The Meaning of Mental Health Recovery for Consumers, Carers and Nurses: A Phenomenological Exploration

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Notice 1

Abstract

Mental health recovery is a prominent topic of discussion in western mental health settings. The concept and application of mental health recovery has been perceived as a guiding vision for many mental health services. However, there is an absence of input on mental health recovery from stakeholders such as carers and family members, service providers and policy makers globally, and a paucity of literature within the Australian context. The overall aim of this study was to explore the meaning and elements of mental health recovery as it is understood by consumers of mental health services (hereafter referred to as 'consumers'), carers[1] and mental health nurses within the Australian context. The four research objectives were to: (i) explore participants' meaning and understanding of mental health recovery, (ii) identify the enablers to mental health recovery, (iii) identify any barriers to mental health recovery and (iv) explore participants' views on recovery-oriented mental health services. This study utilised van Manen's hermeneutic phenomenological method. This approach was carefully considered due to the nature of the study and chosen due to its ability to provide an in-depth understanding of how participants' viewed recovery from mental illness. Van Manen (1997b) describes phenomenology as the study of 'essences', the aim of which is to gain a deep understanding of the nature or meaning of the phenomenon. Twenty-six participants were selected from community mental health services of an Area Mental Health Service in Victoria, Australia. The participants comprised three cohorts: consumers, carers and nurses. The results indicated that the meaning attributed to the term 'mental health recovery'

[1] The word 'carers' represents family members, friends or any persons who actively support a consumer in their recovery journey.

by consumers and nurses described, respectively, two major processes: an internal recovery resulting in the transformation of a person's sense of self; and, an external recovery resulting in the manifestation of a changed self. Many of the carers' views differed from the other two cohorts, as the former, in many instances, believed that recovery from mental illness was impossible. The study identified several themes in relation to factors seen to assist mental health recovery, such as optimism, safety, belongingness and choice. Factors viewed as impeding mental health recovery included control, rejection, necessity and struggle. Participants also suggested that a recovery-oriented mental health service promoted belongingness and autonomy of consumers and increased community awareness to combat the stigma associated with mental illness. In conclusion this study makes recommendations that have implications for education, clinical practice and future research.

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Thesis Including Published Works General Declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes two original papers published in peer-reviewed journals and three publications under review. The core theme of the thesis is Mental Health Recovery. The ideas, development and writing up of all the papers in the thesis were, principally, my responsibility as the candidate working within the Degree of Doctor of Philosophy under the supervision of Dr. Ian Munro, Prof. Beverley Taylor and Assoc. Prof. Debra Griffiths.

In the case of Chapters 2, 5, 6, 7, and 8, my contribution to the work involved the following:

Thesis Chapter	**Publication title**	**Publication status**	**Nature and extent (%) of students contribution**
Chapter 2	Mental health recovery: A review of the peer-reviewed published literature	Published	70 %
Chapter 5	Mental health recovery: Lived experience of consumers, carers and nurses	Published	70 %
Chapter 6	What aids mental health recovery? Views of consumers, carers and nurses. Part 1	Under review	70 %
Chapter 7	Mental health recovery: Perspectives of mental health consumers, carers and nurses: Part 2: Impediments to recovery	Under review	70 %
Chapter 8	Shaping a recovery-oriented mental health service: Insights from consumers, carers and nurses	Under review	70 %

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature: [redacted] **Date: 02/11/2015**

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student and co-authors' contributions to this work.

Main Supervisor signature: [redacted] **Date: 02/11/2015**

DEDICATION

The completion of this thesis has been made possible through the motivation and guidance of highly spiritual and intellectual people. Though I could have chosen from a variety of subjects in the profession of mental health nursing for this doctoral thesis, I was inspired to explore the essence of a person's recovery journey and therefore chose to focus on the concept of mental health recovery. From the very early stages of my life, I developed love and compassion for consumers of mental health services. This came about through the inspiration I have received from my maternal uncle, Rev. Dr. Antony Mannarkulam, Founder of Sanjeevany Rehabilitation Centre, Nedumkunnam, India, to whom I dedicate this work. Fr. Tony has taught me, through his life, passion and love for caring for those who are disadvantaged through mental suffering, and thus I wish to express to him my utmost gratitude and love.

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Statement of editorial practice

Thesis submitted by Sini Jacob, candidate in the Faculty of Medicine, Nursing and Health Sciences, School Of Nursing and Midwifery, Monash University, Australia, for the Degree of Doctor of Philosophy, October 2015.

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This thesis has had the benefit of professional editorial advice according to the guidelines set down by the Institute of Professional Editors (*Australian standards for editing practice*). Editorial advice was restricted to matters of language (including matters of clarity, consistency, voice and tone, grammar, spelling and punctuation, specialized and foreign material); structure (exemplars only); and use of illustrations and tables.

Ruth Fluhr
Academic Editor
October 21, 2015

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List of Acronyms

ABS	Australian Bureau of Statistics
ACMHN	Australian College of Mental Health Nurses
AMHS	Area Mental Health Service
CPU	Central Processing Unit
CSIs	Consumer/Survivor Initiatives
CTO	Community Treatment Order
GDP	Gross Domestic Product
GP	General Practitioner
ImROC	Implementing Recovery Organisational Change
MH	Mental Health
MHA	Mental Health Act
MHR	Mental Health Recovery
MHREP	Mental Health Recovery Education Program
MHS	Mental Health Service
NCD	Non-communicable Disease
NMHC	National Mental Health Commission
NMHCCF	National Mental Health Consumer and Carer Forum
NSW	New South Wales
OPA	Office of the Public Advocate
UK	United Kingdom
USA	United States of America
VCAT	Victorian Civil and Administrative Tribunal
WEF	World Economic Forum
WHO	World Health Organisation

Conference Presentations

Year	Type	Presentation
2015	International	**Jacob, S.,** Munro, I. & Griffiths. D. (2015, October). Break the Barriers to recovery and lead change: A Call for mental health nurses. Paper presented at the 41st International Mental Health Nursing Conference (ACMHN), Brisbane.
2014	International	**Jacob, S.,** Munro, I. & Griffiths. D. (2014, October). Shaping a recovery-oriented mental health services: Insights of Consumers, Carers and Nurses. Paper presented at the 40th International Mental Health Nursing Conference (ACMHN), Melbourne.
2013	International	**Jacob, S.,** Munro, I. & Taylor, B. (2013, October). Don't go ahead or Behind: Walk alongside to understand the real meaning of recovery. Paper presented at the 39th International Mental Health Nursing Conference (ACMHN), Perth.
2011	State	**Jacob, S**., Munro, I. & Obrien, T. (2011, August). The real meaning of recovery: A wake up call for mental health nurses. Paper presented at the Victorian Collaborative Psychiatric Nursing Conference, Melbourne.
2011	International	**Jacob, S**., Munro, I. & Taylor, B. (2011, October). Are mental health nurses preparing a safe beach for consumers? Paper presented at the 37th International Mental Health Nursing Conference (ACMHN), Gold Coast.

