disheartened.



Onken, et al., (2007) stated that recovery is “multidimensional, fluid, nonsequential and complex” (p. 10); however, one suggestion that may simplify the dynamic interactions associated with recovery is when MHSWs and service users have some clarity about their role in the recovery process.

### **The role of the MHSW in facilitating recovery**

Two global themes emerged from the comments of MHSWs when discussing their role in facilitating recovery. First, recovery requires multi-skilled, well-resourced MHSWs; and second, MHSWs are more able to advance service users’ recovery when MHSWs’ values correspond with the recovery philosophy.

Onken, et al., (2007) noted that recovery is a multi-facet complex phenomenon that requires the readiness of service users and the availability of multi-disciplinary teams. MHSWs, as indicated by their comments from the interviews and because of the nature of their occupation, spend more time with service users than other health workers. Their work requires them to assist service users with routine tasks as well as addressing complex needs and wants of service users. MHSWs also need to be well resourced so that they know what services and resources are available that will help service users’ recovery.

MHSWs have found that when their personal values are similar to the values associated with the recovery approach, they appear to be more successful in helping service users recover. This is because MHSWs often apply the recovery values instinctively and find the expectations of working in a recovery-oriented environment more in line with their style of practice.

#### *Global Theme One: Recovery requires multi-skilled, well-resourced MHSWs*

The global theme that MHSWs need to be multi-skilled and well-resourced was derived from the two organising themes, stating the importance of MHSWs spending time with service users, connecting with them and assisting them with their needs; together with MHSWs equipping service users to succeed.

A large portion of a MHSW’s time in the work place is spent face to face with service users. MHSWs are engaged in various tasks ranging in complexity, from cooking or shopping, to counselling and building rapport with service users.

MHSWs are, at times, the multi-disciplinary team. According to Cowan (2008) they are the occupational therapist that is, finding meaningful occupations or improving functionality. Furthermore, they are the psychologist, spending time with service users talking about their disappointments, hopes and dreams. Moreover MHSWs are the social worker ensuring that service users are accessing the resources they are entitled to receive.

In addition to spending time with service users and assisting them in their day-to-day living, another important function of MHSWs is equipping service users to succeed. According to Anthony (2000) the consequences of having a mental illness are often more devastating than the mental illness itself. These consequences include recovery from stigma associated with their condition; the side effects of treatment; lost opportunities for self-determination; the consequences of unemployment; and the disappointment of unfulfilled dreams (Anthony, 1993). Such consequences may leave service users feeling hopeless and shatters their confidence. MHSWs can reverse this process by building service users' confidence through instilling hope, by highlighting achievements, setting attainable goals and empowering service users with a skill set that is pertinent to the lifestyles they want to pursue.

MHSWs also reported that networking was an essential component to equipping service users to succeed. Networking is an effective way to reduce the negative consequences of having a mental illness as has previously been highlighted by Anthony (1993). Furthermore MHSWs can lessen service users' isolation and loneliness by informing them of peer support services. Moreover, MHSWs can source services that help service users find employment or prepare them to enter the job market. Networking is a way in which MHSWs can empower service users with a support system that will help service users to live successfully in the environment of their choice and maintain their wellness.

Thus the multiple roles that MHSWs need to fulfil, together with the need to be well informed regarding what resources are available and how to access them, means that a competent MHSW must be a Jack of all trades and a master of knowing what is out there.

*Global Theme Two: MHSWs are more able to advance service users' recovery when MHSWs' values correspond with the recovery philosophy*

Deegan (1998) described recovery as a lifestyle, an attitude and a way of approaching the day's challenges. Noordsy et al. (2002) spoke about recovery in terms of taking personal responsibility. MHSWs found that service users are more inclined to listen to them when MHSWs' lifestyles mirror the advice they give to service users. For example, when MHSWs teach the principle of budgeting and back it up with evidence from their personal lives, service users respond in the affirmative to their role modelling. In this way MHSWs are not only sending the message that they are genuine but they are also modelling the fundamental recovery value of taking personal responsibility for their lives (Torrey et al., 2005).

Farkas et al. (2005) asserted that recovery involved service users regaining lost roles or the establishing of new roles in their lives. Similarly, MHSWs bring their life's roles into their work. MHSWs may talk about what it means to be father to a service user trying to re-establish his role as a father, or what it means to be an employee.

Tooth et al. (2003) mentioned the importance of service users becoming actively involved in their recovery. One MHSW spoke about his active involvement in his son's life and the impact this had on their relationship as father and son. MHSWs are more at ease when working with service users, when their personal lifestyles incorporate the recovery values, for example, being actively engaged or striving to better one's life through change. Coursey et al. (2000) noted that staff member attitudes and values, that resemble the recovery narratives of service users, understand the critical impact their attitudes and values have on service users' recovery.

MHSWs who are flexible and/or adaptable are able to incorporate Deegan's (1998) philosophy that recovery cannot be predetermined; because recovery differs from person to person. Therefore, MHSWs who are comfortable working in a dynamic environment that requires creative thinking and variation are most suited for the unpredictable setting of recovery-oriented systems. Furthermore, MHSWs who can adapt to the different demands and unique recovery needs of service users, demonstrate the flexibility that will accommodate the core recovery value of choice, that is, according to Farkas et al. (2005), a fundamental prerequisite for recovery to take place and to flourish.

