THE UNIVERSITY OF HULL

Recovery Oriented Services:
Strategies and Barriers

being a Thesis submitted for the Degree of
Doctor of Clinical Psychology

in the University of Hull

by

Leah Talbot
BSc (Psychology)

July 2008

Acknowledgements

I would like to take this opportunity to thank a number of people who have helped me throughout this process. Firstly I would like to thank Sue, whose belief in the study, and indeed my capabilities, has nurtured my already existing enthusiasm for the subject. Her support and guidance has been invaluable throughout the process. I would also like to thank all the participants who have taken part in the study. Their rich contributions have enabled me to produce a piece of work that I am proud of, and their warm welcomes made the recruitment process a pleasure.

I would like to thank my family and friends for their endless support, not just over recent times, but over the past six years. Although my family are further away than they would like, their constant words of encouragement have helped me in more ways than they could ever realise. Finally, I would like to thank Mark, whose unwavering tolerance and ability to dissipate my frustration is remarkable. He has been a consistent source of strength throughout this process.

Contents

Overview

The conceptualisation of severe mental health difficulties is currently undergoing a change. Positive outcomes of longitudinal studies, and increased publications of personal narratives describing recovery from schizophrenia, have paved the way for the development of the recovery model. This model emphasises that the nature of recovery should be defined by each individual themselves, rather than be based on the perceptions of professionals. It also suggests that recovery is about recreating a meaningful and satisfying life, whether that is with or without symptoms. This portfolio thesis is presented in three parts including a literature review, and empirical paper, and a set of appendixes.

The first section of the portfolio is a systematic literature review focusing on the role of hope in recovery from psychosis. An introduction to the transformation of the conceptualisation of schizophrenia, and the importance of understanding hope is presented. This is followed by the methodology used to conduct the literature review. Themes that arise from the review are presented, and a discussion of how hope influences the recovery process follows. The paper highlights the importance of nurturing hope in individuals who experience psychosis.

The second part of the portfolio presents an empirical study examining the experiences of staff working in a recovery oriented service. The study describes the re-conceptualisation of recovery, and highlights policy documents which are encouraging the implementation of recovery oriented practices. Organisational change literature is presented to highlight factors to be considered when transforming services. A qualitative approach was used in order to understand the experiences of staff, with a particular focus on what they found helped and hindered them in providing such a service. Themes from the interviews are presented, and highlight a number of factors which need to be considered in relation to implementing a recovery model.

The final section of the portfolio is a set of appendixes which support the previous sections and includes a statement which reflects upon the process of the research.

Part One

Systematic Literature Review:

The Role of Hope in Recovery from Psychosis

Abstract

Purpose: To gain an understanding of the role of hope in making a recovery from psychosis.

Methods: Various online databases were searched using a range of key words and phrases. In order to be included, studies met a number of criteria including; being primary sources of qualitative, quantitative or mixed design; either a conceptualisation of recovery as a process or a goal, or a description of components which assist recovery or the development of hope in psychosis; and be published in English language, in a peer reviewed journal between 1980 and 2008. Thematic analysis was used to synthesise data extracted from the papers.

Results: The main components identified as important in recovery included; having hope, being involved in relationships, being able to live independently and adequately, experiencing achievement, having spirituality, increased self esteem, having knowledge and control, managing symptoms, and developing a meaningful narrative. Hope is an important factor in recovery in its own right, and also has a role in many of the other factors involved in recovery.

Conclusion: It appears that hope is a motivating factor which begins the process of recovery, and is strengthened within relationships or by spiritual beliefs. As the process of recovery progresses, hope enables service users to begin to engage in other elements of the recovery process such as engaging in meaningful activities and living independently. These activities in turn reinforce hope. It is imperative that mental health professionals promote hope for the future, and identify ways to nurture hope within service users.

The Role of Hope in Recovery from Psychosis

Within mental health services, the medical model is the dominant language of discourse. Within this model, schizophrenia is conceptualised as a chronic and debilitating illness which leaves people diagnosed with schizophrenia consigned to a life of hopelessness and deteriorating future (Kruger, 2000). This is exemplified by the DSM-IV-TR (American Psychiatric Association, 2000), which states that “complete remission…is probably not common in this disorder” (p 309). It has been reported that if an individual recovers from schizophrenia, rather than it being celebrated, an initial misdiagnosis is concluded (Fisher, 2003; Kruger, 2000).

Previous research has often focused on individuals with a diagnosis of schizophrenia, recruited from convenience samples from an inpatient environment (Loughland, et al., 2004). The population of those diagnosed with schizophrenia but who were able to live successfully in the community, with little contact with mental health services, were rarely a focus. This bias in research methodology has perpetuated the idea of schizophrenia as a chronic illness with little hope for the future. However, more longitudinal research has provided a more optimistic picture. Harding, Zubin and Strauss (1987) undertook a review of five longitudinal studies of individuals with schizophrenia, and the number who fully recovered or significantly improved over time, was much greater than originally believed.

Over recent years, schizophrenia and recovery have begun to be conceptualised in new ways. Researchers and clinicians have critiqued the discourse of the medical approaches to psychosis, and questioned the effect of a diagnosis of schizophrenia (May, 2000; Rudge & Morse, 2001). The less value laden term ‘psychosis’ has come to be used instead; an episode of psychosis has fewer connotations of permanency and debilitation. This new dialogue has allowed the existence of hope for recovery in psychosis.

Within the traditional models, recovery from schizophrenia is often conceptualised as a cessation of symptoms. During the 1980s and 1990s, many individuals who had lived through severe mental illness published their accounts of illness and recovery (for example Deegan, 1996; Leete, 1989). This new emergence of literature combined with the longitudinal evidence for recovery has led to the re-conceptualisation of recovery as something more than the cessation of symptoms. The recovery model often describes recovery as a process rather than an outcome (Frese & Walker Davis, 1997). At present there is no clear consensus of a definition of recovery, however one definition that is commonly used within the recovery literature is from Anthony (1993) who described it as:

> …a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 13)

Hope has been widely reported as important in recovery from various illnesses including cancer (for example Chi, 2007; Ebright, 2002) and heart failure (for example Rustoen, Howie, Edismo, & Moum, 2005), and has been defined by Miller and Powers (1988) as:

> …a state of being characterised by an anticipation for a continued good state, an improved state, or a release from perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future which is good, based on mutuality (relationships with others), a sense of personal competence, coping ability, psychological wellbeing, purpose and meaning in life and a sense of the "possible". (p. 6)

It has been reported that more than one in ten individuals with severe mental illness will take their own lives (Department of Health, 1999). It has long been known that the degree of suicidal intent is strongly related to hopelessness (Beck, Steer, Kovacs, & Garrison, 1985). Miller (1985) reports that “hope is the salient quality of the ‘survivor’ attitude” (p. 23) and suggests that hope is essential to protect against the physical and mental impact of despair.

Historically the dominant conceptualisation of schizophrenia was as a biological illness with minimal possibilities of recovery, therefore nurturing hope may not have been previously considered to be an important element of care for this client group. However, hope was emphasised as an important element in recovery by consumer-survivors who wrote about their experiences of psychosis (Deegan, 1996; Murphy, 1998). Deegan (1988) reports that hope is one of the “three cornerstones of recovery” (p. 14), along with willingness and responsible action, and that without hope there is a struggle to visualise a future. Jacobson and Curtis (2000) suggest hope allows individuals to believe that change is possible, and that their lives can and will be different.

Kylmã, Juvakka, Nikkonen, Korhonen and Isohanni (2006) reviewed the literature on hope in schizophrenia, but limited the search terms to the diagnostic label “schizophrenia”. This would have precluded literature which does not use medical model dialogue, and instead prefers to use the terms “psychosis” or “severe or serious mental illness”. This literature review seeks to summarise the current literature relating to the role of hope in making a recovery from psychosis. Its aim is to ensure the inclusion of work from a variety of perspectives, and integrate a body of knowledge.

Method

Search Strategies

A systematic search of electronic databases was undertaken between November 2007 and March 2008. A number of databases were searched in order gain access to a range of journals from multiple disciplines. The journals searched were CINAHL, PsychINFO, PsychARTICLES, Pubmed and Medline. Terms used for the search included; ‘hope’; ‘recovery’; ‘schizophreni*’; ‘psychosis’; ‘severe mental illness’; and ‘serious mental illness’. Reference lists of included papers were searched for additional articles, relevant journals were browsed and the researcher discussed the research with experts in the field.

Study Selection Criteria

In order to be included, studies were required to meet five criteria;

1. Papers must be primary sources of qualitative, quantitative or mixed design studies.
2. They must include either a conceptualisation of recovery as a process or a goal, describe the components which assist recovery, or suggest factors which assist the development of hope in psychosis.
3. Papers must be published in peer reviewed journals.
4. Papers must be published between 1980 and 2008.
5. Papers must be printed in English language.

As a result of the search strategies, a total of 1429 references were identified, 649 of those were duplicates. Of the remaining 780 references, it was apparent from the title or abstract that 699 were not appropriate for inclusion. Reasons why those papers were not incorporated into the literature review included; not being related to psychosis, did not discuss recovery or hope, the studies primarily focused on the use of medication, or were letters or book reviews. The full text of 81 papers were obtained for further scrutiny, and as a result, 63 articles were rejected and 18 included in the literature review. Reasons for exclusion of papers are detailed in Table 1.

Table 1.

Studies excluded.

Exclusion Criteria	Number
Literature review	7
Discussion paper	21
Secondary sources	2
Duplicate publication	2
Narrative	8
Development of a measure	4
Does not include a conceptualisation of recovery or elements that help the process of recovery or hope.	19
Total	63

The reference lists of the 18 papers which met the inclusion criteria were searched, which produced a further two articles. In total, 20 articles were included in the literature review, this includes 17 qualitative study, two quantitative studies and one study with a mixed design. Table 2 displays a summary of the included papers.

Study quality assessment

The papers identified as suitable were assessed for quality using the methodology checklist for qualitative studies from the NICE guidelines (National Institute of Health and Clinical Excellence, 2007) and Fowkes and Fulton’s (1991) Guidelines and Checklist for Appraising a Medical Article for quantitative studies. All studies are of sufficient standard to be included in the review, and comments on methodological concerns can be found in Table 2.

Table 2

Summary of papers included in the literature review.

Author / Date	Main aim of study	Participants	Method	Comments
Borg & Kristiansen (2004)	To identify characteristics of relationships which assist recovery.	15 participants; mixed diagnosis related to psychosis; 53% male; ages 19-63.	Qualitative interviews; thematic analysis.	Limitations of the study not reported.
Bradshaw, Armour & Rosenborough (2007)	To understand the process of recovery.	44 participants; mixed diagnosis including schizophrenia and bipolar; 32% male; mean age 37.	Semi-structured interviews 60-120 minutes; thematic analysis.	Mixed diagnoses.
Bradshaw, Rosenborough & Armour (2006)	To describe the lived experience of recovery.	44 participants; mixed diagnosis including schizophrenia and bipolar; 32% male; mean age 37.	Semi-structured interviews 60-120 minutes; thematic analysis.	Inadequate discussion of limitations of the study. Mixed diagnoses.

Table 2 continued

Summary of papers included in the literature review.

Author / Date	Main aim of study	Participants	Method	Comments
Corrigan, Slopen, Gracia, Phelan, Keogh & Keck (2005)	To provide a consumer developed description of recovery.	57 participants who took part in a GROW program.	Interviews, 120 minutes. Thematic analysis.	Recruitment strategy unclear. Limitations and ethical issues inadequately reported.
Darlington & Bland (1999)	To explore how staff encourage hope.	12 participants; 6 mental health workers, 6 service users diagnosed with schizophrenia.	Semi-structured interviews 30-60 minutes; thematic organisation.	Content of interview not specified, rigour of analysis unclear, limitations of the study not reported.
Davidson, Borg, Marin, Topor, Mezzina & Sells (2005)	To determine common elements of recovery from psychosis.	12 participants with psychosis; 42% male; age 29-55.	Open ended narrative interviews; thematic analysis.	Recruitment strategy unclear. Limitations of the study not reported.

Note: GROW is a mutual support program for individuals recovering from serious mental illness.

Table 2 continued

Summary of papers included in the literature review.

Author / Date	Main aim of study	Participants	Method	Comments
Forchuk, Jewell, Tweedell & Steinnagel (2003)	To describe the experience of recovery from psychosis.	10 participants with psychosis; 70% male, ages 26-35 years.	9 interviews with each participant, thematic analysis.	Limitations and ethical considerations not reported.
Kirkpatrick, Landeen, Byrne, Woodside, Pawlick & Bernardo (1995)	To understand staff perspective of the relationship between hope and schizophrenia.	15 staff members, mixed disciplines.	Interviews 45 minutes; thematic analysis	Rigour of analysis unclear, ethical considerations and limitations of the study not reported.
Kirkpatrick, Landeen, Woodside & Byrne (2001)	To examine perceptions of hope in individuals with schizophrenia.	10 participants diagnosed with schizophrenia; 80% male, mean age 34.7 years.	Semi-structured interviews, 49-50 minutes, thematic analysis.	Rigour of analysis unclear, ethical considerations and limitations of the study not reported.