Research School Presentations

Year	Presentation
2014	**Jacob, S.,** Munro, I. & Taylor, B. (2015, February). Shaping a recovery-oriented mental health services: Insights of Consumers, Carers and Nurses. Paper presented at the Research Conference, SoNM, Berwick.
2013	**Jacob, S.,** Munro, I. & Taylor, B. (2013, September). The real meaning of recovery: Part one of the results. Paper presented at the Research Conference, SoNM, Berwick.
2012	**Jacob, S.,** Munro, I. & Taylor, B. (2012, September). Seasons of my Journey: Progress. Paper presented at the Research Conference, SoNM, Peninsula.
2012	**Jacob, S.** (2012, July). Mental health recovery: Research Presentation. Paper presented at the Peninsula Health Senior Nurses Meeting, Frankston.
2012	**Jacob, S.,** Munro, I. & Taylor, B. (2012, March). Exploring the meaning of recovery. Paper presented at the Confirmation of Candidature, SoNM, Peninsula.

Awards

Year	Position	Conference
2013	Winner	**Best Research Presentation:** ACMHN 39th International Mental Health Nursing Conference (2013, October), Perth.
2012	Winner	**Monash Postgraduate Award:** Peninsula Campus Research Morning, (2012 September), Frankston.

Preface

My journey as a nurse began in 2000 when I graduated with a Diploma in Nursing from Immaculate Heart of Mary Hospital, South India. Soon after graduation, I worked as a general nurse for two years. In 2002, I volunteered as a nurse in a psychiatric rehabilitation centre, the Sanjeevany Rehabilitation Centre, in Nedumkunnam, of which my maternal uncle is the founder and director: thus, I knew about this facility even before completing my studies. This centre is a long-term facility and the consumers live there for the rest of their lives. During the time I was working there, some consumers had family contact and some did not have anyone to support them, other than the staff at the facility. For these consumers, we (the staff) were their 'family'.

The centre had, and has, a regular routine and I observed that most of the consumers were generally settled in their mental health and lived a peaceful life. The routine included exercise, morning prayer, breakfast, reading time, gardening, afternoon nap, afternoon tea, some recreational activities, such as a walk or music, evening prayer, dinner and bed time. Medications were administered during meal times. I enjoyed working there as a nurse and spent a year of quality time, becoming very close with the consumers. Some of their stories were traumatic; however, many of them were happy that they were in a better place. This was my initial experience in a mental health facility.

Thereafter, in 2005, I migrated to Australia and joined an acute mental health ward as a Registered Nurse. The first few months were, quite literally, traumatic for me, as I was faced with different and more severe degrees of mental illness. However, I slowly learned more about mental illness, and developed skills that allowed me to feel motivated and confident enough to work in this challenging clinical environment.

In the acute mental health ward, time is precious and the opportunity to spend time with carers is scant. I remember some of the interactions that divulged the trauma of carers; in one such incident, I cared for a very young man who was diagnosed as having drug-induced psychosis. There was no family history of mental illness and the parents did not understand his mental health condition. They were very distressed and wanted to know whether they would get their son back. When the mother put this question to me, I was speechless and didn't know what to say. I didn't have enough experience and hope with regard to mental health recovery to instil hope for that family.

Currently, I have more than a decade of experience in mental health nursing. I have looked after many consumers and dealt with many carers. The Area Mental Health Service (AMHS), where I am currently employed, formerly had a focus on the cure-oriented approach (medical model of care) to mental illness. However, in 2008, the concept of mental health recovery was introduced to the AMHS; this emphasised the focus on the person, rather than on the illness. However, many mental health clinicians are still following the former approach of cure-orientation. I have also noticed many carers are distressed about their loved ones and their future. Many times, I have wondered what mental health recovery means to these people and how they view recovery from mental illness. Questions as to their awareness of the concept of consumer-centred mental health recovery have also been at the forefront of my mind. These are some of the questions I have addressed in this study.

Chapter 1: The impetus for this journey

Introduction

For centuries, mental illness was seen as a debilitating and stigmatising condition with minimal hope for recovery. Consumers of services provided for people suffering mental health issues have, throughout history, suffered torture and violent practices, some of which were considered as therapies. For example, "people with mental illness were stoned, burned at the stake, locked in cages, chained to posts and walls, confined to squalid and inhumane living conditions, insulin-shocked, hydro-shocked, electro-shocked, and lobotomized" (Davidson, Rakfeldt, & Strauss, 2010, p. 2). In the post-modern era, mental health care has, with the current acceptance of the concept of mental health recovery, advanced considerably in western countries. The contemporary notion of recovery from mental illness has progressed from the concept of symptom remission to the concept of wellness-orientation. Recovery from mental illness is currently considered as the ability to live a meaningful life even with the presence of mental illness (Anthony, 1993).

Davidson et al. (2010) state that the current concept of mental health recovery originated from consumer movements, which emerged as a response to centuries of torture and violence inflicted on those suffering with a mental illness. Further influence is noted in the language used to describe people with mental illness, which has fundamentally changed, expressing the sufferer of mental health issues as a 'consumer'. Watkins (2007) argues that with the increase in the consumer movement towards a recovery paradigm, the suffering of consumers is coming to an end in the western world. This chapter introduces the study and provides an overview of the effects that mental illness imposes on those within a local community, the origins of the mental health recovery movement, and the researcher's position in relation to the

concept of mental health recovery. The chapter also comprises the aim of the study, research question and objectives, significance of the study and overview of subsequent chapters.

The ambiguity

Mental illness has been discussed and interpreted in many ways, due to the prevalence of some firmly held beliefs about the condition, such as: mental illness is a subjective experience of an individual and cannot be scientifically tested or proved (Slade, 2009); the cause of mental illness is unknown and a thorough evidence-based explanation is yet to be identified (Fleming & Martin, 2011; McGorry, 2005; Sharfstein & Dickerson, 2006); at present, there are no effective treatments for mental illness (Collins et al., 2011; Slade, 2009). In ancient times, mental illness was seen as the result of association with sins and demonic possession (Antai-Otong, 2003). However in the present-day setting, it has been argued that there is no such thing as mental illness, but that it is a form of suffering that leads to extraordinary states of consciousness and reality (Watkins, 2007).

The effects of mental illness

Mental illness is one of the major health conditions that affect global society. Collins et al. (2011) reported that mental illness constitutes 13% of the global burden of disease. According to the Australian Bureau of Statistics (2007) (ABS), almost half of the Australian population (45 %) have experienced a mental disorder at some point in their lifetime. Almost one in five Australians surveyed had experienced symptoms of a mental disorder during the 12-month period prior to the 2007 ABS survey. Anxiety disorders were most common (14.4%), followed by affective disorders (6.2%, of which depression is 4.1%), and substance use disorders, 5.1% (of which 4.3% is alcohol-related). The percentage of people meeting the criteria for diagnosis

of a mental illness was highest in younger people, with the prevalence decreasing with age. Of people 18-24 years old, 26 % had experienced a mental disorder, while only 5.9% of people aged 65 years and over had experienced a mental disorder. Unemployed people, or those not in the paid workforce, had the highest rates of mental disorder – a prevalence rate of 26% for unemployed men and 34% for unemployed women (Australian Bureau of Statistics, 2007).