MHSWs who live the values associated with recovery and apply them in their own lives, bring a philosophy and an attitude that compliments rather than competes with the recovery approach. In contrast MHSWs who are rigid and uncomfortable with working in a fluid environment may find it difficult to roll with service users' unique recovery pathways. MHSWs who search for conformity within a system that 'manualise' operations may struggle (Davidson et al., 2007) with the propensity that service users' recovery has the tendency to unfold and evolve unpredictably over time (Deegan 1998).

### **Autonomy in relation to recovery**

The comments from the MHSWs indicated that autonomy could be controlled from different sources and at different levels of service users' lives. Corey, Corey and Callanan (as cited in Harnett & Greaney, 2008) associated the concept of autonomy with the right to self-governance and self-determination. More specifically, Harnett and Greaney (2008) refer to autonomy in the context of caring for people with diminished capacities as an individual's capacity to make rational decisions and to make choices while remaining free from coercive elements. Furthermore, MHSWs said that autonomy has a powerful influence in service users' lives, in that autonomy can either facilitate or impede service users' recovery.

#### *Global Theme One: Autonomy can be controlled from different sources and at different levels of service users' lives*

The MHSWs discussed that under certain conditions service users' autonomy is controlled externally. These external controls operate from different sources and at different levels, and have a bearing on service users' recovery. The participants reported that autonomy could be controlled on a systemic level, that is, the mental health legislation or the criminal law legislation or on an organisational level.

Interestingly, the participants did not mention that MHSWs could also control autonomy on an operations level. Nor did the MHSWs include the service users themselves, who can through their own limitations, such as in the case of learnt helplessness, accept their present circumstances and become resigned to the fact that they are unable to pursue their life's dreams because of their illness (Deegan, 1993). Fardella (2008) noted that service users sometimes see themselves only in terms of their symptoms and have difficulty believing that they can improve. However, even though these restrictions may act as a barrier to recovery, it

can also provide an interim period, that will enable service users time to prepare, in order to pursue higher levels of self-determination and self-governance (Harnett & Greaney, 2008).

*Global Theme Two: Autonomy has a powerful influence on service users lives and on their recovery*

According to the MHSWs, autonomy has the power to act as both a facilitator and a barrier to service users' recovery. The MHSWs understood autonomy in the context of recovery as service users' freedom to choose. Some MHSWs believed that the service user's readiness for autonomy would be the defining feature as to whether autonomy would be a barrier or a facilitator to their recovery.

The MHSWs shared that autonomy can be a barrier to recovery when autonomy is introduced too quickly or when it is inherited against the wishes of the service user, as in when service users come out of hospital and are moved into the community (Anthony, 1993; Krieg, 2001). Increasing service users' autonomy they are not ready, may result in service users making decisions that affect their wellness. For example, one MHSW shared the scenario of a service user leaving the service after two years, only to be re-hospitalised after six months of independent living. The MHSW believed that this was because the service user was left to make decisions without the support of his care team, which, ultimately, lead to a relapse of his mental state. Krieg (2001) made the point that many people with a mental illness are living in the community miserable and destitute and that some service users need treatment not only for their health but to survive. One MHSW shared that he had seen many people struggle, when coming out of hospital, to live in community. He believed that this is because while in hospital, choices were made for service users and they were therefore not prepared for an environment that allowed for greater use of autonomy. He felt that in these situations, service users are still brittle and vulnerable from years of hospitalisation. Therefore when power is handed to them at the wrong time, they do not know how to work with it. The MHSW said that this is because service users were not ready for it or the responsibilities associated with having to making choices. Thus, it is imperative, when intending to introduce or increase service users' autonomy, that health workers consult and negotiate with service users as to how this process can be done constructively and not to the detriment of service users' recovery.

Conversely, when service users consent to an increase of autonomy, then autonomy facilitates their recovery. It is essential that service users and health workers understand how vital autonomy is to recovery. It should be a focus of all recovery work, and given the complexities associated with the concept of autonomy, it is therefore more likely to aid recovery when guided by recovery values of agency, choice, consultation, and growth potential (Farkas et al., 2005).

The two organising themes from the MHSWs comments about what to do when service users do not use their autonomy constructively were first, that punitive consequences should follow; and second, service users should receive an increase in support. The diversity of these two organising themes is indicative of the varied opinions MHSWs have on how to address this issue in mental health. It also draws attention to the fact that how service users use their autonomy has a powerful impact on their lives and on their recovery.

The MHSWs proposed punitive suggestions ranged from reprimanding service users and taking away their autonomy to MHSWs not being sure what to do, while expressing that there should be some consequence. The MHSWs' remarks bring to light the reality that MHSWs hold a position of power. Fardella (2008) alludes to these positions of power in the practical every day occurrence of mental health workers completing support plans, assessments and risk management plans. He cautioned that mental health workers do not develop plans with their expert knowledge while discounting the patient's practical wisdom gained from the lived experience of their illness. Therefore, MHSWs make decisions on a daily basis that affects service users' autonomy, which ultimately affects service users' freedom and potential for recovery (Fardella, 2008).

MHSWs are, on the other hand, also in a position to greatly enhance service users' potential for recovery. MHSWs suggested that when service users do not use their autonomy constructively it may be a cry for help and MHSWs should respond by providing more support to service users. Similarly, MHSWs recognised that service users' poor use of autonomy may not be entirely their fault but the mental health system's failure to support them. This is because service users have not had sufficient support to provide the scaffolding to carry them, while learning how use their agency to promote their recovery.