Table 2 continued

Summary of papers included in the literature review.

Author / Date	Main aim of study	Participants	Method	Comments
Laithwaite & Gumley (2007)	To determine factors forensic population consider important in recovery.	13 participants diagnosed with schizophrenia or bipolar disorder; 92% male; ages 22-60.	Unstructured interviews 60-90 minutes; analysed by Grounded Theory.	Forensic population; possible differences in perceptions of recovery and hope.
Landeen, Pawlick, Woodside, Kirkpatrick & Byrne (2000)	To examine hope in individuals with schizophrenia.	55 participants diagnosed with schizophrenia; 75% male; ages 19-47.	Correlational study using variety of measures; stepwise multiple regression analysis.	Limitations of the study inadequately reported.
McCann (2002)	To describe how nurses assist hope.	41 participants; 9 clients, 8 family members, 24 community nurses.	Unstructured interviews, 60 - 90 minutes and participant observations; thematic analysis.	Results and discussion intertwined, unclear if conclusions derived from data obtained. Limitations not addressed.

Table 2 continued

Summary of papers included in the literature review.

Author / Date	Main aim of study	Participants	Method	Comments
Perry, Taylor & Shaw (2007)	To explore personal experiences and influences on hope.	5 participants diagnosis of psychosis, 100% male, aged 19-35.	Semi-structured interviews 35-90 minutes. Analysed using IPA.	Participants restricted to younger aged males.
Pitt, Kilbride, Nothard, Welford & Morrison (2007)	To define the experience of recovery from service user perspective.	7 participants with experience of psychosis; 71% male; ages 18-65.	Semi-structured interviews, 45-65 minutes. Analysed using IPA.	Ethical considerations not reported.
Resnick, Fontana, Lehman and Rosenheck (2005)	To conceptualise the recovery orientation.	1076 participants from the PORT survey; schizophrenia diagnosis; aged over 18.	Reviews data from PORT study; principle component and confirmatory factor analysis.	No methodological concerns
Spaniol, Wewiorski, Gagne & Anthony (2002)	To describe the process and dimensions of recovery.	12 participants, schizophrenia diagnosis, 50% male, ages 30-53.	Longitudinal; interviews over 4 years; thematic analysis.	Ethical considerations not reported.

Note: IPA = Interpretive Phenomenological Analysis. PORT = Schizophrenia Patient Outcomes Research Team (PORT) Client Survey.

Table 2 continued

Summary of papers included in the literature review.

Author / Date	Main aim of study	Participants	Method	Comments
Sullivan (1994)	To begin to understand the recovery process.	46 participants; mixed diagnosis primarily schizophrenia.	Semi-structured interviews 60 minutes; thematic analysis	Rigour of data analysis is unclear.
Thornhill, Clare & May (2004)	To explore narratives of recovery from psychosis.	15 participants; mixed diagnosis of psychosis; 40% male; ages 30-60.	Interviews between 40-90 minutes; narrative analysis.	Ethical considerations not reported.
Torgalsboen (2001)	To report what individuals and therapists found helpful in treatment.	60 participants; 50 clients recovered and non recovered 60% male, mean age 37 years; 10 participants 50% male.	Semi-structured interview, GAS, UCLA SASSPAS. Correlational and cross tab analysis.	Potential ethical issues not adequately reported. Unclear how interview was analysed.
Young & Ensing (1999)	To develop a model of recovery.	18 participants; diagnosed with severe mental illness, including schizophrenia and bipolar	Semi-structured interviews for 90 minutes; grounded theory.	Mixed diagnosis. Limitations and ethical considerations not reported

Note: GAS = Global Assessment Scale; UCLA SASSPAS = UCLA Social Attainment Survey Premorbid Adjustment

Critical Appraisal

Conducting the quality assessment of the papers highlighted that the included studies are not all of equal quality. Some of the criteria included in the quality checklists was absent from the articles. One criterion regarded the rigour of the analysis. In a number of the included papers, the analysis of data was not described in detail (Darlington & Bland, 1999; Kirkpatrick et al 1995; Kirkpatrick et al 2001; Sullivan, 1994; Torgalsboen, 2001). This does not necessarily mean that the analysis was flawed, but it is not possible to be certain about the quality of the analysis due to the lack of information.

A description of the recruitment strategy was also absent in several articles (Corrigan et al 2005; Davidson et al 2005). Recruitment of individuals with severe mental health problems is fraught with difficulties from a methodological perspective, and likely to result in a biased sample. It is possible that individuals who take part in studies are the least symptomatic, most articulate and may have a variety of personal or political reasons for wishing to take part in research. Without a clear description of the recruitment process, it is not possible to accurately assess the potential for a bias in the sample.

Another difficulty with creating an accurate synthesis of literature is the decision to use a number of different search terms. By widening the search terms to enable the inclusion of papers from a number of different perspectives, subsequently there is a decrease in the conceptual clarity. A number of the studies included participants with a variety of diagnoses including bipolar and personality disorder, but with a majority of participants having a diagnosis of schizophrenia or other diagnoses related to psychosis (Bradshaw et al, 2006; Bradshaw et al, 2007; Darlington & Bland, 1999; Laithwaite & Gumley, 2007; Sullivan, 1994; Young & Ensing, 1999). However, despite these difficulties, it was felt that all papers were suitable for inclusion in the review.

Data Extraction and Synthesis

Information collected from the selected literature included participant demographics, methodology used to collect information, methods of analysis, themes relating to, or components of recovery or hope. Due to the qualitative nature of the majority of the studies, a qualitative thematic analysis of the data was undertaken.

Results

The findings from the studies reviewed were synthesised into a number of themes. These include; hope; having relationships with staff, peers, friends and family; being able to live independently and adequately; engaging in a meaningful and active life; experiencing achievement; spirituality; increased self esteem; knowledge and control; having control over symptoms using medication; and developing a meaningful narrative. Interestingly, hope is not only a factor in its own right, but also appears to be inextricably linked with a number of the other factors in recovery.

Hope

Resnick, Fontana, Lehman and Rosenheck (2005) suggest that together hope and optimism are a main component of recovery. Individuals describe the importance of having hope for the future, hope that they will achieve goals, and having others around who share that hope. A number of studies propose that in the initial stages of recovery, having hope for a better life is essential for motivating people to achieve their daily tasks of living, and taking action to change (Borg & Kristiansen, 2004; Davidson, et al., 2005; Young & Ensing, 1999).

Service user researchers reported that having hope for a better future, not only for themselves but for a wider population of service users, is important in the recovery process. (Pitt, Kilbride, Nothard, Wellford and Morrison, 2007). From this perspective, having hope for the future involves a process of change and challenging others’ beliefs about mental illness and the potential for recovery. It also involves aspiring for an overarching change in service provision, one which includes a wider range of treatment options, more user involvement and greater continuity of care. Pitt et al (2007) also suggest that hope for the future involves hoping for change at a wider societal level. This wider perspective was perhaps elicited due to the study being conducted by service user researchers.

Individuals' hopes are thought to change over the course of their recovery (Forchuck, Jewell, Tweedell and Steinnagel, 2003). Initially individuals hope for their symptoms to reduce and their medication to work in order for them to be able to live a normal life. When their symptoms have subsided, individuals' hopes become more specific such as hoping to live independently, or hoping to get a job.

Relationships with mental health professionals

Many studies emphasised the importance of relationships with staff in the recovery process. The nature of the relationship between service user and staff member was thought to be essential. Having a person-to-person relationship rather than a professional-to-patient relationship was highlighted by many studies as vital in the therapeutic relationship. Individuals in these relationships feel genuinely cared for (Borg & Kristiansen, 2004; Bradshaw, Armour, & Roseborough, 2007; Bradshaw, Roseborough, & Armour, 2006; Davidson, et al., 2005; Torgalsboen, 2001). It has been proposed that small gestures or actions from staff are very meaningful to service users and were described as "on the edge of what is typically considered as professional contact" (Borg & Kristiansen, 2004; p. 499). The importance of showing empathy, equality, respect, trust, acceptance, validation and collaboration within the relationship was also highlighted (Borg & Kristiansen, 2004; Davidson, et al., 2005; Laithwaite & Gumley, 2007; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Sullivan, 1994; Torgalsboen, 2001).

A number of studies highlighted that the nature of these relationships helped to instil or encourage hope in service users (Kirkpatrick, et al., 1995; Kirkpatrick, Landeen, Woodside, & Byrne, 2001; Spaniol, et al., 2002). Studies suggest that the initial spark of hope must be present within the service user, but its growth can be nurtured by mental health workers (Darlington & Bland, 1999; Kirkpatrick, et al., 1995; McCann, 2002; Torgalsboen, 2001). It is also important that mental health professionals themselves have hope for the recovery of service users; they must communicate this hope, and have the ability to hold hope for service users when they are unable to hold it for themselves (Borg & Kristiansen, 2004; Bradshaw, et al., 2006; Kirkpatrick, et al., 1995; Kirkpatrick, et al., 2001). McCann (2002) and Landeen, Pawlick, Woodside, Kirkpatrick and Byrne (2000) report that staff need to determine what would be personally meaningful for service users in order to help uncover hope for the future. It was proposed that the nature of the relationship between staff and service users changes over time; in the initial phases of recovery, relationships were described as superficial, but over time became more trusting (Forchuk et al, 2003), and sometimes individuals found their relationships with staff members difficult to give up (Bradshaw et al. 2007).

Relationship with other service users

Peer support was often reported as important in the recovery process. Being in contact with others who had similar experiences led service users to feel understood and supported in ways that perhaps professionals, family or friends could not offer (Davidson, et al., 2005; Sullivan, 1994; Young & Ensing, 1999). Pitt et al. (2007) report that service users found sharing their experiences a helpful part of the recovery process. In addition to this, individuals began to have reciprocal roles in these relationships, not only were they being supported, but they could support others through their times of difficulty. This increased their sense of belonging and self worth (Davidson, et al., 2005). Young and Ensing (1999) state that participants valued peer relationships above those of friends, family and professionals. However, in this study much of the data was drawn from focus groups, which may have been an environment which influenced their perceptions of supportive peers. Within peer relationships, individuals often heard stories of success and recovery, which gave them a sense of hope for the future. Learning from others and having successful role models were also important in maintaining hope (Kirkpatrick, et al., 1995; Kirkpatrick, et al., 2001; Perry, Taylor, & Shaw, 2007; Pitt, et al., 2007; Resnick, et al., 2005; Young & Ensing, 1999).

Relationships with friends and family

Positive relationships with friends and family were thought to be beneficial factors in recovery (Corrigan, et al., 2005). As symptoms reduce, reconnecting with others is a significant task (Bradshaw, et al., 2007; Forchuk, et al., 2003). Relationships provide guidance and financial and emotional support to individuals (Bradshaw, et al., 2007; Davidson, et al., 2005; Perry, et al., 2007; Pitt, et al., 2007). Resnick et al. (2005) described relationships as part of an individual’s overall life satisfaction, which is an important facet of recovery. Relationships with friends and family also help individuals to feel hopeful about the future (Kirkpatrick, et al., 2001; Perry, et al., 2007; Spaniol, et al., 2002).

Sullivan (1994) highlighted the importance of relationships that were not necessarily care-giving. Having a meaningful role as a partner, friend or parent allows individuals to give, as well as receive love, support and affection (Davidson, et al., 2005; Spaniol, et al., 2002). However, Bradshaw et al. (2007) acknowledges that reconnecting with these relationships is not always an easy task. Similarly, Forchuk et al. (2003) reported that like relationships with professionals, relationships with friends and family can initially be superficial, but become more meaningful over time.

Being able to live independently and adequately

It was suggested that as part of the recovery process, individuals strive to be able to care for themselves and live independently (Bradshaw, et al., 2006; Corrigan, et al., 2005; Perry, et al., 2007; Young & Ensing, 1999). In order to do this, individuals must have adequate financial and practical resources such as housing, food and clothing. It was also noted that adequate finances were necessary in order to be able to engage in meaningful and pleasurable activities (Davidson, et al., 2005; Resnick, et al., 2005; Spaniol, et al., 2002; Young & Ensing, 1999).

Engaging in a meaningful and active life

For many, living a meaningful life involves participating and being valued in the community (Bradshaw, et al., 2007; Bradshaw, et al., 2006), and being able to develop a social identity within that community (Davidson, et al., 2005). Employment and education are often described as ways individuals find meaning in their lives (Davidson, et al., 2005; Spaniol, et al., 2002; Sullivan, 1994; Young & Ensing, 1999). Others find meaning from engaging in other activities within the community such as going to church or joining groups of interest (Bradshaw, et al., 2007). Employment and activity are thought to be important in keeping hope alive; they give structure to the day and reduce isolation (Perry, et al., 2007).