The economic cost to Australia of mental health issues is estimated to be up to $40 billion a year, or more than 2% of Gross Domestic Product (GDP) (National Mental Health Commission, 2014). The World Economic Forum (WEF) predicts that mental illness costs will more than double by 2030 and this dwarfs the cost of any other non-communicable disease (NCD). In addition, "there is a huge global loss in economic output, with mental health conditions having the greatest impact on productivity" (National Mental Health Commission, 2014, p. 24). Therefore, the current concept of mental health recovery (occasionally, MHR[2]) is significant in socio-economic terms in Australia, as it promotes wellness and the integration of consumers in a bid to enhance a better quality of life. However, this can only be achieved by hearing the voices of relevant stakeholders and gaining insight into the recovery movement.

Mental health recovery movement

The twentieth century was known as the 'era of psychiatry', where that discipline improved social attitudes and promoted society's sensitivity towards people with mental illness (Antai-Otong, 2003). Literature suggests that the journey of the current application of the concept of MHR is the third phase in the 'era of psychiatry'

[2] The term mental health recovery and the acronym MHR are used intermittently to prevent multiple repetition of the terms.

(Frese, Knight, & Saks, 2009): the first phase was marked by a cure-oriented approach that attempted to diminish or eliminate the symptoms of a disorder; the second phase was marked with a psychiatric rehabilitation model of care, in which the primary goal of care was to increase patients' ability to function in society; and the third phase is the current recovery approach, which is yet to be widely adopted by many mental health systems (Frese et al., 2009, p. 371).

The mental health consumer movement began in the mid-twentieth century and gained the support of federal agencies in America (Antai-Otong, 2003). The current concept of recovery originated from two interrelated sources in the United States of America (USA) – the mental health consumer movements and the trends in psychiatric rehabilitation (Anthony, 1993; Frese et al., 2009; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Jacobson & Curtis, 2000). The consumer movements began in the wake of a radical restructuring of the American mental health system between 1950-1970, resulting from deinstitutionalisation, new psychotropic drug treatments, legal conceptions of patient rights and intellectual critiques associated with the anti-psychiatric movement (Tomes, 2006).

From 1970, in the USA, ex-consumers who were educated and articulate began to speak out and started to reform the mental health field, which was, at that time, largely based on the cure-oriented model (Frese et al., 2001; O'Brien, 2001). Many local organisations were established by consumers, such as: the Oregon Insane Liberation Front (1970); New York City's Mental Patients' Liberation Project (1971); and Boston's Mental Patients' Liberation Project (1971) (Frese et al., 2009; Frese et al., 2001). In 1973, in Detroit, the first national meeting of the consumer groups, (referred to as 'the Conference on Human Rights and Psychiatric Oppression') occurred; they met every year until 1985 (Frese et al., 2009). These meetings in the

USA focused primarily on ways to gain more dignity and freedom from what was perceived as cruel and demanding treatment by the mental health system. Since the first organisational meeting, many consumers began to produce reports about their perspectives and opinions concerning their experiences of recovery, which were different from the perspectives of professionals who had been managing the mental health services (Frese et al., 2009). Many consumers began to demand the treatment of mental illness to be considered through the unique lens of those experiencing the symptoms; this approach included their preferences and goals (Frese et al., 2009).

These catalytic activities generated by mental health consumer movements resulted in many developments in mental health care, such as policies in relation to consumer partnerships and more optimistic views towards recovering from mental illness (Anthony, 1993; Brower, 2003; National Institute for Mental Health in England, 2005; New Zealand Minister of Health, 2005). Compared to previous decades, the terms 'mental health recovery' and 'recovery-oriented practices' are more frequently used in many western mental health systems today, despite the challenges and scrutiny raised by those who focus on the cure-oriented medical model of care (Frese et al., 2001; Lester & Gask, 2006). Peyser (2001) and Frese et al. (2001) warn that enthusiasm towards the recovery model should not interfere with the benefits of medical treatment for consumers who require treatment.

Researcher's experience with the concept of mental health recovery

As a practising mental health nurse recently introduced to the concept of recovery, I was unsure about the possibility of recovery from mental illness, and believed that recovery meant the cure of symptoms. All clinical interventions and education of consumers by the researcher were oriented towards a complete cure. The experience of working in an acute mental health ward challenged this researcher's

own sense of hope for mental health recovery, due to the 'revolving door' concept, where, most often, the same consumers were frequently readmitted due to reasons such as the use of illicit drugs or alcohol, non-adherence with medications and/or crisis issues and relapses of their mental illness.

In 2009, the researcher attended an education session in mental health recovery and was exposed to the fascinating concept that recovery is about living life, regardless of the presence or absence of symptoms of mental illness. The focus is not on cure or remission, but rather on improving consumers' capacity to live more productively within the community. Mental health recovery means growing one's ability to learn and understand oneself more, in terms of a particular mindset that asks 'who am I?' and 'what is one's purpose in life?' (Coleman, 2008).

This concept of MHR was appealing to the researcher for two reasons: firstly, as a mental health nurse and researcher, I was forming the belief that many consumers have the potential to live a productive life within the community, even though they may not be actively promoting themselves; secondly, I was coming to realize that working with the person and the family, rather than providing basic nursing care, is the most efficacious practice in terms of recovery. However, from this researcher's clinical observation, the concept of MHR was not widely understood by mental health clinicians, consumers or carers, and was not widely established within the Area Mental Health Service (AMHS). This concept of MHR was a new way of thinking and there were no policies or practice guidelines available for staff. A literature review revealed a lack of wider examination of the concept of MHR within the Australian context, and a paucity of knowledge about the diverse views of recovery among carers, service providers and policy makers.

Therefore, the researcher sought to discover more about what recovery means to consumers, carers and clinicians in a bid to identify and understand the various perspectives that may give rise to gaps in service delivery. To provide recovery-oriented care, a good understanding about the enablers of and barriers to mental health recovery is necessary. For that reason, it is necessary to explore factors that facilitate and hinder MHR. Identifying participant views about a recovery-oriented mental health service enabled the researcher to understand the future direction. Hence, the questions regarding views in relation to recovery-oriented service are significant. This researcher believes these questions can bring a better understanding of the concept of MHR and will equip the researcher to influence and contribute to local, national, and international mental health practice. In this study, the researcher seeks to explore the experience of participants in order to address these questions.

Aim of the Study

The overall aim of this study was to explore the perceptions of MHR held by consumers, carers and mental health nurses in a community setting in Victoria, Australia.