MHSWs should also be cognisant of their own values in relation to the principle of autonomy and how this translates into their daily practice. Furthermore, MHSWs should have an awareness of the personal values of the many people responsible for service users and the systemic impact of different agencies that are ever present with service users. Engelhardt (2001) noted that, “patients, physicians and health care professionals can experience their lives within radically divergent moral narratives” (p. 284). When MHSWs acknowledge and accommodate these dynamics and seek an optimal balance of service users’ autonomy with the support they provide, then MHSWs position themselves best, to assist service users in their recovery.

### **Implication of Findings**

#### *MHSWs understanding of recovery*

A fundamental aspect of working within the recovery paradigm is that MHSWs work collaboratively with service users. However, within this collaborative framework the study has revealed that service users and MHSWs have distinct roles in aspects of the recovery process. MHSWs identified that part of service users’ recovery work involved defining what recovery means to them and regaining lost roles and/or the pursuing of new ones.

On the other hand, MHSWs identified that one of their own core roles was to ensure that they created the type of conditions at the work place that allow the service user’s recovery to happen. MHSWs said establishing relationships with a ‘can do’ optimistic attitude, sets the platform for service users recovery to take place. What also helps is when MHSWs maintain service users’ recovery momentum through continuity of care by making sure that service users’ plans are carried out.

Highlighting that MHSWs and service users have distinct roles in the recovery process, and making explicit what these roles are, will help MHSWs better understand what they can do to facilitate service users’ recovery. Moreover, organisations can adjust or incorporate training on this issue with current staff and make it a core component of the orientation package for newly employed staff. Davidson et al. (2007) recommended that organisations set up specific recovery oriented training to improve the staff’s competency as recovery guides.

### *The role of the MHSW in facilitating recovery*

The research undertaken in this thesis identified that MHSWs need to be multi-skilled and well resourced and that MHSWs are more able to advance service users recovery when their values are aligned with the recovery philosophies.

These from the thesis undertaken have implications for training and recruiting of staff. MHSWs have indicated that their work requires them to be proficient in many areas. MHSWs need to be competent in inter-personal skills while supporting service users in basic practical tasks. Further MHSWs proficiency would include addressing complex tasks and needs such as developing goal plans and counselling service users. In addition to this, MHSWs need to be well resourced, particularly with reference to networking. Being aware of what resources are available will mean that MHSWswill greatly enhance their ability to support service users' recovery.

According to the theme, MHSWs need to be multi-skilled and well resourced; the research suggests organisations need to attract people that place a high priority on their own education and personal development. Organisations should aim to recruit people that are both task and process orientated so that they are able to assist service users with both the practical and emotional aspects of their recovery.

MHSWs have indicated that they are more successful in advancing service users' recovery when their values are congruent to the recovery philosophy. In describing the support worker, Cowan (2008) reported, "A good heart is a good start" with reference to support worker's temperament in relation to their role (p. 44). The recovery values require MHSWs to be service user centred, hopeful, optimistic, empowering and non-judgmental (Davidson et al., 2006; Farkas et al., 2005; Jacobson & Curtis 2000; Lehman 2000; Torrey & Wyzik 2000). Therefore, according to Cowan (2008) and perspectives from the MHSW participants in this study, MHSWs who have a recovery oriented temperament are more able to assist service users in their recovery.

The MHSWs have indicated, from this study, that certain personalities are more conducive to working in a recovery-oriented environment. Does this mean that recovery-orientated organisations need to look at their recruiting processes and systems to examine



whether they are attracting people that will support the organisation's recovery vision? Organisations wanting to recruit certain personality types would need to look at the way they advertise, interview, and screen potential candidates for employment. On the other hand, potential challenges and/or barriers that could arise from the abovementioned recruiting process would be whether this could create exclusion. If so, there needs to be a way to negotiate between varying tensions including how a MHSW projects the recovery based values both in theory and practice. The above aspect was obtained from the interviews with MHSWs and was not derived from literature review, and is beyond the scope of this study.

#### *Autonomy in relation to recovery*

The research revealed that the MHSWs understood that the defining feature that would indicate whether service users' autonomy would be a barrier or a facilitator to recovery was service users' readiness for autonomy. MHSWs understood autonomy, as espoused by Engelhardt (2001) to mean freedom of choice, which in the context of this research meant allowing service users more latitude to make decisions over all aspects of their lives. Having stated this, MHSWs need to work closely with service users as to how best increase service users' latitude on autonomy. This may include, if available, the use of an autonomy readiness assessment (Crane-Ross, Lutz & Roth, 2006).

## **Critique**

#### *The researcher as the primary research instrument*

Kvale and Brinkmann, (2009) stated that the interviewer is the primary research instrument of an interview inquiry and that interviewers perfect their craft through practicing. They added that a good interviewer must be able to guide interviewees in their narratives and make spontaneous decisions about what to ask, what to follow up on, what to interpret and what to leave out. The researcher is aware in relation to the above statement of his novice status as an interviewer and how his inexperience may have impacted on the quality of the data collected. Furthermore Kvale and Brinkmann, noted that when a person conducting research becomes the main research instrument, as was the case in this research, the competencies, experience and expertise of the researcher is essential to the quality of the knowledge produced. The researcher is aware that his lack of experience, particularly with

regards to data collection, may have lead to the missing or glossing over of key information vital to the research topic.