Achievement

Experiencing achievement is thought to be an important factor in recovery, even achievements which may be considered small need to be recognised by the individual and by others (Pitt, et al., 2007; Sullivan, 1994). Davidson et al. (2005) reported small accomplishments help an individual to cultivate hope. Setting realistic goals that can be achieved, and experiencing successes help to encourage hope for the future. Staff members can help individuals develop appropriate pathways to achieving these goals

(Corrigan, et al., 2005; Darlington & Bland, 1999; Davidson, et al., 2005; Kirkpatrick, et al., 1995; Kirkpatrick, et al., 2001; McCann, 2002).

Spirituality

Some individuals find meaning in their lives through spirituality (Young & Ensing, 1999). Spirituality has been identified as a valuable part of recovery for individuals with or without religious beliefs (Bradshaw, et al., 2006; Spaniol, et al., 2002; Torgalsboen, 2001). Spirituality provides individuals with comfort and support, and is also a source of strength, inspiration and hope in recovery (Sullivan, 1994; Young & Ensing, 1999). Kirkpatrick et al. (2001) reported that a number of participants described spirituality as valuable in developing in hope; some felt God had a purpose for them or had helped them to accept their illness. Perry et al. (2007) reported that for some, experiencing psychosis had helped to strengthen their faith, however for others their faith had been shattered by their experiences.

Self esteem

A number of studies highlighted the importance of regaining self esteem and confidence in the recovery process (Corrigan, et al., 2005; Laithwaite & Gumley, 2007; Resnick, et al., 2005; Young & Ensing, 1999). Young and Ensing (1999) describe the need to rebuild the self image after the distressing effects of developing psychosis. Pitt et al. (2007) stated that service users described seeking out activities which help to build self esteem and in turn help them to assert their own needs better.

Knowledge and control

Some of the studies highlighted the need for individuals to accept their illness in order for them to move forward in their recovery. Following this, knowledge about psychosis and possible beneficial interventions enabled individuals to increase the control they had over their lives (Davidson, et al., 2005; Pitt, et al., 2007; Sullivan, 1994; Young & Ensing, 1999). A number of studies highlighted the value of taking personal responsibility for recovery and being able to make choices about treatments, although relying on professional expertise for information and guidance (Bradshaw, et al., 2007; Forchuk, et al., 2003; Resnick, et al., 2005; Young & Ensing, 1999). Darlington and Bland (1999) reported clients found that guidance and the experience of others helped service users to nurture their hope for recovery.

Symptoms and medication

Forchuk (2003) described that in the initial stages of recovery, service users found symptoms the most troubling aspect of their illness. In these stages, service users' main hopes were for medication to be effective in eliminating or reducing symptoms (Corrigan, et al., 2005; Davidson, et al., 2005; Spaniol, et al., 2002; Young & Ensing, 1999). Spaniol at al. (2002) and Sullivan (1994) suggest that many service users felt that regular use of medication and adequate management of side effects was essential for a successful recovery. However Forchuk et al. (2003) found service users had mixed opinions on the usefulness of medication. In addition to medication, Sullivan (1994) suggested that personal drive and attitude are important elements in combating symptoms. Many researchers report that getting control of symptoms, often by using appropriate medication, helps people to foster hope and enables them to concentrate on cultivating other areas of their life (Kirkpatrick, et al., 1995; Kirkpatrick, et al., 2001; Spaniol, et al., 2002). However in opposition to this proposal, Landeen et al. (2000) reported a lack of correlation between hope and symptom severity. This could be as a result of this study using quantitative rather than qualitative methodology.

Developing a meaningful narrative

Extracting meaning from or developing an understanding of their experiences is another important component of the recovery process for service users. This might include reflecting on the impact of the past events and current issues, addressing these and moving on from them (Bradshaw, et al., 2007; Perry, et al., 2007; Pitt, et al., 2007;

Thornhill, Clare, & May, 2004). Individuals have many diverse ways of understanding their experiences. Some may prefer to conceptualise their experiences as a result of a chemical imbalance, others a result of past experiences or a test from God (Perry, et al., 2007; Spaniol, et al., 2002). Young and Ensing (1999) describe that one phase of recovery involves a process of redefining themselves. This involves gaining insight into themselves and their relationship with their illness, uncovering old and discovering new elements about themselves.

Discussion

The role of hope in recovery from psychosis appears to be a central one. The themes that emerge from the literature show hope not only to be an important initiating factor, but also as relevant to other key stages of the process. Recovery is often conceptualised as a process rather than an outcome, it could be argued that hope can be understood as both entwined within this process, and also as an outcome of recovery.

Hope and recovery appear to influence each other in a symbiotic fashion. Having hope is one of the motivating factors in the recovery process, and experiencing some of the elements of the recovery process helps to promote hope. The role of hope at these different stages in the recovery process has been well documented in some but not in others. Engaging in relationships with family, professionals or peers are considered to be important elements in the recovery process. Hope can be triggered in the context of relationships, either by another actively nurturing hope in the service user, or by them being inspired by others who have recovered. Participating in a meaningful and active life is also thought to be crucial in the recovery process. This could involve education, employment, achievement, or for some spirituality. These elements involved in recovery have also been highlighted as triggers for hope. A further factor important in the process of recovery is gaining knowledge about psychosis and being able to make informed choices about possible treatments, in order to gain control over symptoms.

Gaining control over symptoms with the help of others was also highlighted as helpful in fostering hope for the future.

Coming to an understanding of experiences, creating an explanatory framework, or finding meaning in what has occurred is thought to be an important part of the recovery process. However, this is not something which is commented on in the existing literature as having a relationship to hope. Jacobson (2001) described different explanatory frameworks and their influence on the recovery process. She argues that if an individual conceptualises their difficulties as a biological illness, then the task of recovery is accepting the illness and acquiring knowledge about symptoms and treatment options. If an individual conceptualises their experiences as a spiritual crisis, recovery involves endurance and emerging from the experience with a new conceptualisation of the self. It could be similarly argued that the explanatory framework the individual creates will lead them to experience different sources of hope, and subsequently the creation of meaning will in itself engender hope as an outcome. It has been previously suggested that hope emerges from different sources for different individuals, Miller (1985) suggests hope can arise from faith, relationships, and the drive for accomplishment. It could be argued that individuals who conceptualise their experiences as a biological illness may find hope in medication and the expertise of others; individuals who conceptualise their difficulties as a spiritual crisis may find hope from spirituality or religious communities. Landeen et al. (2000) report it is important for professionals to understand what the service user finds personally meaningful in order to encourage hope. Assisting services users to understand and develop a narrative that helps them derive meaning from their experience is also an important part of the process of becoming more hopeful for the future.

When an individual initially develops psychosis, in order for the process of recovery to begin, they must have hope for the future. It appears that the process of nurturing hope is strengthened by it occurring within a relationship or in the context of spirituality. This could be relationships with mental health professionals, other service users, family, friends, or religious communities, or within a relationship with their own intrinsic spiritual beliefs. Mental health professionals need to help inspire hope in order for individuals to find the motivation to take steps to begin the process of recovery. The process may then include taking control of symptoms, becoming actively involved in employment, living independently, experiencing achievement and reconnecting with other relationships. Hope and these activities then become mutually reinforcing; for example hope helps individuals become motivated to strive to achieve, and achievement then inspires further hope. Self esteem did not emerge as a factor influencing hope; however this could be the result of the stage in the recovery process. When individuals begin to engage in activities and experience achievement, this then increases self esteem. It could be argued that when an individual has an increase in self esteem and perceived self efficacy, these become facilitators of change in their own right and the role of hope then becomes less crucial.

The need to promote recovery by addressing mental health problems with hope and optimism, and for staff to “understand the essential role of hope in the recovery process” is highlighted in the Department of Health’s Ten Shared Essential Capabilities document (2004, p. 15). These capabilities draw on information from both values based and evidence based practices. The National Framework Values for Mental Health (National Institute for Mental Health in England, n.d.) have helped inform these capabilities, and they highlight the importance of values in practice and emphasise the need to provide recovery oriented services.

There is a great deal of literature which emphases how mental health professionals can help service users overcoming psychosis, by providing medication, psychological input, social support and so on, but there is less emphasis on what personal resources an individual has which help them to cope and recover from mental illness themselves (Jobe & Harrow, 2005; Tooth, Kalyanasundaram, Glover & Momenzadah, 2003). One factor which is thought to be important in coping in the face of aversive experiences is resilience. Resilience refers to “a class of phenomena characterised by good outcomes in spite of serious threats to adaptation or development” (Masten, 2001; p. 228). The concept of resilience has been described by Ridgeway (2001) as focusing attention on an individuals ability to achieve mastery, personal growth and constructive change. It has been suggested that resilience enables individuals with psychosis to adapt to their circumstances by developing resourcefulness, finding their inner strength, and utilizing supportive relationships (Geanellos, 2005).

Gillian (2000) suggests there are three important components of resilience. These include; feeling a sense of belonging within a social network and having a structure to their life; having self worth and self esteem, cultivated by experiencing positive relationships and feelings of achievement; and experiencing self efficacy and a belief that they have control over their lives. It has been suggested that there are a number of different pathways to individuals becoming resilient; one of those pathways is hardiness (Bonanno, 2004). Hardiness is thought to comprise of a combination of interrelated attitudes of commitment, control and challenge, which help people develop positive coping strategies in difficult situations (Maddi, Khoshaba, Persico, Lu, Harvey, Bleecker, 2002). The attitude of commitment relates to an individual’s belief that if they are active and become involved in their environment rather than withdrawing from the situation, they are able to make changes to the situation they are in (Maddi et al, 2002). Individuals who have an attitude of commitment have a purpose in life, and are able to identify activities and relationships that are meaningful to them (Kobasa, Maddi & Kahn, 1982).

Individuals who have a strong attitude of control believe that if they exert enough effort they will be able to achieve control over their situation, as opposed to being a passive recipient of others control of their personal experiences (Maddi et al, 2002). Individuals with this attitude mould unexpected situations into something that can be consistent within their original plans for their lives, and so experience the situation as less aversive (Kobasa et al, 1982). Finally, individuals with a strong attitude of challenge believe that fulfilment and satisfaction in life is not found within routines and security, rather fulfilment if achieved from living a life which involves challenging situations, and the personal growth which results from having both positive and negative experiences (Maddi et al, 2002; Kobasa et al, 1982).

Although hardiness and other personal resources are not widely discussed within the recovery model, it is easy to see how the personal trait of hardiness would help individuals in their journey of recovery. Being proactive in one’s recovery is something that is often cited in the recovery literature. Deegan (1988) highlights that recovery is not something that mental health professionals can do to service users, rather that service users do for themselves, and are supported by professionals in doing that. The idea of challenge and personal growth is related to the concept of recovery as a whole, as Ridgeway (2001) writes “as part of the recovery journey, people learn to make decisions and choices that are real, take risks in order to experience growth, and assume primary responsibility for the recovery process”. It was highlighted by Maddi et al (2002) that hardiness relates to individuals having a belief that they have control and influence over their lives, the importance of control and choice has been highlighted in this literature review. Therefore, although the concept of hardiness is not emphasised in the recovery model, it appears that the two concepts have many connecting components.

This literature review has focused on a different literature to that identified by Kylmã et al. (2006). The previous review contained an overview of all the hope literature regarding schizophrenia, including hope within families, hope as a result of medication and staff member’s levels of hopefulness. In the current review, the researcher aimed to understand the role of hope in the recovery process, and so explored perceptions of hope in the recovery literature, in which hope was not necessarily the main focus of the research. These differences led to the two reviews only having four papers in common, which describe hope engendering strategies including the importance of maintaining relationships, motivation and creating meaning in their lives.

In conclusion, the importance of hope in recovery is multifaceted, and is intimately connected with various elements of the recovery process. Whilst hope is the initiating factor in the process of recovery, as this process unfolds other factors may come into prominence. These factors lead to outcomes, which in turn may reinforce hope. Conceptualising hope in this way, as a stand alone factor and also a factor which is intrinsically link with, and reinforced by, other factors, has not been previously described in the literature, and highlights the importance of hope at many different stages of recovery. It is imperative that mental health professionals promote hope for the future, and identify ways to nurture hope within service users. Further research in this area should focus on the connection between the meanings people ascribe to their experiences and the potential impact on their sources for hope. This would enable mental health professionals to identify the most meaningful way of nurturing hope within service users.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, DC: American Psychiatric Association.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23.

Beck, A. T., Steer, R. A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: a 10 year prospective study of patients hospitalised with suicidal ideation. *American Journal of Psychiatry, 142,* 559-563.

Bonanno, G. A. (2004). Loss, trauma, and human resilience. Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59 (1),* 20-18.

Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health, 13*(5), 493-505.

Bradshaw, W., Armour, M. P., & Roseborough, D. (2007). Finding a place in the world: the experience of recovery from severe mental illness. *Qualitative Social Work, 6*(1), 27-47

Bradshaw, W., Roseborough, D., & Armour, M. P. (2006). Recovery from severe mental illness: the lived experience of the initial phase of treatment. *International Journal of Psychosocial Rehabilitation, 10*(1), 123-131.

Chi, G. C. (2007). The role of hope in patients with cancer. *Oncology Nursing Forum, 34*(2), 415-424.

Corrigan, P., Slopen, N., Gracia, G., Phelan, S., Keogh, C., & Keck, L. (2005). Some recovery processes in mutual-help groups with persons with mental illness; II:

Qualitative analysis of participant interviews. *Community Mental Health Journal. , 41*(6), 721-735.

Darlington, Y., & Bland, R. (1999). Strategies for encouraging and maintaining hope among people living with serious mental illness. *Australian Social Work, 52*(3), 17-23.

Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R., & Sells, D. (2005). Processes of recovery in serious mental illness: Findings from a multinational study. . *American Journal of Psychiatric Rehabilitation, 8*, 177-201.

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19*(3), 91-97.

Department of Health (1999). *National Service Framework for Mental Health: Modern Standards and Service Models.* London: Department of Health

Department of Health (2004). *The Ten Shared Essential Shared Capabilities: A framework for the whole of the mental health workforce*. London: Department of Health.

Ebright, P. R. (2002). Understanding hope and factors that enhance hope in women with breast cancer. *Oncology Nursing Forum, 29*(3), 561-568.

Fisher, D. B. (2003). People are more important than pills in recovery from mental disorder. *Journal of Humanistic Psychology, 43*(2), 65-68.

Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Reconnecting: the client experience of recovery from psychosis. *Perspectives in Psychiatric Care, 39*(4), 141-150.

Fowkes, F. G., & Fulton, P. M. (1991). Critical appraisal of published research: introductory guidelines. *British Medical Journal, 302*, 1136-1140.

Frese, F. J., & Walker Davis, W. (1997). The consumer-survivor movement, recovery and consumer professionals. *Professional Psychology: Research and Practice. 28*(3), 243-245.

Geanellos, R. (2005). Adversity as opportunity: living with schizophrenia and developing a resilient self. *International Journal of Mental Health Nursing, 14,* 7-15.

Gillian, R. (2000). Adversity, resilience and young people: The protective value of positive school and spare time experiences. *Child and Society, 14,* 37-47.

Harding, C., Zubin, J., & Strauss, J. (1987). Chronicity in schizophrenia: Fact, partial fact, or artefact? *Hospital & Community Psychiatry, 38*(5), 477-486.

Jacobson, N. (2001). Experiencing recovery: a dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal, 24*(3), 248-257.

Jacobson, N., & Curtis, L. (2000). Recovery as a policy in mental health services: strategies emerging from the states. *Psychiatric Rehabilitation Journal, 23*(4), 333-341.

Jobe, T. H. & Harrow, M. (2005). Long-term outcome of patients with schizophrenia: a review. *Canadian Journal of Psychiatry, 50(14),* 892-900.

Kirkpatrick, H., Landeen, J., Byrne, C., Woodside, H., Pawlick, J., & Bernardo, A. (1995). Hope and schizophrenia: clinicians identify hope instilling strategies. *Journal of Psychosocial Nursing, 33*(6), 15-19.

Kirkpatrick, H., Landeen, J., Woodside, H., & Byrne, C. (2001). How people with schizophrenia build their hope. *Journal of Psychosocial Nursing and Mental Health Services, 39*(1), 46-53.

Kobasa, S. C., Maddi, S. R., & Kahn, S. (1982). Hardiness and heath: a prospective study. Journal of Personality and Social Psychology, 42 (1), 168-177.

Kruger, A. (2000). Schizophrenia: Recovery and hope. *Psychiatric Rehabilitation Journal, 24*(1), 29-37.

Kylma, J., Juvakka, T., Nikkonen, M., Korhonen, T., & Isohanni, M. (2006). Hope and schizophrenia: An integrative review. *Journal of Psychiatric and Mental Health Nursing, 13*(6), 651-664.

Laithwaite, H., & Gumley, A. (2007). Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clinical Psychology & Psychotherapy, 14*(4), 302-316.

Landeen, J., Pawlick, J., Woodside, H., Kirkpatrick, H., & Byrne, C. (2000). Hope, quality of life, and symptom severity in individuals with schizophrenia. *Psychiatric Rehabilitation Journal, 23*(4), 364-369.

Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin, 15*(2), 197-200.

Longhland, C. M., Carr, V. J., Lewin, T. J., Barnard, E., Chapman, J. L., & Walton, J. M. (2004) Potential sampling and recruitment source impacts in schizophrenia research. *Psychiatry Research, 125(2),* 117-127.

Maddi, S. R., Khoshaba, D. M., Persico, M., Lu, J., Harvey, R. & Bleecker, F. (2002) The personality construct of hardiness: II. Relationships with comprehensive tests of personality and psychopathology. *Journal of Research in Personality,* 36, 72-85.

Masten, A. S. (2001). Ordinary magic: resilience processes in development. *American Psychologist, 56(3),* 227-238.

May, R. (2000). Routes to recovery from psychosis: the roots of a clinical psychologist *Clinical Psychology Forum, 146,* 6-10.

McCann, T. V. (2002). Uncovering hope with clients who have psychotic illness. *Journal of Holistic Nursing, 20*(1), 81-99.

Miller, J. F. (1985). Hope doesn't necessarily spring eternal - sometimes it has to be carefully mined and channelled. *American Journal of Nursing, 85*, 23-25.

Miller, J. F., & Powers, M. P. (1988). Development of an instrument to measure hope. *Nursing Research, 37*(1), 6-9.

Murphy, M. A. (1998). Rejection, stigma, and hope. *Psychiatric Rehabilitation Journal, 22*(2), 185-188.

National Institute for Mental Health in England (n.d.) *National Framework of Values for Mental Health.* Retrieved on June 15, 2008 from: http://www.nimhe.csip.org.uk/publications-and-other-resources/publications/equalities-and-diversity-.html.

National Institute of Health and Clinical Excellence (2007). *The Guidelines Manual.* London: National Institute of Health and Clinical Excellence.

Perry, B. M., Taylor, D., & Shaw, S. K. (2007). 'You've got to have a positive state of mind': An interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health, 16*(6), 781-793.

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: A user-led project. *Psychiatric Bulletin, 31*(2), 55-60.

Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2005). An empirical conceptualization of the recovery orientation. *Schizophrenia Research, 75*, 119-128.

Ridgeway, P. (2001). Restorying psychiatric disability: learning from first person narratives. *Psychiatric Rehabilitation Journal, 24(4),* 335-343.

Rudge, T., & Morse, K. (2001). Re-awakenings?: A discourse analysis of the recovery from schizophrenia after medication change. *Australian and New Zealand Journal of Mental Health Nursing, 10*, 66-76.

Rustoen, T., Howie, J., Edismo, I., & Moum, T. (2005). Hope in patients hospitalised with heart failure. *American Journal of Critical Care, 14*(5), 417-425.

Spaniol, L., Wewiorski, N., Gagne, C., & Anthony, W. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry, 14,* 327-336.

Sullivan, W. P. (1994). A long and winding road: the process of recovery from severe mental illness. *Innovations and Research, 3*(3), 19-27.

Thornhill, M., Clare, L., & May, R. (2004). Escape, enlightenment and endurance: narratives of recovery from psychosis. *Anthropology and Medicine*, *11*(2), 181-199.

Tooth, B., Kalyanasundaram, V., Glover, H. & Momenzadah, S. (2003). Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry, 11 (Supplement),* S70-S77.

Torgalsboen, A. (2001). Consumer satisfaction and attributions of improvement among fully recovered schizophrenics. *Scandinavian Journal of Psychology, 42*, 33-40.

Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspectives of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 22*(3), 219-231.

Empirical Paper:

Recovery Oriented Services: Strategies and Barriers

Abstract

Objectives: To explore the experiences of staff working in a recovery oriented service, with particular focus on the elements which help and hinder the provision of the service.

Design: A qualitative approach was taken, in which interviews were used to produce data.

Methods: Twelve participants were interviewed using a semi structured interview. The participants were from a variety of professional backgrounds and worked for a recovery oriented Early Intervention Team. The interviews were analysed using Interpretive Phenomenological Analysis.

Results: Participants highlighted the importance of having a strong team culture which involved having a strong leadership, a clear vision, an absence of a medical focus, a mutually supportive team, and the role of STR workers. Barriers to providing a recovery oriented service focused on the attitudes of others and the position of the team in the wider service. Participants highlighted the issues regarding the role of generic workers. Some difficulties with the implementation of the model itself were highlighted.

Conclusions: This paper highlights many of the factors which need to be considered when operationalising the recovery model. Recently there has been an influx of policy documents which support the implementation of recovery oriented services. However, fundamental conflicts between the recovery model and the medical model may hamper its implementation.

Recovery Oriented Services: Strategies and Barriers.

Historically, schizophrenia has been conceptualised as a chronic and debilitating illness, with little hope for recovery. However, longitudinal studies have reported that even after many years of being ill, complete or partial recovery is possible (Harding, et al., 1987). Recovery has been traditionally described as a cessation of symptoms and related difficulties, which allow a return to previous functioning (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). However, the mental health consumer-survivor movement in the 1980s and 1990s conceptualised recovery as something more, they argue that recovery might not involve a cessation of symptoms at all.

Jacobson and Curtis (2000) suggest there is no clear definition of recovery due to the unique nature of each individual’s journey. However, one commonly used definition is by Anthony (1993), who having synthesised narrative accounts of “lived experience” of psychosis, defined recovery as;

> …a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (p. 527)

Anthony’s definition of recovery is similar to Tedeschi and Calhoun’s (1996) description of posttraumatic growth. This link is reinforced by the descriptions of psychotic episodes as being both a response to trauma and traumatic events in themselves (Morrison, Frame, & Larkin, 2003).

Many researchers have highlighted the need to define recovery in a more concrete fashion in order to measure outcomes (Andresen, Oades, & Caputi, 2003; Resnick, et al., 2005). There have been a number of attempts to measure recovery including the Recovery Assessment Scale (RAS; Giffort, Schmook, Woody, Vollendorf,

& Gervain, 1995) and the Stages of Recovery Instrument (STORI; Andresen, Caputi, & Oades, 2006). Attempts to measure recovery as an outcome exist in parallel with the recognition that recovery is a process. The role of services therefore becomes one of facilitating the recovery process rather than treatment of illness.

This new conceptualisation of recovery has begun to shape service provision in several countries. The recovery model is clear in policy documents in the US (Beale & Lambric, 1995; Blue Ribbon Commission, 1997; Office of the Surgeon General, 1999; Tondora & Davidson, 2006), New Zealand (Mental Health Commission, 1998, 2001), Australia (Australian Health Ministers, 2003), Ireland (Mental Health Commission, 2005), Scotland, (Scottish Government, 2006) and England (Department of Health, 2001a, 2001b; National Institute of Mental Health in England, 2005; Shepherd, Boardman, & Slade, 2008).

Researchers have tried to identify what a recovery oriented service should provide (Farkas, Gagne, Anthony, & Chamberlin, 2005; Mental Health Commission, 2005; National Institute of Mental Health in England, 2005; O'Connell, Tondora, Croog, Evans, & Davidson, 2005), and suggest they should involve; providing choices, involvement in planning and developing services, providing a range of treatment options, developing support networks, emphasising strengths, and helping to develop roles and meaningful activities. Several tools have been developed for assessing the recovery orientation of a service. These include the Developing Recovery Enhancing Environment Measure (DREEM; Allot & Higginson, 2004; Ridgeway, 2003), Recovery Oriented Practice Index (ROPI; Mancini & Finnerty, 2005), and Recovery Self Assessment (RSA; O'Connell, et al., 2005). A comprehensive compendium of measures of recovery and recovery orientation has been produced by Campbell-Orde, Chamberlin, Carpenter and Leff (2005). It has been highlighted that believing recovery is possible, conveying that to service users, and promoting hope and empowerment, is a large part of the recovery orientation (Jacobson & Greenley, 2001; Salyers & Macy, 2005; Sowers, 2005).

It can be argued that mental health services are on the verge of a Kuhnian paradigm shift (Keen, 2003). Periods of certainty and stability in knowledge will shift when a novel finding is uncovered that does not fit with the existing paradigm. This leads to a state of opposing views, with some defending the existing paradigm, while others strive for a new paradigm to emerge. Eventually the new paradigm emerges and periods of stability begin again (Heather & Robertson, 1985). Within mental health, the medical paradigm has been shaken by evidence that people do recover. Shepherd et al. (2008) propose "the concept of recovery requires further development, but it provides a framework which, if seriously adopted will bring a radical transformation of mental health services in this country in the future" (p. 1).