Research Question

The research question underlying the aim of the study was '*What does recovery from mental illness mean to you?'*

Research objectives

The research objectives were:

- to explore the participants' views on the meaning of mental health recovery.
- to identify differences and/or similarities in their views.
- to identify enablers and/ or barriers to mental health recovery.

- to explore the participants' insights on a recovery-oriented mental health system.
- to make recommendations based on the participants' views.

Significance of the study

Many recovery studies, conducted internationally, have focused on gaining the views of consumers in relation to mental health recovery (Borg & Davidson, 2008; Browne, Hemsley, & St. John, 2008; Cohen, 2005; Davidson et al., 2005; Drake et al., 2006; Hipolito, Carpenter-Song, & Whitley, 2011; Jensen & Wadkins, 2007; Ng, Pearson, Lam, et al., 2008; Piat et al., 2009; Ridge & Ziebland, 2006). While these studies are important, two major gaps exist in the current literature. Firstly, the concept has not been widely explored in the Australian context. Secondly, the concept has not been widely explored among other stakeholders such as: carers, service providers such as doctors, mental health nurses, and policy makers.

The potential significance of this study lies in an understanding of the meaning of mental health recovery among consumers, carers and mental health nurses within the Australian context. As mental health recovery is an important concept that has relevance to service delivery, knowing more about the concept will enable key stakeholders, such as service providers, to identify and rectify gaps in current service delivery, and thus potentially benefit all involved. While the Australian policy documents promote a recovery-orientated approach, many mental health settings have a medically-dominated approach (Happell, 2008b). The service delivery practices provided in many mental health settings may be directly at odds with the expectation of recovery outcomes of consumers and carers. Therefore, this study potentially compliments the advancement of clinical practice guidelines and policies.

In summary, exploring the meaning of mental health recovery among consumers, carers and mental health nurses is important for several reasons: firstly, the study enables a better understanding of the concept of recovery and factors influencing recovery within the Australian context; second, understanding the concept of MHR among these three cohorts and highlighting the differences and similarities in these views may influence the development of inclusive guidelines and practice standards informed by research outcomes; third, the study provides a foundation to reduce the existing gap in the current literature by contributing to the body of knowledge about mental health recovery in the Australian context; and, lastly, the study suggests future research directions into this relevant topic to further enhance mental health care.

Structure of the Thesis

Chapter 2 provides a detailed discussion of the literature relating to mental health recovery. The theoretical framework on the definition of mental health recovery has been examined. The literature suggests that two major conflicting views of mental health recovery exist, cure-orientation and future-orientation. This chapter contains a publication in a peer-reviewed journal that highlights the research on recovery. This chapter identifies the gaps in the current literature and the benefits this study brings to the world of evidence-based practice.

Chapter 3 discusses the methodology used for this study. Van Manen's Hermeneutic Phenomenological approach was used in this study. In this chapter, a brief overview of the origin of phenomenological movements and the two intellectual pillars of phenomenological philosophy – Husserl & Heidegger – are discussed. This chapter details van Manen's human science approach and its benefits to mental health nursing research.

Chapter 4 provides a detailed description of how this research was conducted. The process of planning for the study, recruitment, ethical considerations, data collection and data analysis are outlined in this chapter. This chapter also provides van Manen's guidelines in relation to assessing the validity and reliability of phenomenological studies. At the end of the chapter a brief background of the participants is provided.

Chapters 5 to 8 illustrate the findings and discussions from this study. In Chapter 5, the meaning attributed to mental health recovery by participants is discussed. This chapter contains a published paper. The paper details similar and dissimilar views of mental health recovery. The similar views have been categorised into two perceptions relating to self – an internal process and an external process. These two perceptions involve reclaiming various aspects of self, such as self-understanding, self-control, self-belief and self-acceptance, living life, cure or absence of symptoms, and contribution to community. The other views of recovery involve returning to a pre-illness state and presumed impossibility of recovery. Additionally, the paper discusses the importance of a 'sense of self' for the person with mental illness and the ability to understand 'who am I' as the essence of mental health recovery.

Chapter 6 discusses findings in relation to factors contributing to MHR. The chapter comprises a paper submitted for publication. The submitted paper addresses the major themes that evolved from the data, which include: optimism, safety, belongingness and choices; the remainder of the chapter covers additional findings.

Chapter 7 outlines the impediments to MHR. This chapter also contains an article submitted for publication. This paper presented factors identified by consumers, carers and nurses as inhibiting mental health recovery. Four major themes

were identified as barriers to mental health recovery: control, rejection, necessity and struggle. The remainder of the chapter covers some additional findings.

Chapter 8 focuses on the insights of participants about a recovery-oriented mental health system and includes an article submitted for publication. This paper offers insights into the consumers, carers and nurses in relation to promoting a recovery-oriented Mental Health Service (MHS). The findings suggest three overarching themes as necessary for such a service. These themes are promotion of belongingness, promotion of autonomy, and promotion of community awareness. The remainder of the chapter covers some additional findings.

In Chapter 9, a short summary of the research is provided, as well as the participants' and the researcher's own insights, formulated as recommendations, and suggestions as to how these recommendations can be utilised in practice at local, national, and international levels. This chapter also outlines what has been achieved thus far to disseminate these findings and recommendations. Furthermore, the researcher has stated the limitations for this research and discussed three other questions that could be explored further to enhance knowledge in this area.

Chapter 2

Mental health recovery: A journey through the literature

Introduction

This chapter focuses on the literature related to the concept of mental health recovery. The chapter includes: an overview of the theoretical framework of the meaning of recovery; an article accepted for publication; a discussion of recovery-oriented practice; factors influencing mental health recovery; international and national responses to the concept of mental health recovery; and an identification of the gaps in the current literature.

Mental health recovery

The theoretical framework for the concept of mental health recovery is well established within the current literature. Many authors including consumers and professionals have endeavoured to define MHR (Anthony, 1993; Jacobson & Curtis, 2000; Noiseux et al., 2010; Piat et al., 2009; Slade, 2009; Slade, Amering, & Oades, 2008). Many definitions suggest that MHR is not based on objective outcomes, but is a subjective process unique to each individual. MHR does not dictate any particular way to recover from mental illness. For example, the concept of MHR is perceived as, variously: a transformative process of changing oneself; an on-going occurrence (Jacobson & Curtis, 2000; Onken, 2007), rather than an outcome; and, a desirable end state (Jacobson & Curtis, 2000; Roe, Rudnick, & Gill, 2007).

The concept of MHR outlined above redefines the previously accepted notion of cure-orientation. For instance, some influential definitions of MHR (Anthony, 1993; Deegan, 1988) depict a more open and hopeful premise that promotes acceptance, inclusion and respect of the individual and that values one's position in society. For

example, Deegan, a person with lived experience of mental illness, has defined mental health recovery as:

> a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, [and] regroup again. The need is to meet the challenges of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (1988, p. 15).