#### *The researcher's own bias influencing the research*

The researcher who is a mental health worker himself, working in a recovery-oriented environment, brought to the research his own worldviews of recovery and values he believed should encompass the recovery process. Therefore, even though the researcher is aware of this, there is still the danger and tendency for the researcher to impose his worldviews and values that may influence the findings in the research. Jootun, McGhee and Marland (2009), referred to this as reflexivity, which is related to the “degree of influence that the researcher exerts, either intentionally or unintentionally, on the findings” in quality research (p. 42). To address this, the researcher arranged a pre-research interview (with ascholar/counsellor with a research interest in depression) to discuss with, and raise, his own awareness of his perceptions of recovery. The researcher found that his personal values were similar to the recovery values; however, the researcher discovered that there is a tendency for the researcher to be paternalistic. It was also highlighted that the researcher places a strong value on positive role modelling. Kvale and Brinkmann, (2009) stressed the importance of “reflexive objectivity” in that researchers are reflective about their contribution to the construction of research knowledge (p. 242).

#### *Location*

All the MHSWs opted to be interviewed in their work place and although this was convenient for both the interviewees and the researcher, conducting the interview in this setting meant that interviews were subject to a number of distractions and interruptions. As a result, there were times when the interviews had gained momentum and the interviewees were expressing their thoughts freely, that an interruption would break the momentum and the interviewees would loose their train of thought. The researcher is of the opinion that these distractions and interruptions may have interfered with the quality of the data collected and ultimately to the findings of the research. Additionally, having the interviews on site may have a bearing on the extent to which the participants were comfortable being completely honest as there was a possibility that they would be overheard.

### *Participants work for same organisation*

The researcher is aware of the possible limitations of the findings from this research in light of the fact that all the participants were employees of the same organisation.

Consequently, participants' views on recovery may have been influenced and shaped by the organisation's philosophy as taught and operationalised by the organisation's own model of recovery. Pascaris, Shields and Wolf (2008) noted that organisation philosophy and culture are designed to get staff thinking and working in a set way and are difficult to change.

Therefore the participants' views on recovery may be a reflection of one organisation's outlook and may not include the wider views of recovery in general. Furthermore, six of the eight participants, including the researcher, work in a forensic setting in mental health in which a high degree of the service users are under compulsory treatment orders. This specialised highly regulated area in mental health may have had some bearing on MHSW's perceptions of recovery given that often what service users are allowed or not allowed to do is regulated externally. In this way MHSW's perceptions of recovery are not only shaped by the organisation but also by the setting, as in this case a forensic setting.

### **Future Research**

The research revealed that MHSWs believe that those with a temperament and personality type that mirror the recovery values are more able to facilitate service users' recovery. Additional research around this topic could be beneficial. Moreover, it was recommended that for organisations to recruit the right people, and in this case, a particular personality type conducive to aiding recovery, organisations must look at its recruiting processes and systems. One way of recruiting certain personality types, whose values mirror the recovery values, is for organisations to use personality assessments in recruiting. However, perhaps it would be prudent to research and formulate a personality assessment tool designed to measure the congruency of a person's personality to those of the recovery values. As previously mentioned, there is a possibility that this might exclude MHSWs who do not present well in an interview but do hold the values of recovery. Further considerations relate to issues such as: (1) in the recruiting process which candidates would be required to undergo the personality test, in other words, is this test only for operational staff or all staff; (2) who would administer the tests; (3) who would interpret the results; and (4) what are the costs to the organisation in using the personality test in the recruiting process. The proposal of an

assessment tool was a result of the interviews with the MHSWs and requires further research, which is beyond the scope of this study.

Similarly, MHSWs referred to the importance of service users' readiness for autonomy, which was an essential indicator of the impact autonomy would have on their recovery. Deciding to increase service users' autonomy with the potential positive or negative impact this may have on a service users' recovery has enormous consequences to their recovery. Making this decision would involve the service users and other supporting staff, depending on the magnitude of the decision. In addition to following this process, service users and practitioners could benefit from the use of an autonomy readiness assessment tool in making these decisions. In this way service users and health workers can plan with the aid of an evidence-based tool, how best to use autonomy in facilitating service users' recovery.

Finally, in researching the connection between autonomy and recovery it was difficult to find literature on this specific topic. There is much research done on autonomy and its relation to mental health as well as its relation to ethics and coercion. However, there seems to be a dearth of research specifically in relation to autonomy and recovery. The mental health sector, service users, and health workers would benefit from research conducted specifically examining the connection of autonomy to recovery; given that agency is a core component of service users' recovery (Mancini, Hardiman & Lawson, 2005).

## **Conclusion**

MHSWs were asked to share their views of recovery, how they can foster service users' recovery in the work place, and the role of autonomy in service users' recovery. Although the roles of MHSWs and service users in fostering recovery overlap, MHSWs and service users also have distinct roles within the recovery process. For example, it is imperative that service users define what recovery means to them; however, it is equally important that MHSWs allow service users the freedom to do this, even though they may assist in the process. Furthermore, a key aspect of MHSWs role is that they engender a platform that will allow service users' recovery to flourish.