If mental health services are on the verge of transformation, it is important to understand factors which will both assist and hinder this change (Grol, 1997; Liberman, 2002; Onyett, 2004). In the organisational literature, Kotter (1998) describes eight critical stages which need to be met in order to achieve change, including to; "establish a sense of urgency; form a powerful coalition; create a clear vision; communicate the vision; empower others to act on the vision; plan for and create short term wins; consolidate improvements and produce still more change; and institutionalise the new approaches" (p. 32). Onyett (2004) highlighted that appropriate conditions are needed for change to be nurtured. He states "change is influenced by context; push and exhortation by charismatic leaders in not enough" (pg. 38). Sowers (2005) suggests that for recovery oriented services to develop, the appropriate political environment needs to be created. Grol (1997) identified several barriers to change including attitudes and skills of individuals clinicians, context of change, reactions of colleagues and authorities, structure of the organisation, and availability of resources.

Grol and Grimshaw (2003) suggest several factors which hinder the implementation of evidence and guidelines into clinical practice, and could be considered in relation to the implementation of recovery ideas. One factor is the quality of evidence supporting the recommendations. This has been highlighted in relation to the recovery model in comparison to the medical model's focus on evidence based practice (Mental Health Commission, 2005). However, some suggest the perceived dichotomy is unhelpful, and the two models are not mutually exclusive (American Psychiatric Association, 2005; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Resnick, et al., 2005). A further factor identified is the "compatibility of recommendations with existing values" (Grol & Grimshaw, 2003; Onyett, 2004, p. 1126). This may be pertinent for the recovery model due to the dominant medical discourse in healthcare, and conceptualisation of schizophrenia as a chronic and debilitating illness. Disbelief in the possibility of recovery may prevent the development of recovery oriented services. Indeed, Jacobson and Curtis (2000) and Glover (2005) highlight the concern that services may rename themselves without truly embracing the values of the model.

In summary, the recovery model appears to be becoming increasingly influential in determining mental health policy. This new emphasis may lead to a transformation in the way services conceptualise and work with people who experience psychosis. Organisational change literature highlights the need to understand factors which assist and hinder effective change. The current study aims to explore the experiences of staff working within a recovery oriented service. The objective of the study is therefore to gain an understanding of mental health workers perceptions of what has helped and what has hindered them in the provision of the recovery oriented service that they provide. The author was unable to find any previous studies which have examined the experience of staff working in a recovery oriented service, either in the US or the UK.

Method

Participants

Participants were recruited from an Early Intervention Team, which offers a service to clients for three years and utilises a recovery model. Purposeful sampling was used to recruit a range of disciplines. The entire team consented to take part in the study, individuals were recruited in order to include the full range of the disciplines within the team. The researcher stopped recruiting new participants when the same themes were consistently emerging from the interviews, and all the disciplines had been accounted for. This occurred after interviewing 80% of the multidisciplinary team. Twelve participants were recruited, a description of the sample can be found in Table 1. Individuals were informed of the research purpose both verbally and via a participant information sheet.

Table 1.

Description of the sample

Professional Background	
Nursing	3
Social Work	3
Occupational Therapy	1
Clinical Psychology	1
Psychotherapy	1
Drug Rehabilitation	1
Support Time Recovery	2

Table 1 continued

Description of the sample

Number of years qualified		
	No professional qualification	3
	Less than 1 year	0
	1-5 years	3
	6-10 years	2
	11-15 years	2
	More than 16 years	2

Number of years in the team		
	Less than 1 year	2
	Between 1 and 2 years	3
	Between 2 and 3 years	2
	More than three years	5
Gender		
	Male	7
	Female	5
Age		
	Range	28-53 years
	Mean	37.8 years

Design

A qualitative design was used and participants were interviewed following a semi-structured interview schedule. Interpretive Phenomenological Analysis (IPA) was used to guide the collection and analysis of data. IPA was employed as it is a qualitative methodology used to explore individual's perceptions of their social and personal experiences. The researcher was previously known to the team, however IPA recognises the role of the researcher's own conceptions in the interpretive element of the analysis (Smith & Osborn, 2003).

Interview schedule

The semi structured interview focused around four main topics;

1. What is it about the service that makes it recovery oriented?
2. What would make the service more recovery oriented?
3. What has helped the team provide a recovery oriented service?
4. What has made it hard to provide a recovery oriented service?

Initial introductory questions were asked to elicit individuals' understanding of recovery from psychosis. The structure of the interview was flexible to participant's responses. Predetermined prompts were used if necessary to elicit additional information.

Procedure

Participants were approached by the principle researcher to discuss the study and were provided with an information sheet. Written informed consent was obtained prior to commencing the interview. This covered; taking part in the study; audio-recording the interview and publication of anonymous direct quotes. Interviews took place at the team base, and lasted between 25 and 80 minutes.

Ethical issues

Ethical approval was given by a local research ethical committee, all information was confidential and anonymised, and individuals were informed of this verbally and in writing. Further anonymity was ensured by reassigning participant numbers for the purpose of this paper. Digital recordings of interviews were kept secure on a password protected computer.

Analysis

Interviews were digitally recorded and transcribed verbatim, and read several times to facilitate familiarity with the transcript. Initial coding was undertaken using the ATLAS.ti computer program (Muhr, 2007). Codes were then grouped into themes, and recurrent themes were identified between transcripts. Constant reflection on the process and re-examination of transcripts led to refining the themes, with some expanded and others rejected. Themes were then clustered into overarching superordinate themes. Analysis was undertaken by the author, and external validity was ensured by a colleague with experience of recovery ideas reading the transcripts, assessing the process of analysis including the coding, clustering of codes, and organisation of themes. In addition, anonymised sections of text were analysed by members of an IPA discussion group, in order to ensure appropriate links were made between the text and emergent themes.

Results

Analysis of the transcripts resulted in the extraction of four superordinate themes and twelve subordinate themes (see Table 2).

Table 2.

Summary of superordinate and subordinate themes.

Superordinate	Subordinate
1. Being different: them and us	Other people's attitudes Having to justify ourselves
2. It's a struggle, can we do it?	It's hard work Have we got the skills?
3. Operationalizing the model	Organisational boundaries vs. individual need Therapeutic experiences vs. reintegration Links with others
4. Creation of a culture	A different emphasis A clear vision Service user involvement Shared beliefs Mutual support

Participants' understanding of recovery and recovery oriented services proved to be consistent with previously described literature. All felt they worked within a recovery oriented service. This confirmed that the sample was appropriate in order to explore the experience of working in a recovery oriented service.

Superordinate 1: Being different: them and us

Other people's attitudes. Participants reported that the position of the team within the NHS presented challenges to providing a recovery oriented service. Participants suggested the NHS operates within a traditional medical model with clear and pre-determined methods of working, including a strong focus on risk management and symptom reduction. It was felt this was not the optimal environment for an emerging service to develop. Many reported that staff external to the team hinder their ability to provide a recovery oriented service. Participants felt others were sceptical about the service they provide, and failed to appreciate the therapeutic benefit of the approach to service provision.

> I suppose people's views, medical staff, nurses that see things very much through…, as I was saying earlier about recovery being medication and relieving people of their symptoms, and that's the end, and that's the answer. I think those views are still very much there. (Participant 1)
>
> The fact that some psychiatrists aren't on board, sometimes you feel there's a political battle going on, and not one that I particularly want to fight as a care-co. (Participant 12)

Having to justify ourselves. As a result of this environment of perceived opposition, several participants felt under the scrutiny of others. Despite this, many believed they were proving to others their effectiveness, which was evidenced by a dramatic reduction in hospitalisation rates, suicide rates, and discharge to further mental health services. These outcomes helped to increase the team's credibility within the Trust, which led to further funding and expansion of the service. Participants reported that recent government drivers which support the service, also helped produce a fertile environment which enabled the team to flourish, and retain its plausibility despite others' disapproval.

> …when we started out up to probably six months a year ago, it felt like people really watching us, wanting us to mess up, you know, the whole organisation was peering at us 'cause we were so different, and wanting us to trip up which we ain't (*sic*) done actually which is good. (Participant 8)

> But I also think it's been at a time of national drivers as well, and increasing recognition that the traditional medical approach to mental health services isn't necessarily good for individuals or good for society really. (Participant 5)

Superordinate 2: It's a struggle, can we do it?

It's hard work. Several staff reported that the nature of the service users' difficulties, the service that individuals provide, and the position of the team within the Trust left them feeling overwhelmed and tired. In addition, participants reported that there was a push from the Trust to increase caseload size.

> … I think we almost work too hard….I feel tired a lot of the time…I think that's because we work so bloody hard. (Participant 8)

Restricted time, financial limitations and paperwork were often cited as barriers to spending more time with clients or providing a wider range of activities. However, some acknowledged that the resources in this team were perhaps better than in other teams.

> I just think it's probably just a time pressure thing that we have and often just think I wish I had more time… (Participant 10)

Have we got the skills? Many reported the diverse nature of skills helped them to provide a recovery oriented service. However, others highlighted the pressures of being a generic worker, and the desire for additional skills in the team. Participants offered three solutions to this; increasing the skills of staff within the team by being trained to be more competent generic workers; expanding the skills in the team by becoming specialists in particular fields and increasing co-working; or bringing in new professionals with additional skills.

> … we've got discrete disciplines within the team … but I feel that as a team we're sometimes expected to undertake pieces of work that we've not receive any formalised training to do... (Participant 6)

> To have staff who aren't necessarily pulled in from the NHS arena if you like, because I think that for example if somebody came in from the sports development side they could bring those skills here… (Participant 2)

Superordinate 3: Operationalizing the model

Organisational boundaries versus individual needs. Many participants highlighted the importance of relationships with clients, and emphasised having more personal rather than traditional patient-professional relationships. These relationships are consistent for three years whilst the service user is with the team. However, the nature of these relationships makes it difficult to disengage at the end of three years, both for service users and for staff. Some reported that three years with the service is sometimes not enough.

> Like building such a good relationship with clients that at the end of the time with us they potentially relapse simply because they know we're gonna be moving out of their life. (Participant 7)

> Yeah I think it, it can go on and on, 'cause you know, (pause) actually discharging people is very difficult, 'cause it's always "oh I can hang on to them for a little bit" but that, you cant, you know, the service couldn't run if it didn't actually discharge people. (Participant 8)

Therapeutic experiences versus reintegration. Many participants highlighted the importance of activities run by the team. However, concerns were expressed that a reliance on activities provided purely for service users may decrease their opportunity for engaging in activities and developing support networks within the community. Furthermore, the transportation of clients by team staff to these activities, although often beneficial for service users and helpful in engagement, may impact on their development of their own capacity to efficiently navigate the world without mental health services.

> I've got certain issues with sort of like, all the activities we do here, only in one sense, because I think it's almost like institutionalisation in a different form .... It's good in one way, 'cause it you know, but it can be really difficult to disentangle people from it at the other end. (Participant 8)

> I think all those things are really important but I think that sometimes there's a danger that, I mean ideally we want people to be doing that for themselves and I think it's very safe to be doing it within our service and that level of sort of, it almost connects people to [the team] more when we would ideally want them to be connecting outside our mental health service. (Participant 5)

Links with others. Many participants reported having positive links with others external to the team helped the development of the service. This involves links with other services within and outside the NHS, and with non-mental health related organisations within the community such as the local council, benefits service and university. The team also reported having direct and open lines of communication with the community; anyone can contact the team directly, for advice or support for themselves or for others.

> There is a whole range really of things like for training, [the] College, the University. The list is very long of other networks that people relate to and I think [the team] has some pretty strong partnerships with some of those organisations… (Participant 11)

> You know, having a contact with the homelessness team and benefits … they're quite well aware that them liaising with us as well is going to prevent anything bad happening from their end, especially with tenancies and things like that. (Participant 3)

Superordinate 4: Creation of a culture

A different emphasis. One idea that regularly emerged was that the team had its own culture based on psychological rather than medical models. Team members felt that the lack of a psychiatrist within the team enabled them to have a different focus. They were able to provide a strengths based approach, with psychosocial interventions and recovery focus rather than symptom reduction and medication management. The strength with which this culture had been established was evidenced by several participants who recoiled at the use of certain terminology with medical connotations such as “treatment” and “symptoms”.

> I guess it’s about the fact that our team’s not got a strong medical force, we have to engage in recovery oriented sort of interventions. (Participant 6)

Despite the absence of the medical model, many individuals highlighted the importance of medication, but specified it as a tool chosen by service users to ease distressing symptoms, rather than as a cure for their difficulties.

> … you know there’s definitely a place for medication, its whether you use it as a necessity or just a tool. (Participant 10)

A clear vision. Participants reported that management were crucial in making the team recovery oriented; they created a clear vision which was filtered down through the team. This vision seemed to be at the core of the culture, and appeared to motivate the team.