Deegan's views on MHR not only reflect the ongoing nature of the recovery process, but also the dimensions of humanistic vulnerabilities within that process. Deegan emphasises the importance of personal development, which enables a person to overcome the limitations of mental illness. She proclaims that the individual's aspirations to live, love, work and contribute to community like everyone else are central to recovery. Anthony (1993), a mental health professional, expresses similar views in stating that recovery is:

> 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 within the limitation 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 (Anthony, 1993, p. 15).

These two definitions of MHR portray a sense of hope for recovery from mental illness and yet remain a catalyst for the MHR movement in contemporary settings. It is clear from these definitions that, for some people, MHR is not an end point or final

outcome; rather, it is a journey or a process which is unique to each individual (Deegan, 1997). However, this optimistic concept of MHR is yet to be recognised and applied in many mental health services, which continue to be based around a traditional medical model of care, focusing on symptom remission (Schrank & Slade, 2007). The concept of MHR confuses and generates ambiguity among mental health stakeholders due to lack of a precise definition (Lal, 2010). The concept of MHR is harder to understand for those focused on cure-orientation. Additionally, the concept of MHR has been criticized for its lack of an evidence base (Frese et al., 2001), its inability to apply cross-culturally across the lifespan (Lal, 2010), and for setting unrealistic expectations (Masland, 2006). Nevertheless, various definitions of MHR have been explored in the literature and are described below.

Definitions of mental health recovery

Service based & user-based definitions

Mental health recovery is described as a term with two meanings (Schrank & Slade, 2007). The first meaning is based on the mental health service perspective, that recovery is a remission or improvement in symptoms from mental illness; it is called the 'service-based' definition of recovery and can be attributed as the medical model of recovery. The second meaning of recovery has evolved from the self-help and consumers' movement and is called the 'user-based' definition of recovery. The user-based definition describes recovery as a process of personal growth and development, and involves overcoming the effects of being mentally ill; this might involve living with some deficits of the illness (Schrank & Slade, 2007).

Personal recovery

Slade (2009) distinguished mental health recovery as involving or comprising both personal recovery and clinical recovery. Personal recovery emerged from the

expertise of people with lived experience of mental illness. Personal recovery is about growth and development, and not necessarily about symptom remission. Slade provides a summary description of personal recovery, as follows:

> Recovery involves a journey, from disengagement to engagement, from surviving to living and growing. Although awareness of the journey often starts in adversity such as mental illness, the journey is not about the adversity. Although the journey has many routes, each person's journey is unique. It often involves finding the courage to hope for a good future and to relate to yourself and others in beneficial ways. Setbacks are inevitable, but the challenge is universal (p. 39).

The concept of personal recovery generates a sense of hope and optimism and is not affected by evaluative elements or externalised criteria employed to measure recovery. However, Slade (2009) states that the concept of personal recovery is disadvantaged in terms of the difficulty in operationalising and undertaking empirical investigations because of the highly individual nature of the concept with its many individual elements.

Clinical recovery

According to Slade (2009), clinical recovery is different to personal recovery, as the former concept emerged largely from the expertise of mental health professionals. Clinical recovery involves an absence of symptoms or a return to normal behaviour and the restoration of social functioning (Slade, 2009). Slade emphasises that "clinical recovery is subordinate to personal recovery … [and] a primary focus on clinical recovery is incompatible with a primary focus on personal recovery" (2009, p. 40). He argues that having hope and meaning in life is central to MHR. The notion of clinical recovery can be detrimental to the sense of hope and

meaning of a person due to its emphasis on the absence of symptoms. Besides, the notion of symptom remission can lead to compulsive treatments and power struggles between mental health professionals and consumers (Slade, 2009).

Social recovery

While the personal and clinical aspects of MHR are important, other facets such as the social, functional, family and spiritual dimensions of mental health recovery are also equally important and are explored in the literature (Lloyd, Waghorn, & Williams, 2008; Watkins, 2007). Lloyd et al (2008) discuss that support from society, including supported employment (Munro & Edward, 2008), housing, groups and education, all result in recovering damaged social relationships; thus, they identify MHR as social and functional recovery. People and families who are affected by mental illness are often marginalised and stigmatised in society (Watkins, 2007). Therefore, they need to recover from the effects of such stigma and marginalisation. Watkins (2007) argues that social inclusion and full citizenship – that is, significant participation in society – have a greater positive impact on recovery. He asserts these factors should be promoted and should be a priority of mental health policies and professionals.

Functional recovery

Part of mental health recovery is the ability to live and function well in society like everyone else. Functioning well in society connotes the ability to work, as well as to earn a living. The effect of mental illness significantly reduces a person's ability to work compared to a person with no mental illness. For example, according to data by Mindframe (2014), unemployed people had the highest rates of mental disorder, a prevalence rate of 26% for unemployed men and 34% for unemployed women.

Therefore, as suggested by Lloyd et al. (2008) and Munro and Edward (2008), part of mental health recovery includes successful return to work schemes and education; they describe this as functional mental health recovery.

Family recovery

Mental illness not only affects a person, but the whole family. Some effects of mental illness include loss of loved ones, trauma, aggression and violence within families, and internal and external stigma (Rapaport, 2005; Wallace, 2012; Watkins, 2007; West, Hewstone, & Holmes, 2010). Regardless of these devastating effects, the majority of time, families are often the major and only supporters for those affected by mental illness. For example, Watkins (2007) argues that the influence of the family network in the psychological survival and well-being of an individual can be crucial. Likewise, the families role in supporting the quality of life and return to well-being of a person with mental illness is pivotal (Rapaport, 2005; Watkins, 2007). However, Watkins (2007, p. 89) asserts "one of the most difficult aspects of recovery for families is in an area of what we might call relationship realignment". Due to the various features of mental illness, such as aggression, violence and suspicious behaviours, it is possible to have discord within the family, weakened sibling bonds and resentments. Therefore, a realignment of family relationships and emotional support for families and/ or carers is important towards mental health recovery.

Spiritual recovery

Spirituality is an essential component of holistic care and the healing process. In mental health, many consumers describe having spiritual or mystical experiences (Watkins, 2007). Spirituality can be defined in many ways, Powell (2007) describes spirituality, as the:

> experience of a deep-seated sense of meaning and purpose in life, a wholeness that brings with it the feeling of belonging, harmony and peace. It entails searching for answers about the infinite, and is particularly important in times of stress, illness, loss, bereavement and death (2007, p. 162).