In order for MHSWs to foster service users' recovery, MHSWs need to be multi-skilled and well resourced. Moreover MHSWs are more able to advance service users' recovery when their values correspond with the recovery philosophy.

The research revealed that MHSWs believe that service users' autonomy is influenced on multiple levels from systemic influences within society and the mental health sector to an inter-personal level. In addition, autonomy was seen, as integral to service users' recovery; and MHSWs and service users, should work together to discover how to use autonomy to optimise service users' recovery.

## References

- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37, 586-594.
- Anthony, W.,A. (1991). Recovery from mental illness: the new vision of services researchers. *Innovations & Research*, 1(1), 13-14.
- Anthony, W.,A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.
- Anthony, W.,A. (2000). A recovery-orientated service system: setting some system level standards. *Psychosocial Rehabilitation Journal*, 24(2), 159-168.
- Attride-Stirling, J. (2001). Thematic networks: an analytical tool for qualitative research. *Qualitative Research*, 1(3), 385-405.
- Aubry, T. D., Flynn, R. J., Gerber, G., & Dostaler, T. (2005). Identifying the core competencies of community support providers working with people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 28(4), 346-353.
- Bradley, S., Hickey, N., Kramer, T., & Garralda, M. E. (2009). What makes a good CAMHS Primary Mental Health Worker? *Child and Adolescent Mental Health*, 14(1), 15-19.
- Briggs, C. (1986). *Learning how to ask: a sociolinguistic appraisal of the role of interview in social science research*. Cambridge: Cambridge University Press.
- Cardol, M., De Jong, B. A., & Ward, C. (2002). On autonomy and participation in rehabilitation. *Disability and Rehabilitation*, 24(18), 970-974.
- Coffey, D. S. (2003). Connection and autonomy in the case management relationship. *Psychiatric Rehabilitation Journal*, 26(4), 404-412.
- Coursey, R. D., Curtis, L., Marsh, D. T., Campbell, J., Harding, C., Spaniol, L. et al., (2000). Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal*, 23(4) 370-377.
- Cowan, C. (2008). *Supporting the journey of recovery in mental health*. Wellington: Dunmore Press.

- Crane-Ross, D., Lutz, W. J., & Roth, D. (2006). Consumer and case manager perspectives of service empowerment: Relationships to mental health recovery. *The Journal of Behavioural Health Sciences and Research*, 33(2), 142-155.
- Davidson, L., O'Connell, M., Tondora, J., Stryron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(5), 640-645.
- Davidson, L., Tondora, J., O'Connell, M. J., Kirk, T., Jr., Rockholz, P. & Evans, A. C. (2007). Creating a recovery-orientated system of behavioural health care: moving from concept to reality. *Psychiatric Rehabilitation Journal*, 31(1), 23-31.
- Deegan, G. (2003). Discovering recovery. *Psychiatric Rehabilitation Journal*, 26(4), 368- 376.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11-19.
- Deegan, P. E. (1993). Recovery and empowerment for people with psychiatric disabilities. *Social Work and Health Care*, 25, 11-24.
- Dickerson, F.,B. (2006). Disquieting aspects of the recovery paradigm. *Psychiatric Services*, 57, 647.
- Donalek, J. G. (2004). Phenomenology as a qualitative research method. *Urologic Nursing*, 24(6), 516-517.
- Engelhardt, H. T. (2001). The many faces of autonomy. *Health Care Analysis*, 9, 283-297.
- Fardella, J. A (2008). The recovery model: discourse ethics and the retrieval of self. *Journal of Medical Humanities*, 29(2), 111-126.
- Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidenced based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41(2), 141-158.
- Farkas, M., & Anthony, W. (2006). System transformation through best practices. *Psychiatric Rehabilitation Journal*, 30(2), 87-88.
- Farkas, M., Ashcraft, L., & Anthony, W. (2008). The 3Cs for recovery services. *Behavioral Healthcare*, 28(2), 27-27.
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, 36(6), 717-732.
- Gagne, C., White, W., & Anthony, W. A. (2007). Recovery: a common vision for

- the fields of mental health and addictions. *Psychiatric Rehabilitation Journal*, 31(1), 32-37.
- Gibson, C. H. (1993). Underpinnings of ethical reasoning in nursing. *Journal of Advanced Nursing*, 18, 2003-2007.
- Goodyear-Smith, F., & Buetow, S. (2001). Power issues in the doctor-patient relationship. *Health Care Analysis*, 9, 449-462.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness: long term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry*, 144, 727-735.
- Harnett, P. J., & Greaney, A. M. (2008). Operationalizing autonomy: solutions for mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing*, 15, 2-9.
- Henderson, H. (2004). From depths of despair to heights of recovery. *Psychiatric Rehabilitation Journal*, 28(1), 83-87.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: strategies emerging from the States. *Psychiatric Rehabilitation Journal*, 23(4), 333-341.
- Jootun, D., McGhee, G., & Marland G. R. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing Standard*, 23(23), 42-46.
- Kelly, M., & Gamble, C. (2005). Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 12, 245-251.
- Krieg, R.G. (2001). An interdisciplinary look at the deinstitutionalization of the mentally ill. *The Social Science Journal*, 38(3), 367-380.
- Kvale, S., & Brinkmann, S. (2009) *Interviews: learning the craft of a qualitative research interviewing*. Los Angeles: Sage.
- Lawrence, J. (2004). Mental health survivors: your colleagues. *International Journal of Mental Health Nursing*, 13, 185-190.
- Lehman, A., F. (2000). Putting recovery into practice: a commentary on "What recovery means to us". *Community Mental Health Journal*, 36(3), 329-331.
- Lester, H., & Gask, L. (2006). Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? *British Journal of Psychiatry*, 188, 401-402.
- Lunt, M. (2002). A theory of recovery. *Journal of Psychosocial Nursing and Mental Health Services*, 40(12), 32-47.