> Well when you’ve got someone like [X] who’s really enthusiastic and who’s got these ideas of recovery and what the team should be like and how we should be working, I think that sort of enthusiasm and optimism, it sort of spreads to the other team members and then the new people like me join and you can get caught up in the whole, whole idea of it. (Participant 9)

> …and also it’s the culture of the team as well. Erm, and the culture I guess is, comes from the top doesn’t it? i.e. the management. (Participant 6)

Service user involvement. Participants valued the Support Time Recovery worker role (STR) and the new dimension of expertise and practical assistance they provided given their personal experiences. Individuals also highlighted the role that both current and ex service users play in making the service recovery oriented. Service users help the team to run activities and act as role models for newer service users by sharing their experiences of recovery, and factors which helped and hindered their progress.

> Cause you’ve got people there who’ve experienced it for real you know, really at the sharp end, you know I’m only, I’m on this being a member of staff, who can understand better than those who have been there, lived it, want to put something back in. I think that’s superb. (Participant 8)

> I think [the team] encourages more contact between service users as a general rule than most mental health services encourage between their service users and that’s good because there is a network which goes beyond this building of service users that are reaching each other and you know giving each other support. (Participant 11)

Mutual support. The cohesiveness of the team was cited as a valued characteristic, and participants described a process of effective information sharing, support, motivation and good intra-team relationships.

> … I think we have an exceptionally nice group of people, who are very committed, and so on and so forth and that helps, it’s not just a job it’s slightly more than just a job, and I don’t know I suppose a culture of not settling for ok. (Participant 4)

> …it's genuinely supportive I think rather than a lot just of ticking boxes supportive organisation, well it's not, I think it's perhaps as supportive as you can get. (Participant 8)

Shared beliefs. Beliefs and values featured heavily throughout interviews, and individuals showed conviction in their beliefs about the aims of the service and the potential for recovery. Participants reported recovery is generally about moving on with life with or without symptoms, although should be defined by each individual service user rather than by professionals. Individual's beliefs were a valued component of the recruitment process, and once recruited those beliefs were nurtured and strengthened within the existing culture.

> …the best thing about it to make it a recovery oriented service is we don't have any preconceived ideas of what recovery should be. (Participant 10)

> I think you can recover, completely recover without symptoms but, I also feel that people are in recovery when they've still got symptoms and I see it as a journey really throughout their life. (Participant 9)

Discussion

Many participants cited the team culture as an important factor in providing a recovery oriented service. Elements which were seen to have helped in the development of the culture included an effective leadership, and creating and communicating a clear vision. These elements are highlighted by Kotter (1998) as critical stages in creating change. Participants' strong emphasis on the importance of believing in recovery echo the suggestions in previous literature (Jacobson & Greenley, 2001; Salyers & Macy, 2005; Sowers, 2005). In addition, the lack of medical dominance was perceived to help the team provide a more recovery oriented approach.

It was highlighted that the team was mutually supportive and cohesive. Douglas (1995) suggests group cohesion has many functions including; facilitating change;

prioritising common goals; and defending the group against attack from others. STR workers were highly valued members of the team. Huxley, King, Evans, Davidson and Beresford (2006) reported generally positive responses to introducing STR workers into teams, however acknowledged that in some teams, staff members failed to understand the value of personal experience. This was not the case here and suggests that team culture may be a crucial factor in the successful integration of STR workers.

Participants identified several barriers to providing a recovery oriented service, which reflected previous organisational change literature. Although the team reported having effective leadership, Onyett (2004) suggested this was not enough, being supported in the wider context is essential. The opinions of others and being situated within a traditional NHS were often highlighted by participants as problematic. Attitudes and reactions of others, and the wider context of the change, were reported by several researchers as factors which hinder organisational change (Grol, 1997; Grol & Grimshaw, 2003; Onyett, 2004; Sowers, 2005). However, although on a practical level, the team may have experienced resistance at times, participants reported that in the wider context more recent conceptualisations of mental health, and subsequent impact on government policy, has provided an environment which has allowed, and indeed encouraged the service to flourish. This mismatch at an operational level was experienced as both stressful by staff and detrimental to service users. The lack of consistent messages to service users about how their presentation was conceptualised is not unexpected in a time of paradigm shift, this however had the potential to undermine the work of the team.

The skills necessary for effective generic working, and the benefits of generic as opposed to MDT working have been the focus of much debate within the new mental health services (Division of Clinical Psychology, 2006). It has been suggested that assessing the necessary skills needed within the team, and identifying current skills and areas which need further development would be beneficial in order to better meet the needs of service users (Department of Health, 2007). Participants proposed various solutions to their concerns about the skills in the team, but at present it is unclear from the literature which option has the most potential.

Within this team, relationships are formed with service users in line with those described by Borg and Kristiansen (2004) and Topor et al.(2006), who described ‘friendship-like’ relationships and sometimes ‘breaking the rules’ of what might be considered ‘normal’ practice. Within Assertive Outreach and Early Intervention Teams, engagement is a crucial factor in service provision. Within Assertive Outreach, service users continue to receive a service indefinitely, providing they are benefiting from it. However this is not the case for Early Intervention Teams who tend to provide a service for three years in order to intervene during the “critical period” of onset of psychosis (Birchwood, McGorry, & Jackson, 1997; Department of Health, 2001c). This suggests that although the engagement process may be similar, the process of discharge will be very different. Adopting a recovery model is clearly beneficial for engagement, but difficulties disengaging from these “friendship-like” relationships could be expected, and needs further examination. This does not mean that these ways of relating should be called into question, but because they are new ways of relating, their boundaries need to be considered and incorporated into policy documents.

The British Psychological Society (2007) has begun to highlight some of these differences in relation to New Ways of Working. The Working Psychologically in Teams document has highlighted some new ideas around the most effective ways for psychologists to work in Early Intervention, Assertive Outreach, Crisis Resolution and Home Treatment Teams. These include; more self-disclosure than would traditionally be expected; taking on roles that psychologists would not traditionally undertake such as helping with tasks of daily living, help with travel issues and participation in leisure activities; engaging with service users in settings other than mental health facilities; and communicating with service users in new ways such as email, texting and online forums.

Many reported that strong links with other services enables individuals to become involved in meaningful activities in a supportive environment. The team also have an open referral system which means concerned friends or family can contact the service. The importance of family and friends in recovery from psychosis has been widely recognised (Corrigan, et al., 2005; Forchuk, et al., 2003), however, effective communication and information sharing between services and family members can be difficult due to confidentiality issues (Bogart & Soloman, 1999). This is a complex area which requires further research and guidance.

Several participants suggested that it may be more advantageous to facilitate service users' connection with other opportunities within the community rather than being limited to activities within mental health services. Some felt that service users should be reconnecting with their old lives, rather than becoming integrated within a life created by the team. This is a valid argument, and one which requires consideration. However, the benefits of peer support are well known for individuals who have experienced cancer, addiction and posttraumatic stress. It has also been reported as beneficial for individuals with psychosis (Davidson, et al., 2005; Sullivan, 1994; Young & Ensing, 1999). Perhaps these conflicting positions highlight the importance of reflecting on assumptions about what would be beneficial for service users. This not only applies to peer support but other interventions such as medication and psychological therapies. Having options and making choices is vital in providing a recovery oriented service, and it is essential that the recovery orientation does not evolve into another prescriptive model.

The aim of the current study was to explore the experiences of staff working within a recovery oriented service, particularly their perception of what helped and hindered them in the provision of the service. One limitation of the design therefore is that the Early Intervention Service was not undergoing a change in itself; it was a newly created team. The outcome was that it did not experience internal conflict in beliefs and values whilst developing; individuals who shared beliefs were recruited to the team. Other teams which are transforming into a recovery oriented service may face different challenges including conflict within the team itself. This team is unusual in that there was no psychiatrist within the team. For other services which include a psychiatrist, it is possible that having a more traditionally oriented practitioner would hamper the development of a recovery oriented culture due to a traditional understanding of schizophrenia. It would be beneficial for further research to explore the perceptions of other teams' experiences of implementing a recovery model, particularly those who have a psychiatrist within the team, and those who have undergone a transformation into a recovery oriented service.

One criticism of qualitative research is that the analysis is open to researcher bias. Due to the researcher already knowing the participants and the service that they worked in, this is a potential criticism of the study. However, one of the reasons IPA was chosen for this study is that it recognises the role of the researcher in the process of conducting and analysing the research, and emphasises the importance of the process of 'bracketing', which involves the researcher acknowledging their preconceptions and then setting them aside in order to focus on and reflect upon the participants experiences (Dowling, 2007).

A further criticism of qualitative methodology is that the results are not reproducible or generalisable to the wider population. However, this study does not aim to produce an objective statement about what helps and hinders the provision of a recovery oriented service, rather it provides an exploratory account of one group of individuals experiences, which highlight factors for others to consider and are potentially the groundwork for further research. Some methods have been suggested for increasing the reliability of qualitative studies, such as triangulation. However, this was not thought to be appropriate for this study. This was because research in this area is in its infancy, and there is no appropriate questionnaire or other quantitative methodology which would adequately measure participants’ experiences of working in a recovery oriented service.

Themes which emerged from interviews provided a rich source of information about factors which are important in operating a recovery oriented service. Interviews highlighted a number of issues in operating the service, and the context in which the service is based. The current thrust of policy documents highlighting the importance of a recovery model suggests a commitment to taking recovery prerequisites forward in the wider service. However, some of the fundamental conflicts between the recovery and medical model may hamper its implementation.

References

Allot, P., & Higginson, P. (2004). *Assessing the recovery-commitment of your mental health service: a users guide for Developing Recovery Enhancing Environment Measure (DREEM.)* UK Version 1.

American Psychiatric Association (2005). Use of the concept of recovery: position statement. Retrieved May 10, 2008 from: http://psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200504.aspx.

Andresen, R., Caputi, P., & Oades, L. (2006). Stages of a recovery instrument: development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry, 40*, 972-980.

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*(5), 586-594.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23.

Australian Health Ministers (2003). *National Mental Health Plan 2003-2008*. Canberra: Australian Government

Beale, V., & Lambric, T. (1995). *The recovery concept: implementation in the mental health system: a report by the community support program advisor committee*. Columbus: Ohio Department of Mental Health.

Birchwood, M., McGorry, P., & Jackson, H. (1997). Early intervention in schizophrenia. *British Journal of Psychiatry, 170*, 2-5.

Blue Ribbon Commission (1997). *The Blue Ribbon Commission on Mental Health: Final Report: Executive Summary*. Madison, WI: Wisconsin Department of Health.

Bogart, T., & Soloman, P. (1999). Procedures to share treatment information among mental health providers, consumers and families. *Psychiatric Services, 50*(10), 1321-1325.

Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health, 13*(5), 493-505.

British Psychological Society (2007). *New ways of working for applied psychologists in health and social care: working psychologically in teams*. Leicester: Onyett, S.

Campbell-Orde, T., Chamberlin, J., Carpenter, J., & Leff, H. S. (2005). *Measuring the promise: A compendium of recovery measures: Volume II*. Cambridge, MA: The Evaluation Center at Human Services Research Institute.

Corrigan, P., Slopen, N., Gracia, G., Phelan, S., Keogh, C., & Keck, L. (2005). Some recovery processes in mutual-help groups with persons with mental illness; II: Qualitative analysis of participant interviews. *Community Mental Health Journal, 41*(6), 721-735.

Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R., & Sells, D. (2005). Processes of recovery in serious mental illness: Findings from a multinational study. *American Journal of Psychiatric Rehabilitation, 8*, 177-201.

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: a new wine or just a new bottle? . *Professional Psychology: Research and Practice, 36*(5), 480-487.

Davidson, L., O'Connell, M. J., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*(5), 640-645.

Department of Health (2001a). *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*. London: Department of Health

Department of Health (2001b). *The Journey to Recovery: the Government's Vision for Mental Health Care*. London: Department of Health Publications.

Department of Health (2001c). *Mental Health Policy Implementation Guide*. London: Department of Health.

Department of Health (2007). *Mental Health Policy Implementation Guide: A Learning and Development Toolkit*. London Department of Health

Division of Clinical Psychology (2006). *Clinical Psychologists and Assertive Outreach* Leicester: The British Psychological Society

Douglas, T. (1995). *Survival in Groups: The Basics of Group Membership*. Buckingham: Open University Press.

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies, 44,* 131-142.

Farkas, M., Gagne, C., Anthony, W. A., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: identifying the critical dimensions *Community Mental Health Journal, 41*(2), 141-158.

Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Reconnecting: the client experience of recovery from psychosis. *Perspectives in Psychiatric Care, 39*(4), 141-150.

Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). *Construction of a scale to measure consumer recovery.* Springfield, IL: Illinois Office of Mental Health.