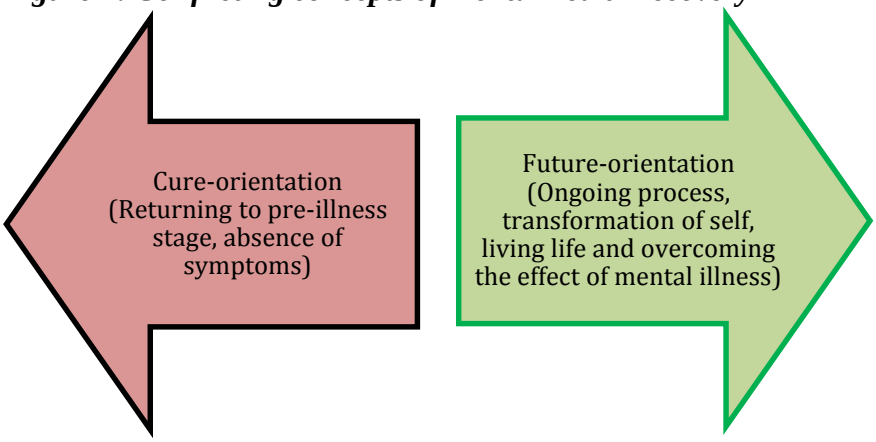
Mental health recovery is a process that involves healing and the transformation of a person wrought by a variety of means, as well as a 'maturation of the life process' and 'spirituality' (Griffiths, 1988, p. 71). However, the biomedical model of care is more of a "mechanistic approach" and the concept of "God was dismissed by science as irrelevant . . ." (Powell, 2007, p. 163) and therefore not considered in biomedical care. While spirituality can be seen as a connection with God, it is a more broader concept. Galanter (2005) reasons the removal of the spiritual component from medical care is possibly due to the rise of managed care and the reliance of medical institutions on drug companies. He argues that in order to provide comprehensive care, the spiritual needs of the person should be considered. Gomi, Starnino, and Canda (2014) suggest that spirituality has been recognised as key to MHR by recovery-oriented and proponents of the strengths model. For these reasons, service providers and carers should adopt an attitude of receptivity, acceptance and responsiveness to the personal and spiritual needs of a person affected by mental illness in order to promote mental health recovery.

The above definitions illuminate that MHR is a multidimensional process (Fig. 1 below), which includes personal, clinical, social, family-oriented, functional and spiritual facets. Arguably the concept of mental health recovery can be seen as related to time, body, space, and relationship, and influenced by various other factors such as socio-economic status (Arboleda-Florez & Sartorius, 2008). Additionally, people with mental illness experience the sense of recovery in these various aspects of life. These dimensions of MHR are closely aligned to van Manen's notion of "lifeworld existentials" (van Manen, 1997b, 2014b), described as 'lived time, lived body, lived space, lived self-other, lived things and lived cyborg relations' (van Manen, 2014b, p. 306). In order to understand the concept of MHR comprehensively, the researcher explored the experience of mental health recovery by the first four dimensions of the 'lifeworld existential', which van Manen suggests, allow the researcher to understand the 'essence' of the experience and interpret the deeper meaning of the phenomenon (1997b, p. 9).

Figure 1: Multidimensional process of mental health recovery

The multidimensional process of mental health recovery encompasses two major conflicting views of MHR; one is focused on cure-orientation, and the other is focused on the future-orientation or transformative process (Fig. 2 below).

Figure 2: Conflicting concepts of mental health recovery



Cure-orientation

Cure-orientation refers to the traditional medical model of care that emphasises cure from mental illness, freedom from symptoms, and expects people affected by mental illness to function and return to their pre-illness state (Shanley & Jubb-Shanley, 2007). For centuries, the traditional medical model of care dominated mental health care, with a focus on containing the symptoms of chronic mental health conditions that require ongoing medical care (Shanley & Jubb-Shanley, 2007). The notions of clinical and functional recovery align with cure-orientation.

Future-orientation

This term refers to a process of transformation and is not concerned about symptoms of mental illness. The transformation of the person occurs in the context of being able to live a satisfactory life in the community. This involves finding meaning and purpose in life, overcoming the effects of mental illness and realigning oneself in the community. Future-orientation of care is consistent with current MHR philosophy.

The notions of personal, spiritual, social and family recovery are in alliance with future-orientation. The term 'concept of mental health recovery' is used to refer to future-orientation within this thesis. The following manuscript builds on the concepts described above and provides a thorough review of the literature to assist understanding of the research question and the gaps in the literature pertaining to MHR.

Mental health recovery: A review of the peer-reviewed published literature

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Prof. Beverley Taylor
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Declaration for Thesis Chapter Two

Declaration by candidate

In the case of paper entitled: Mental health recovery: A review of the peer-reviewed published literature, which appears in Chapter Two, the nature and extent of my contribution to the work was the following:

Nature of contribution	**Extent of contribution (%)**
Concept development, research, original ideas, writing up	70

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Dr. Ian Munro	Draft review and editing	
Prof. Beverley Taylor	Draft review and editing	
Assoc. Prof. Debra Griffiths	Draft review and editing	

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date: 02/11/2015**
Main Supervisor's Signature	[redacted]	**Date: 02/11/2015**

Mental health recovery: A review of the peer-reviewed published literature

Introduction

The concept of mental health recovery has been a topic of discussion for decades in mental health settings. Collaboration and partnership among consumers, carers and service providers are underpinning principles of mental health recovery. However, to this end, the concept has been less explored among carers and service providers.

Mental health recovery has been defined by service providers and consumers in various ways (Anthony, 1993; Davidson, 2003; Deegan, 1988; Lloyd, Waghorn, & Williams, 2008; Piat et al., 2009; Ridgeway, 2001; Schrank & Slade, 2007; Slade, 2009; Slade, Amering, & Oades, 2008). Slade (2009) distinguished mental health recovery as personal recovery versus clinical recovery. Slade (2009) asserts that clinical recovery is different to personal recovery, as clinical recovery emerged from the expertise of service providers and personal recovery emerged from people with lived experience of mental illness.

This paper outlines a thorough search of literature that includes mental health consumers, and/or carers and/or service providers. Types of studies included are peer reviewed research. The aims were to look at the extent of research that examined the views of mental health consumers, carers and service providers on mental health recovery and factors influencing mental health recovery and identify the similarities and differences in the views and its relevance in the Australian mental health practices. This review is part of a study that explores the views of mental health consumers, carers and mental health nurses on mental health recovery and the factors influencing mental health recovery. Given the views of mental health recovery often differs from person to person, it follows that there will be differences in understanding what

recovery means to the above cohort. Understanding various views on mental health recovery will enable better collaboration of services and may meet expectations of consumers, carers and service providers.

Method

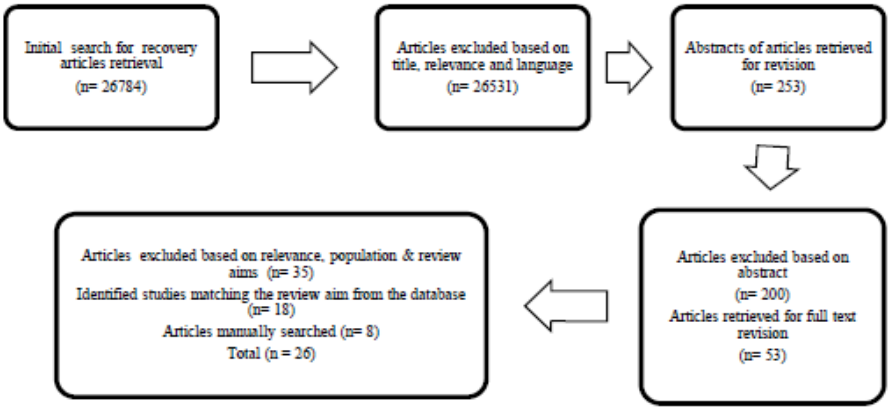
The databases used to search for relevant articles were ASAP, Best Practice, CINAHL, Cochrane Systematic Review, EMBASE, Joanna Briggs, Medline, OVID, Proquest, PsychINFO and SCOPUS. The search terms used were: "mental health recovery" AND "meaning" OR "perspective/s" OR "definition" AND "client" OR "consumers" OR "patient" OR "service users" OR "carers" OR "family" OR "professionals OR Nurs*" OR "service providers" (Table 1).