- Mancini, M. A., Hardiman, E. R., & Lawson, H. A. (2005). Making sense of it all: consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 29(3), 48-55.
- Meehan, T. J., King, R.,J., Beavis, P.,H., & Robinson, J.,D. (2008). Recovery-based practice: do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry*, 42(3), 177-182.
- Mental Health Commission. (2001). *Recovery competencies' for New Zealand mental health workers*. Wellington, New Zealand: Author.
- Mental Health Commission. (2007). *Te Haererenga mo te Whakaooranga 1996-2006*. Wellington, New Zealand: Author.
- Mental Health Commission. (2007). *Te Hononga 2015. Connection for greater well-being*. Wellington, New Zealand: Author.
- Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C., & Fox, L. (2002). Recovery from severe mental illness: an intrapersonal and functional outcome definition. *International Review of Psychiatry*, 14, 318-326.
- O'Connell, M., Tondora, J., Croog, G., Evans A., & Davidson, L. (2005). From rhetoric to routine assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 28(4), 378-386.
- Onken, S. J., Craig, C.,M., Ridgway, P., Ralph, R. O., & Cook, J.,A. (2007). An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal*, 31(1), 9-22.
- Pascaris, A., Shields, L. R., Wolf, J. (2008). The work and recovery project: changing organisational culture and practice in New York City outpatients services. *Psychiatric Rehabilitation Journal*, 32(1), 47-54.
- Peters, M., Abu-Saad, H. H., Vydellingum, V., & Murphy, M. (2002). Research into headache: the contribution of qualitative methods. *Headache: The Journal of Head & Face Pain*, 42(10), 1051-1059.
- Ralph, R.O. (2004). Visual definitions and visual models of recovery: focus on the recovery model. In R. O. Ralph & R. W. Corrigan (Eds.), *Recovery in mental illness: broadening our understanding of wellness* (pp. 131-146). Washington. DC: American Psychological Association.
- Repper, J. (2000). Adjusting the focus of mental health nursing: incorporating service users' experience of recovery. *Journal of Mental Health*, 9(6), 575-587.
- Roe, D., Rudnick, A., & Gill, K. J. (2007). The concept of "Being in Recovery"

- Psychiatric Rehabilitation Journal*, 30(3), 171-173.
- Rothman, D. J. (2001). The origins and consequences of patient autonomy: a 25-year retrospective. *Health Care Analysis*, 9, 255-264.
- Roulston, K. (2001). Data analysis and theorizing as ideology. *Qualitative Research*, 1(3), 279-302.
- Saadah M. A. (2002). 'On autonomy and participation in rehabilitation'. *Disability and Rehabilitation*, 24(18), 977-982.
- Spaniol, L (2000). Cautions in implementing models of recovery. *Psychiatric Rehabilitation Journal*, 23(3), 213-214.
- Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal*, 29(4), 311-313.
- Tooth, B., Kalyanasundaram, V., Glover, H., & Momenzadah, S. (2003). Factors consumers identify as important to recover from schizophrenia. *Australasian Psychiatry*, 11, Supplement, 70-77.
- Torrey, W. C., & Wyzik, P. (2000). The recovery vision as a service improvement guide for community mental health center providers. *Community Mental Health Journal*, 36(2), 209-216.
- Torrey, W. C., Rapp, C. A., Van Tosh, L., McNabb, C. R. A., & Ralph R. O. (2005). Recovery principles and evidence-based practice: essential ingredients of service improvement. *Community Mental Health Journal*, 41(1), 91-100.
- Vishnevsky, T., & Beanlands, H. (2004). Interpreting research in Nephrology nursing. *Nephrology Nursing Journal*, 31(2), 234-238.
- Vivar, C. G., McQueen, A., Whyte, D. A., & Armayor, N. C. (2007). Getting started with qualitative research: developing a research proposal. *Nurse Researcher*, 14(3), 60-73.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.
- Young, S.,L., & Ensing, D. S. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 22, 210-231.

## Appendix A



# MEMORANDUM

## Auckland University of Technology Ethics Committee (AUTEC)

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To: Kate Diesfeld  
From: **Madeline Banda** Executive Secretary, AUTEC  
Date: 30 January 2009  
Subject: Ethics Application Number 09/03 **Mental Illness and Recovery: A Mental Health Support worker's Perspective.**

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Dear Kate

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 19 January 2009, subject to the following conditions:

1. Use of an independent third party to manage the recruitment and consent processes and provision of a revised response to section D.2.1 reflecting this;
2. Provision of a revised response to section E.4 of the application. This should include reference to a number of ethical risks involved in this study such as insider research and confidentiality;
3. Provision of an assurance that the organisation named in the response to section A.6.2 has no role in the research other than being the organisation in which the research is being undertaken;
4. Amendment of the Information Sheet as follows:
  - a. Careful checking of the spelling and grammar;
  - b. Revision of the wording to reduce the overly persuasive tone of the language (e.g. '...it provides an opportunity for sound reflective practice' in the section titled 'What are the discomforts...');
  - c. Alteration of the Information Sheet to reflect the response to the first condition above regarding the use of an independent third party.