Glover, H. (2005). Recovery based service delivery: are we ready to transform the words into a paradigm shift? *Australian e-Journal for the Advancement of Mental Health. , 4(3).* Retrieved June 6, 2008 from: www.auseinet.com/journal/vol4iss3/glovereditorial.pdf

Grol, R. (1997). Beliefs and evidence in changing clinical practice. *British Medical Journal, 315*, 418-421.

Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: effective implementation of change in patients' care. *The Lancet, 362*(9391), 1225-1230.

Harding, C., Zubin, J., & Strauss, J. (1987). Chronicity in schizophrenia: Fact, partial fact, or artefact? *Hospital & Community Psychiatry, 38*(5), 477-486.

Heather, N., & Robertson, I. (1985). *Problem Drinking: The New Approach* Harmondsworth: Penguin Books Ltd. .

Huxley, P., King, S., Evans, S., Davidson, B., & Beresford, P. (2006). *'No recovery without time and support' (or 'more than bowling together'): Evaluation of the introduction of support, time and recovery workers in 3 pilot sites.* London: National Institute of Mental Health in England

Jacobson, N., & Curtis, L. (2000). Recovery as a policy in mental health services: strategies emerging from the states. *Psychiatric Rehabilitation Journal, 23*(4), 333-341.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*(4), 482-485.

Keen, T. M. (2003). Post-psychiatry: paradigm shift or wishful thinking? A speculative review of future possibles for psychiatry. *Journal of Psychiatric and Mental Health Nursing, 10*, 29-37.

Kotter, J. P. (1998). Winning at change. *Leader to Leader, 10*, 27-33.

Liberman, R. P. (2002). Future directions for research studies and clinical work on recovery from schizophrenia: questions with some answers. *International Review of Psychiatry, 14*, 337-342.

Mancini, A., & Finnerty, M. (2005). Recovery Oriented Practices Index. Cited in Scottish Recovery Network (2006). Retrieved June 30, 2006 from:

http://www.scottishrecovery.net/content/default.asp?page=s7_1&newsid=807&back=s7

Mental Health Commission (1998). *Blueprint for mental health services in New Zealand: how things need to be.* Wellington: Mental Health Commission

Mental Health Commission (2001). *Recovery competencies for New Zealand mental health workers* Wellington: Mental Health Commission.

Mental Health Commission (2005). *A vision for a recovery model in Irish Mental Health Services*. Dublin Mental Health Commission.

Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42*(331-353).

Muhr, T. (2007). *User's manual for ATLAS.ti 5.2, ATLAS.ti scientific software development.* Berlin: GmbH.

National Institute of Mental Health in England (2005). *NIMHE guiding statement on recovery*. London National Institute of Mental Health in England.

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.

Office of the Surgeon General (1999). *Mental health: a report of the Surgeon General*. Rockville, MD Public Health Service.

Onyett, S. (2004). The joy of wading: leadership and team working in swampy conditions. *The Mental Health Review, 9*(3), 35-41.

Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2005). An empirical conceptualization of the recovery orientation. *Schizophrenia Research, 75*, 119-128.

Ridgeway, P. (2003). Recovery plenary: The Recovery Enhancing Environments Measure (REE): Using measurement tools to understand and shape recovery-oriented practice. Retrieved March 29, 2007 from: http://www.mhsip.org/2003%20presentations/Plenary/RidgewayPlenary.pdf

Salyers, M. P., & Macy, V. R. (2005). Recovery-oriented evidence-based practices: a commentary *Community Mental Health Journal, 41*(1), 101-103.

Scottish Government (2006). *Rights, relationships, and recovery: the report of the national review of mental health nursing in Scotland.* Edinburgh Scottish Executive.

Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*. London: Sainsbury Centre for Mental Health.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* London: SAGE Publications.

Sowers, W. (2005). Transforming systems of care: the American Association of Community Psychiatrists guidelines for recovery oriented services *Community Mental Health Journal, 41*(6), 757-774.

Sullivan, W. P. (1994). A long and winding road: the process of recovery from severe mental illness. *Innovations and Research, 3*(3), 19-27.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 445-471.

Tondora, J., & Davidson, L. (2006). *Practice guidelines for recovery-oriented behavioral health care.* Hartford, CT: Connecticut Department of Mental Health and Addiction Services.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation.*, *9*, 17-37.

Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspectives of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal 22*(3), 219-231.

Part Three

Appendixes

Appendix A: Feedback to participants.

Following the analysis of the transcripts, the themes that emerged from the interviews and the implications for the service was fed back to the Clinical Lead of the Early Intervention Team who participated in the research. There was a positive response to the feedback, which highlighted both strengths of the team and difficulties the team had faced. Although at times it appeared as though some of the feedback of the dilemmas the team faced was difficult to hear, the Clinical Lead was already conscious of some of the problems that individuals had highlighted. Following the interviews, some of the difficulties experienced began to be discussed within the team, and procedures have begun to be developed in order to overcome some of these difficulties. For example, concerns were raised about the transportation of service users to groups when perhaps there is a greater need to foster independence, and the reliance on the team to provide activities when there may be opportunities for connecting with existing activities within the community. Highlighting these difficulties has lead to the development of a booklet for service users to use in conjunction with their care co-ordinator, which identifies the rationale for engaging in the activity and the objectives to be met. It also details plans for transportation which takes into consideration plans for increasing independence and ability to individually finance their participation in the activities.

The Clinical Lead reported that he appreciated the feedback from the study, and discussed areas which he would consider important for further research such as exploring whether service users perceptions of what they had found important in their recovery matched with staff perceptions of what was helpful in services users’ journey of recovery. The Clinical Lead requested that the results of the study be fed back to the team as a whole in order for further discussion.

Appendix B: Process of external validation

Part of the process of analysis involves spending time discussing themes that emerge through coding of the transcripts, and organising these themes in a way that makes sense. During the process of organising these themes, at times the researcher and a colleague, who ensured validity, discussed the possible content and structure of the themes. At times there were conflicting opinions about the organisation of the themes, however the disagreements strengthened the process of analysis. When disagreements occurred, the researcher was able to examine the themes and the content of the interviews in the light of these new perceptions. Broadly speaking there were three outcomes. Either a) further examinations of the transcripts provided support for the initial ideas which was then fed back to the colleague, b) further scrutiny provided support for the new idea, or c) the process resulted in a synthesis of ideas. The differing opinions enabled a more thorough examination of the data and undoubtedly influenced the final organisation of themes.

Appendix C: Reflective Statement

Reflective Statement

I have had an interest in the provision of services for individuals with psychosis for a number of years. This interest manifested whilst I was working as a health care assistant on an acute mental health unit. Individuals spent most of their days sitting in the smoke room; if they did not already smoke, they soon started the habit. Patients mainly left the smoke room for meal times and for medication. Interaction between staff and service users was minimal; observations were frequent but attempts to engage in dialogue or activities were limited. Young adults who experienced their first lapse into psychosis were the most concerning. I wondered how they could possibly retain hope for recovery when their main interactions were with chronic and floridly psychotic fellow patients. The only input they received was in the form of medication, and no one addressed the issue of the lives they were going back to when they were discharged. I felt that it was perhaps not surprising that the environment which led them to psychosis in the first instance, would impact on them in the same way again, and lead them back into inpatient services. It was at this time that I began to feel that services needed to change in order to effectively meet the needs of individuals with psychosis.

These experiences led me to become interested in researching the issue of recovery from psychosis, which led me to literature regarding the recovery model and recovery oriented services. The ideas explored within this literature reflected my perceptions of the potential for service development. Whilst undertaking my research, it became apparent that there was a constant flow of emergence of recovery ideas and recovery orientation focus in policy documents. This literature supports the theory that services are undergoing a process of change.

As a result of my interest in psychosis, I undertook a placement within the Early Intervention Team which participated in this research. This meant that I had continuing relationships with the individuals I was interviewing. Conducting research interviews with peers brings about different challenges from interviews with previously unknown participants. One marked difference is the nature of the relationship between interviewer and participant; they have a joint history and will have a future outside the interview process, which is unlike other research interviews. This relationship brought about both positive and negative differences. On the positive side, individuals seemed to be comfortable talking to me, and I felt able to understand the context of the comments they were making, due to my past experiences of working in the team and having an understanding of some of the issues that arise. However, this sometimes had a negative component. On one occasion a section of a transcript taken from an early interview, showed that although we were engaging in a dialogue about a certain topic, the topic was alluded to but not clearly stated in the text. Following this occasion, it became clear that it was important for me to ensure individuals made it transparent and clear on the tape the issues they were discussing. This experience also emphasised the possibility that my previous experiences in the team may have had the potential for me making assumptions in my interpretations of the data. For this reason, keeping a reflective diary was essential in order to reflect on the potential impact of my own experiences on the process. Platt (1981) provides an interesting account of some of the difficulties experienced when interviewing one’s peers, and helped me to reflect on the process further. This article is one which I would have perhaps benefited more from if I had read it earlier on in the research process, and would recommend it to others undertaking research with individuals known to them.

I had placed great value on the recovery model; possibly because of my previous experiences of services for people with psychosis. This was perhaps best highlighted for me during the IPA discussion groups. The IPA groups involved meeting on a regular basis with fellow researchers who were also using IPA for their research, and together we discussed transcripts and emerging themes. I found myself feeling that others were being very critical of the team in general. There were two reasons why I found this difficult, one reason was that they were colleagues with whom I had developed a positive relationship with over the time I was on placement in the service. However, after reflecting on the process it seemed that my real concern was for the model. The second reason therefore was that it felt as though the model was fragile, and needed protection. I felt at times it was though I was actually exposing the model's vulnerability; by seeking problems with the implementation of the model and the model itself in order for it to be able to move on and grow stronger, I was at risk of others being disillusioned with the model and so dismissing it as ineffective. Being aware of these issues enabled me to acknowledge problems with the model and its implementation, despite the fact that this may make it vulnerable.

One factor which helped the progress of research was my passion for the subject throughout the process. At times, the process proved to be very challenging, and I believe that my long standing interest in the subject and the desire to improve the services for individuals with psychosis motivated me to continue. Writing about a new paradigm was difficult at times. Although there are many policy documents which highlight the recovery approach and the importance of recovery oriented services produced by many different sources including; the Department of Health, National Institute of Mental Health in England, and the Sainsbury Centre for Mental Health, it seems as though many people I have spoken to about my research are unaware of the prominence of the model. At times I experienced a resistance to the model, as if it were impossible that there could ever be a shift in the way that mental health difficulties are conceptualised. However, I feel that change is already afoot; it seems at times the movement is under the surface, and is waiting to break out into the wider mental health services.

Practical issues which assisted me included using the ATLAS.ti computer program to help the coding process. By using this program, I was able to explore the transcripts more efficiently; it enabled me to test out clusters of codes and themes rapidly. These can be altered in a matter of seconds. The programme enables the user to test out multiple hypotheses of thematic clusters at the same time. This speeded up the process of analysis without impacting on its integrity. In addition I had the total support of the teams management with undertaking the study, and participants were available and willing to take part.

Within the systematic literature review, one difficulty was the nature of the factors being described. Hope is an amorphous concept and one that is difficult to gain a full understanding of. The literature being integrated is very complex, it aims to describe the relationship between hope and recovery from psychosis, both of which can be defined as a process and a goal. In addition, hope and recovery are related in a symbiotic fashion. Hope is a factor which assists the process of recovery, and the various components of recovery assist the development of hope. The factors within recovery are closely intertwined, this makes it hard to determine where one construct begins and another ends.

This is an important area for clinical psychologists to engage with for many reasons. The recovery model recognises the importance of hope, empowerment, relationships, self esteem and so on. These elements are consistently considered and nurtured by psychologists within their working practice. Indeed many of the concepts within the recovery model are not new to psychologists. Currently there is a push for clinical psychologists to become more integrated into teams. Within those teams it has been emphasised that psychologists should regain a clear professional identity in order to have a role as counterbalancing the medical model. In this position, clinical psychologists are in an optimal position to influence the team, challenge less helpful conceptualisations of mental health difficulties, and assist the implementation of this empowering and strengths based model.

Justification for choice of journal

The journal chosen for submission to is Psychology and Psychotherapy: Theory, Research and Practice. This journal was chosen for several reasons. I observed that much of the previous research on the recovery models and recovery oriented services were published in the US or New Zealand, there were limited papers published in the UK. For this reason, I felt it was important to publish in a British journal. This particular journal is published by the British Psychological Society and is peer reviewed. This journal regularly features articles about psychosis and qualitative studies, and is interested in recovery from and practice in mental health difficulties. For these reasons, both systematic literature review and empirical paper are suitable for publication in this journal.

Platt, J. (1981). On interviewing one's peers*.* *British Journal of Sociology, 32* (1), 75-91.