Table 1 Literature review parameters

Database searched	ASAP, Best Practice, CINAHL, Cochrane Systematic Review, EMBASE, Joanna Briggs, Medline, OVID, Proquest, PsychINFO and SCOPUS
Search terms	"mental health recovery" AND "meaning" OR "perspective/s" OR "definition" AND "client" OR "consumers" OR "patient" OR "service users" OR "carers" OR "family" OR "professionals OR Nurs*" OR "service providers"
Primary parameters	English language, full text articles and adults (aged 18 years +), published after 2005
Excluded articles	Articles including recovery from other medical disorders, children and forensic patients were excluded from the review

The review was conducted in 2013. Publications matching the search terms were selected. Primary parameters for the search were: English language, full text articles, published between 2005 and 2013 and adults (aged 18 years +). Articles including recovery from other medical disorders, children and forensic patients were excluded from the review. The initial search for recovery articles retrieved 26784 publications. 26531 articles were excluded based on title, relevance and language. 253 abstracts were retrieved to review the aims, population and relevance. Based on the literature review aim 18 full text articles were selected and the rest of the 8 articles were obtained by manually searching the reference list of the selected articles. Figure 1 describes the article search reduction process.

Figure 1 The article search reduction method



Results

Twenty seven publications were selected for the review, which included a Delphi study, two mixed methodology studies, three quantitative and twenty one qualitative studies. The selected records were reviewed and tabulated; Table 2 provides a summary of the selected studies. Fifteen studies explored participants' views of mental health recovery. Seven studies explored

participants' views on mental health recovery and the factors influencing mental health recovery and five studies explored the factors influencing mental health recovery. The dominant views of consumers, carers, and service providers were identified and are described under results.

Table 2 Summary of the selected studies

Studies selected	Study involved consumers & carers & service providers n =2	Studies involved service providers n = 4	Studies involved mental health consumers n =23	Views on mental health recovery explored	Factors relating to recovery explored
Cleary et al (2013)		✓		✓	
Aston & Coffey (2012)		✓	✓	✓	
Windell et al (2012)			✓	✓	
Katsakou et al (2012)			✓	✓	
Siu et al (2012)			✓		✓
McEvoy et al (2012)			✓	✓	
Hipolito et al (2011)			✓	✓	
Ng et al (2011)		✓		✓	
Noiseux et al (2010)	✓			✓	
Lakeman (2010)			✓	✓	✓
Pernice-Duca (2010)			✓		✓
Piat et al (2009)			✓	✓	
Ng et al (2008a)			✓	✓	✓
Ng et al (2008b)		✓		✓	✓
Happell (2008a)			✓		✓
Happell (2008b)			✓		✓
Browne et al (2008)			✓	✓	
Noiseux & Ricard (2008)	✓			✓	✓
Borg & Davidson (2008)			✓	✓	
Mancini et al (2007)			✓	✓	
Jensen & Wadkins (2007)			✓	✓	✓
Ridge & Ziebland (2006)			✓	✓	
Davidson et al (2006)			✓	✓	✓
Drake et al (2006)			✓	✓	
Mancini et al (2005)			✓		✓
Cohen O (2005)			✓	✓	✓

Views about mental health recovery

The majority of the studies (21/26) selected in this review explored the views of consumers in relation to mental health recovery. The review findings suggested there were differing views about mental health recovery among consumers, carers and service providers. However, only limited studies (S. Noiseux & Ricard, 2008; S. Noiseux et al., 2010) are available to underscore this assertion. The findings showed significant differences among consumers' and carers' views in terms of mental health recovery. For example, consumers' experiences and views of mental health recovery did not match with carers' views as carers were more focused on outcomes or absence of symptoms and/or improved functioning in the community. Whereas, consumers were more inclined to the concept that mental health recovery is a multidimensional process which focus on having meaning in life and transformation. Four studies (Aston & Coffey, 2012; Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013b; Ng, Pearson, Chen, & Law, 2011; Ng, Pearson, & Chen, 2008) explored the views of service providers on mental health recovery and showed the differences in their views. For example, some service providers views were more in line with return to pre-illness state and/or cessation of medication whereas the others seen mental health recovery as a process.

Consumers' views on mental health recovery

Three dominant themes emerged from the meaning of mental health recovery from these studies (Table 3). Firstly, a future-oriented view on mental health recovery. Consumers viewed mental health recovery as a transformation of self from an illness identity to an identity marked by meaning and well-being (Borg & Davidson, 2008; Hipolito, Carpenter-Song, & Whitley, 2011; Lakeman, 2010; Mancini, 2007; Mancini, Hardiman, & Lawson, 2005; Piat et al., 2009; Siu et al., 2012). Secondly, a cure-oriented view on mental health recovery that emphasises on cure or absence of symptoms, and an achievement of the pre-illness state (Katsakou et al., 2012;

Ng et al., 2011; Ng, Pearson, Lam, et al., 2008; Piat et al., 2009; Ridge & Ziebland, 2006).

Thirdly, some consumers also reported that mental health recovery is impossible.

Table 3: Consumers views on recovery

Consumers' views	Themes	Meaning of MHR
Katsakou et al (2012); Siu et al (2012); Browne et al (2008); Mancini et al (2005); Windell et al (2012); McEvoy et al (2012); Davidson et al (2005); Drake et al (2006)	Engage in meaningful activities	
Siu et al (2012); Lakeman (2010); Noiseux & Ricard (2007)	Having meaning in life	
Katsakou et al (2012); Ng et al (2008); Ridge & Zieland (2006); Davidson et al (2005); Noiseux & Ricard (2008); Jensen & Wadkins (2007); Hipolito et al (2011); Piat et al (2009); Mancini et al (2007); Mancini et al (2005); Windell et al (2012); McEvoy et al (2012)	Self-acceptance & Self-control Transformation of self/ sense of self	
Noiseux et al (2010); Piat et al (2009); Noiseux & Ricard (2007)	Inner wellbeing	
Aston et al (2012) ; Browne et al (2008); Mancini et al (2005); Davidson et al (2005); Drake et al (2006) ; Hipolito et al (2011) ; Katsakou et al (2012) ; Lakeman (2010); Ng et al (2008a); Ridge & Zieland (2006); Hipolito et al (2011); Mancini et al (2007); Noiseux & Ricard (2008); Jensen & Wadkins (2007); Noiseux et al (2010); Piat et al (2009) ; Pernice-Duca (2010); Windell et al (2012); Cohen O (2005); Noiseux & Ricard (2008); Aston & Coffey (2011)	Multidimensional process	**Future-orientation**
Lakeman (2010); Piat et al (2009); Borg & Davidson (2008); Ridge & Zieland (2006); Drake et al (2006); Aston & Coffey (2012)	Return to the pre-illness state/ Absence of symptoms. Fixing chemical balance	**Cure-orientation**
Ng et al (2008); Piat et al (2009); Windell et al 2012)	Recovery is not possible	**Recovery is impossible**