AUTEC suggests that the title of the research may be better if the phrase 'from the eyes of' was replaced by something like 'as observed by' or 'in the perception of'.

I request that you provide the Ethics Coordinator with a written response to the points raised in these conditions at your earliest convenience, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires written evidence of any altered documents, such as Information Sheets, surveys etc. Once this response and its supporting written evidence has been received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application.

When approval has been given subject to conditions, full approval is not effective until *all* the concerns expressed in the conditions have been met to the satisfaction of the Committee. Data collection may not commence until full approval has been confirmed. Should these conditions not be satisfactorily met within six months, your application may be closed and you will need to submit a new application should you wish to continue with this research project.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [charles.grinter@aut.ac.nz](mailto:charles.grinter@aut.ac.nz) or by telephone on 921 9999 at extension 8860.

Yours sincerely

Madeline Banda  
Executive Secretary

Auckland University of Technology Ethics Committee

Appendix B



# Confidentiality Agreement

*For a data analysis rater.*

*Project title: Mental Illness and Recovery: A Mental Health Support Worker’s Perspective*

*Project Supervisor: Kate Diesfeld*

*Researcher: Paulo Bisogno*

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- I understand that all the material I will be asked to review/analyse is confidential.
- I understand that the contents of the Consent Forms, tapes, or interview notes can only be discussed with the researchers.
- I will not keep any copies of the information nor allow third parties access to them.

Interrater’s signature: .....

Interater’s name:  
.....

Interrater’s Contact Details (if appropriate):  
.....  
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.....  
.....

Date:

Project Supervisor’s Contact Details (if appropriate):  
.....  
.....  
.....

***Approved by the Auckland University of Technology Ethics Committee on 7 April 09  
AUTEK Reference number 09/03 Note: The Intermediary should retain a copy of this form.***

## Appendix C

# Participant Information Sheet



### **Date Information Sheet Produced:**

23 March 2009

### **Project Title**

Mental Illness and Recovery: A Mental Health Support Worker's Perspective.

### **An Invitation**

My name is Paulo Bisogno and I am a Psychology Masters student at AUT University. I am currently employed by Challenge Trust as a mental health professional. In order to graduate as a Masters student, I am required to design and submit a research project. I have chosen the topic of recovery because I believe the research aims to explore mental health support workers understanding of recovery. Also, I hope it may eventually contribute to clearer definitions that underpin policies and services. I have invited mental health support workers because I believe you have a vital role to play in facilitating the transition to more recovery-based services in New Zealand.

Your participation will be strictly voluntary and you may withdraw at any stage without any adverse consequences.

### **What is the purpose of this research?**

The purpose of this research is to gain a better understanding of recovery from your perspective, based on your work experiences. I will present the findings of the research at a public forum at the university as part of the requirements for the Masters program. I may present findings at a conference and publish an article in a journal. The research is a requirement for graduation from the Masters program.

### **How was I chosen for this invitation?**

You have been chosen to participant in this research because you have worked as a mental health support worker in the past year in a recovery-based service. You were also chosen because a high proportion of your work time is dedicated to face-to-face work with service users; therefore I am interested in your views of recovery.

A case manager from the clinical team would have initially approached you with this criterion in mind, to invite you to participate in this research project. I, or any Challenge Trust staff members, were intentionally excluded from personally approaching candidates to alleviate any pressure candidates may have felt, from a direct invitation.

### **What will happen in this research?**

You will be invited to talk about your experience of working in a recovery-based mental health service through semi-structured qualitative interviews. Interviews will take place either at the work place, provided the venue allows for privacy with no interruptions, or at AUT Akoranga campus interview rooms.

The Cultural Advisor/Manager and Kaumatua for Challenge Trust will accompany me, if requested, with the initial stages of the research for Maori participants. Semi-structured interviews will be in the form of the researcher asking you a few simple questions such as, "What does recovery mean to you?" etc. Your individual audiotaped material will be typed up (transcribed), and then you will be given the opportunity to sit down with me and review the transcribed material

individually. This will give you the opportunity to check the accuracy of the material and to make any changes you request, including removing any content you feel will disclose your identity. Also, in order to increase research reliability and accuracy of data interpretation an additional person will be invited to analyse interview material.

**What are the discomforts and risks?**

Potentially there may be psychological and emotional risks when talking about your work experiences. In addition, you may feel embarrassed or become self-conscious because we are work colleagues.

**How will these discomforts and risks be alleviated?**

If participants request counselling, up to three free counselling sessions will be offered at the AUT counselling service. Counselling service will be provided on the North Shore Campus, 921 9998, at room AS104.

**What are the benefits?**

This research project could help me understand recovery from the mental health support worker's perspective and provide potential recovery strategies for further research and practice developments in mental health services. It also provides an opportunity for you to share your knowledge of your experiences in the work place.

**What compensation is available for injury or negligence?**

N/A

**How will my privacy be protected?**

All participants will be referred to with fictitious names in the final report. Written interview material will be stored at AUT University in the Psychology lab in locked filing cabinets. Computer storage of interview material on researcher's computer will have password protection. Fictitious code names will be used of individual's interviews on data files. Your consent forms will also be stored at AUT University in the Psychology lab in locked filing cabinets, which will be separate from interview data storage.