Appendix D: Interview schedule

Semi Structured Interview

1. What do you understand by the term recovery?

2. What does [the team] understand by the term recovery?

3. Do you think the [the team] is a recovery oriented service?

4. What is it about the service that makes it recovery oriented?

5. What do you think would make it more so?

Research in this area describes a number of things which are important in running recovery oriented services. Perhaps we could run through these, and you can tell me what you think about them?

- Choice for service users
- Service users being involved in the planning and development of the services they receive
- Having a wide range of treatment options
- Helping service users to develop their own support networks
- Emphasising service users strengths
- Helping service users develop other roles and meaningful activities

6. What has helped provide a recovery oriented service?

7. What has made it hard to provide a service that is recovery oriented?

8. Do you have any ideas how to overcome any of those problems?

Appendix E: Participant Information Sheet

Participant Information Sheet

(Version 2: 12.07.07)

Study Title: Recovery Oriented Services: Strategies and Boundaries.

You are being invited to take part in a research study as part of an educational qualification. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully, and talk to others about the study if you wish. Please feel free to ask questions about anything that is not clear, or if you would like some more information before deciding whether to take part.

What is the purpose of the study?

Traditional services for individuals with mental health problems, normally focus on the cessation of symptoms and relapse prevention. However, the service user movement has conceptualised recovery as something more than the cessation of symptoms, with an emphasis on developing relationships, engaging in activities and having meaningful roles. Services which aim toward recovery in this sense have been termed recovery oriented services. The purpose of this study is to identify what helps and what hinders the provision of recovery oriented services.

Why have I been chosen?

You have been asked to take part because you work in a team that provides a service that is oriented towards the recovery model.

Do I have to take part?

Taking part in this study is entirely voluntary. I will describe the study and go through this information sheet with you, it is then up to you to decide if you wish to take part. If you agree to take part then I will ask you to sign a consent form to show you have agreed to take part, which you will then keep a copy of. You are free to withdraw from the study at any time, without giving a reason.

What happens to me if I take part?

If you agree to take part there will be an interview with myself which will last around an hour. The interview will be digitally recorded, and the content will remain confidential and stored on a password protected computer. If specific consent is given, direct quotes from the interview may be published, and these quotes will be completely anonymised.

What are the possible benefits of taking part?

You will be contributing to knowledge of benefit to service development.

What will happen if I don’t want to carry on with the study?

You are free to withdraw from the study at any time, and all information will be removed from the study.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to myself and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

Will my taking part in the study be confidential?

I will follow ethical and legal practice and all information will be handled in confidence. Only myself and my research supervisor will have access to identifiable data. Information and consent forms will be stored in a locked cabinet. The digital recording of interviews will be anonymised and stored on a password protected computer. Information and interviews will be kept for 5 years and then disposed of securely.

What happens to the results of the research study?

The results of the study will be disseminated to the team in a feedback session, and an executive summary of the research will be distributed to appropriate service managers. Results of the study will also be published in a peer reviewed scientific journal.

Who is organising and funding the research?

As this research is part of a Doctoral in Clinical Psychology, a small amount of funding will be allocated by the University of Hull. Humber Mental Health Teaching NHS Trust will be sponsoring the research.

Who has reviewed the study?

All research in the NHS is reviewed by an independent group of people, called a Research Ethics committee to protect your rights and wellbeing. This study has been reviewed and given a favourable opinion by Humber Mental Health Teaching NHS Trust Research Ethics committee.

Further information and contact details

1. For general information regarding research please contact myself on

2. For information regarding who to approach if they are unhappy with the study please contact my supervisor on

Appendix F: Participant details sheet.

Participant Details Sheet

(Version 1: 25.05.2007)

Participant identification number:

1. Age:

2. Sex: M/F

3. Current position:

4. Professional background:

5. Number of years qualified:

6. Length of time at [the team]:

Appendix G: Consent form

Centre Number:
Study Number:
Participant Identification Number:

Consent Form

(Version 1: 25.05.2007)

Title of Study: Recovery oriented services: strategies and boundaries.
Name of Researcher: Leah Talbot

Please initial box

1. I confirm I have read and understood the information sheet Dated 12.07.2007 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and had these answered satisfactorily. ☐
2. I understand that my participation is voluntary, and I am free to withdraw from the study at any time without giving reason. ☐
3. I agree to take part in the study. ☐
4. I agree to the interview being audio recorded. ☐
5. I agree to the publication of anonymous direct quotes. ☐

____________________	____________	____________________
Name of participant	Date	Signature
____________________	____________	____________________
Name of person Taking consent	Date	Signature

When completed, 1 copy for participant, 1 for researcher site file.

Appendix H: Local research ethics committee approval.

Appendix I: Research and Development Department Approval

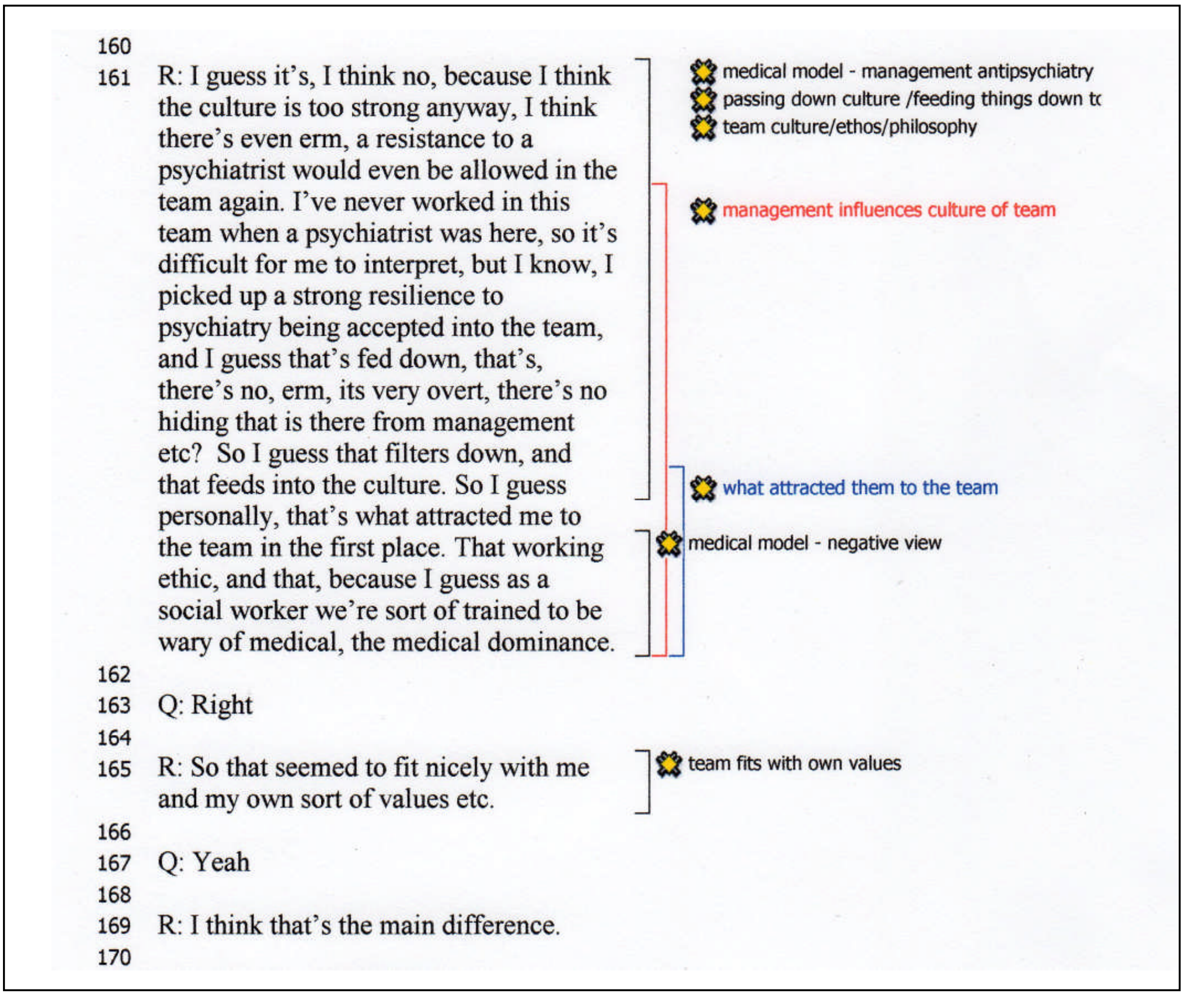
Appendix J: Worked Example of Interpretive Phenomenological Analysis.

To assist with the coding and organisation of themes, I used the ALTAS.ti software. This software is described by the product brochure as:

> "a powerful workbench for the qualitative analysis of large bodies of textual, graphical, audio and video data. Sophisticated tools help you to arrange, reassemble, and manage your material in creative, yet systematic ways. ATLAS.ti keeps you focused on the material itself."

The initial stage of Interpretive Phenomenological Analysis is reading and re-reading the transcripts in order to become familiar with the text. The second stage is to begin to annotate the transcript and comment on the content, whether it be interesting or significant. An example of this process using ATLAS.ti is shown in Figure 1.

Figure 1.



R: I guess it's, I think no, because I think the culture is too strong anyway, I think there's even erm, a resistance to a psychiatrist would even be allowed in the team again. I've never worked in this team when a psychiatrist was here, so it's difficult for me to interpret, but I know, I picked up a strong resilience to psychiatry being accepted into the team, and I guess that's fed down, that's, there's no, erm, its very overt, there's no hiding that is there from management etc? So I guess that filters down, and that feeds into the culture. So I guess personally, that's what attracted me to the team in the first place. That working ethic, and that, because I guess as a social worker we're sort of trained to be wary of medical, the medical dominance.

Q: Right

R: So that seemed to fit nicely with me and my own sort of values etc.

Q: Yeah

R: I think that's the main difference.

Following this process links between codes are made within transcripts, and themes begin to emerge. Within ATLAS.ti these themes are known as Code Families. This process continues throughout each transcript. An example of initial themes that emerged is shown in Figure 2.

Figure 2.

Code Family: staff - management
Created: 14/03/08 17:54:25 (Super)
Codes (5): [importance of management] [management influences culture of team] [medical model - management anti-psychiatry] [passing down culture /feeding things down to new members]
Quotation(s): 18

Code Family: staff - recruitment
Created: 14/03/08 17:41:24 (Super)
Codes (5): [team attracts certain people] [recruiting staff who share the same philosophy] [team fits with own values] [type of people that work at team important] [what attracted them to the team]
Quotation(s): 9

Code Family: skills of staff
Created: 14/03/08 16:54:34 (Super)
Codes (4): [different professional backgrounds] [different skill mix - using that effectively] [skills of the team] [use others to get a different perspective]
Quotation(s): 18

Following this process, links between the initial emerging themes are made. Some themes are divided and some are combined in a process of attempting to try to make sense of the connections in the data. Figure 3 illustrates several of the themes which emerged during this process.

Figure 3.

Code Family: barriers have we got the skills
Created: 26/05/08 17:13:26 (Super)
Codes (8): [drugs specialist] [generic worker - being all things to all people] [generic worker - not trained] [generic worker - who am I?] [need for more therapeutic intervention] [need more OTs] [other professions in team] [uncertain about skills]
Quotation(s): 25

Code Family: strategies links with others
Created: 29/05/08 11:16:06 (Super)
Codes (7): [good relationship with psychiatrist] [good relationship with community] [good relationship with other services] [links with organisations within the community] [other people on board] [people think we're ok/getting good feedback] [team received positively]
Quotation(s): 14

Code Family: strategies proof/government initiatives
Created: 07/05/08 23:33:34 (Super)
Codes (5): [government initiatives] [politics good] [previous research suggests this approach better outcome] [research - this way of working] [statistics and figures]
Quotation(s): 19

In the final stage, themes are clustered together, and in this process some themes are combined, some divided and some rejected. Clusters are then given an identifying name which represents the themes within it. The final superordinate and subordinate themes are shown in Table 1.

Table 1.

Superordinate	Subordinate
1. Being different: them and us	Other people's attitudes Having to justify ourselves
2. It's a struggle, can we do it?	Its hard work Have we got the skills?
3. Operationalizing the model	Organisational boundaries vs. individual need Therapeutic experiences vs. reintegration Links with others
4. Creation of a culture	A different emphasis A clear vision Service user involvement Shared beliefs Mutual support

Appendix K: Psychology and Psychotherapy: Theory, Research and Practice Author Guidelines.

Notes for Contributors

Psychology and Psychotherapy: Theory Research and Practice (formerly *The British Journal of Medical Psychology*) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at http://paptrap.edmgr.com.

First-time users: Click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

Registered users: Click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:

- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - Manuscript title page template
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - Editorial Manager - Tutorial for Authors
Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions:

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc. for which they do not own copyright.

6. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

7. Publication ethics

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines (2004)
Principles of Publishing - Principles of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs
- Tables, figures, captions placed at the end of the article or attached as separate files