**What are the costs of participating in this research?**

Participant's time will be the main cost; initial interviews will take approximately one to one and a half hours. This will be followed by (at a later stage) the researcher going over the transcribed material, which would take another one hour. In addition, if participants want to, researcher will share final report either on an individual bases or as a group. This may take approximately 30 minutes to an hour.

**What opportunity do I have to consider this invitation?**

You will be given one week from the time the case manager from the clinical team approaches you to make a decision. Remember participation is voluntary and you may withdraw without consequence as a participant at any stage of the project even though you may have signed a consent form. If you wish to withdraw you may approach the case manager, or the Challenge Trust Team Leader or me. You are welcome to contact the project supervisor, Associate Professor Kate Diesfeld, or me to clarify or rectify any concerns.

**How do I agree to participate in this research?**

After a case manager from the clinical team has approached you, and you have signed the consent form agreeing to participate, I will meet with you for orientation and to answer your questions. However, even though you have signed a consent form you are allowed to withdraw as a participant at any stage of the research project.

**Will I receive feedback on the results of this research?**

Yes, if you want it. I'll review the transcriptions of your interview with you. A copy of the research project will be available electronically and you may also access a copy at the AUT University 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 Supervisor, Kate Diesfeld, [kate.diesfeld@aut.ac.nz](mailto:kate.diesfeld@aut.ac.nz), 921 99999 ext 7799.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, [madeline.banda@aut.ac.nz](mailto:madeline.banda@aut.ac.nz), 921 9999 ext 8044.

**Whom do I contact for further information about this research?**

**Researcher Contact Details:**

Paulo Bisogno. Contact number: 838 4822 (work) Contact hours: 15:00 to 23:00

**Project Supervisor Contact Details:**

Associate Professor Kate Diesfeld. Contact number: 921 9999 ext 7799

Approved by the Auckland University of Technology Ethics Committee on *23 March 2009*, AUTEK Reference number *09/03*.

## Appendix D

### Practice Research Project/Masters Thesis

#### Mental Illness and Recovery: A Mental Health Support Worker's Perspective

##### Research Interview Questions

I would like you to think about the recovery of the people (service users) you work with as we go through the interview.

1. What has worked well when working with service users in their recovery?
2. What has not worked well when working with service users in their recovery?
3. Based on your experience, what has been helpful for service user's recovery?
4. Based on your experience, what has been less helpful for service user's recovery?
5. How would you summarise the concept of recovery?
6. What is your understanding of your role as a support worker in the recovery process when working with service users?
7. What makes a good recovery mental health support worker?

**One of the core principles of recovery is the process of handing power back to service users and allowing them more autonomy.**

8. Do you see autonomy as a barrier or a facilitator of recovery?
9. When autonomy is not used wisely, how do you negotiate the tension between autonomy and power sharing?



Appendix E  
**Consent Form**

For use when interviews are involved.



*Project title: Mental Illness and Recovery: A Mental Health Support Worker’s Perspective*

*Project Supervisor: Kate Diesfeld*

*Researcher: Paulo Bisogno*

- I have read and understood the information provided about this research project in the Information Sheet dated 23 March 2009.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that the researcher’s analysis of data will be compared with a third party’s analysis to enhance data interpretation and research reliability.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to have access to the report from the researcher (please tick one): Yes  No

Participant’s signature: .....

Participant’s name: .....

Participant’s Contact Details (if appropriate):  
.....  
.....  
.....

Date:

*Approved by the Auckland University of Technology Ethics Committee on 7 April 09 2009  
AUTEK Reference number 09/03*

## Appendix F



Clinical Director  
The Recovery Foundation  
PO Box 259 352  
Greenmount  
2141  
Auckland

16/12/ 2009

Mr Paulo Bisognio  
95 Bruce McClaren  
Henderson  
0612

Dear Paulo,

**Re: Request for Challenge Trust Approval to Complete Research.**

Referring to your previous discussions you had with the then Regional Manager and General Manager Operations, around doing a research project and the positive indications given at this time. I understand you now require a letter confirming the organisation has provided approval for the research.

I understand the staff have been approached and have voluntarily engaged in your research initiative. Thank you for providing me with copies of the informed consent for those staff who agreed to participate.

Please accept this letter as confirmation of Challenge Trust's support and approval of your research in regards to the "Mental Illness and Recovery – A Mental Health Support Workers Perspective"

Kind Regards



Dianne Bartlett  
Clinical Director/Special Projects  
The Recovery Foundation

Appendix G

# Confidentiality Agreement



*For someone transcribing data, e.g. audio-tapes of interviews*

Project title:           **Mental Illness and Recovery: A Mental Health Support Worker’s Perspective**  
Project Supervisor:   **Kate Diesfeld**  
Researcher:           **Paulo Bisogno**

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- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber’s signature : .....

Transcriber’s name: .....

Transcriber’s Contact Details (if appropriate):  
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Date:

Project Supervisor’s Contact Details (if appropriate):  
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***Approved by the Auckland University of Technology Ethics Committee on 23 March 2009***  
***AUTEC Reference number 09/03***

*Note: The Transcriber should retain a copy of this form.*