These differences in the views among consumers suggest both pessimistic and optimistic attitudes towards mental health recovery. Recovery was seen as an impossible goal by many consumers in the studies undertaken by Piat et al (2009) and Ng et al (2008). Similarly, consumers in many other studies identified recovery as absence of symptoms or going back to the pre-illness state (Borg & Davidson, 2008; Lakeman, 2010; Ng, Pearson, Lam, et al., 2008; Piat et al., 2009; Ridge & Ziebland, 2006). In contrast, more optimistic attitudes towards recovery such as transformation of self and/or finding personal meaning was expressed by some other consumers (Hipolito et al., 2011; Lakeman, 2010; Mancini, 2007; Mancini et al., 2005; Piat et al., 2009). The ability to engage in meaningful activities such as work was also seen as an important aspect of recovering from mental illness (Browne, Hemsley, & St. John, 2008; Katsakou et al., 2012; Mancini et al., 2005; Siu et al., 2012). While consumers demonstrated diverse views on recovery, carers and service providers had less variability in their views and are described below.

Carers and service providers views on mental health recovery

The available data suggested carers and service providers had similar views on mental health recovery compared to consumers (Table 4). However, there were significantly few studies available to support these findings (Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013a; Ng et al., 2011; S. Noiseux, et.al., 2010). The findings indicated both cohorts expressed pessimistic views in relation to mental health recovery. This included that recovery is impossible, so too the possibility of returning to a pre-illness state or improvement in symptoms (Cleary et al., 2013a; Ng et al., 2011; S. Noiseux, et.al., 2010). These views of carers and service providers correlated with the Slade's (2009) clinical recovery, as clinical recovery focused on outcomes or remission

of symptoms. The cohort, especially service providers, also asserted the importance of medications to one's recovery (Cleary et al., 2013a; Ng et al., 2011). However, service providers involved in Noiseux et al's (2010) study had both personal and clinical views (Slade, 2009) in relation to recovery. Nevertheless, these findings suggested that consumers, carers and service providers did share some similarity, but also demonstrated clear diversity in their views on mental health recovery.

Table 4: Carers and service providers' views on recovery

Carers Views	Service providers views	Themes	Meaning of recovery
Noiseux et al (2010)	Noiseux et al (2010) Ng et al (2011); Ng et al (2008a)	Engage in meaningful activities Self-acceptance and self-control Inner wellbeing Multidimensional process	**Future-orientation**
Noiseux et al (2010); Noiseux & Ricard (2008)	Cleary et al (2013) ; Ng et al (2011); Ng et al (2008a) ; Noiseux et al (2010); Noiseux & Ricard (2008) ; Aston & Coffey (2011)	Return to the pre-illness state/ Absence of symptoms	**Cure-orientation**
Noiseux et al (2010); Noiseux & Ricard (2008)	Ng et al (2011); Ng et al (2008a)	Recovery is not possible	**Recovery is impossible**

Factors facilitating mental health recovery

Factors influencing mental health recovery were mainly explored among consumers. Many factors were identified by consumers as facilitators or turning points to mental health recovery (Browne et al., 2008; Happell, 2008a; Lakeman, 2010; Mancini, 2007; Mancini et al., 2005; Pernice-Duca, 2010; Tsai, Salyers, & McGuire, 2011). Participants in the qualitative study by Mancini et al. (2005, p.52) described how supportive relationships between family members and friends are often provided in an '…unwavering and steadfast belief in consumer's ability to

recover'. Similar views were expressed by participants in the quantitative study (n=169) by Pernice-Duca (2010), that support and reciprocity with family members often smooth the process of mental health recovery. Participants disclosed that relationships with supportive service providers are collaborative partnerships characterized by trust and respect, which are essential to help the journey towards mental health recovery (Mancini et al., 2005). Peers were also significant sources of support and encouragement according to Mancini et al (2005), as they provided inspiration, education, and support.

Happell (2008a) found in her study that many interventions including medications, spiritual and counselling therapies, crisis management plans and even cigarettes, helped in mental health recovery. Other factors, such as support and social connectedness, supportive staff, follow up from services, respect, peer support, promoting social connectedness, and individual responsibility for mental health recovery were also considered as facilitators of mental health recovery. These findings by Happell (2008a) were similar to findings by Mancini et al (2005), creating a homogeneity among consumers' perspectives on facilitators of mental health recovery.

Consumers (n=8) involved in a qualitative study by Browne et al. (2008) described the negative impact of mental illness on self-esteem and the importance of good support from case workers who listen and act in consumers' interests. They asserted that a thorough understanding about the person's mental illness from caseworkers was a great asset to recovery from mental illness. Similarly, the Delphi study by Lakeman (2010) identified many important factors, all essential recovery competencies for service providers. These include listening to, and respecting personal view points, conveying the belief that mental health recovery is possible, recognising, and promoting the person's resources and capacity for mental health recovery. Moreover,

Browne et al. (2008) found that good quality housing was a critical element in the recovery of people living with mental illness.

Barriers to mental health recovery

Happell (2008b) found that staffing shortages was a significant barrier to service delivery, especially in rural Australia. Other impeding factors included negative staff attitudes, lack of trust, failure to take the situation seriously, poor listening skills, treatment according to symptoms rather than the needs, lack of safety and security especially in in-patients units, early discharge with no follow up, seclusion and neglecting physical health issues. Whereas, Mancini et al (2005) found that paternalistic attitudes of staff hindered the process of mental health recovery, for example, staff who do not allow consumers to make decisions about going back to work due to fear that stress could cause relapse. Another important factor was coercion, which was described as one of the primary problems with the formal mental health treatment which promoted dependency and fear. Happell's (2008b) findings concur with Mancini et al's (2005), who also found that indifferent and judgemental service providers pose a threat towards a person's journey to mental health recovery. Mancini et al (2005) found that being judged as a chronically dysfunctional individual and unable to develop meaningful lives in the larger community, was disempowering and was a humiliating and antagonising practice from those who are in situations of authority and power. Mancini et al (2005) also found that side effects of medications act as barriers to mental health recovery, even though many consumers identified medication was a key aspect to their mental health recovery.

Discussion

Mental health recovery - A transformation

Consumers defined mental health recovery as a multidimensional process involving personal growth and transformation of oneself with new meaning and purpose (Mancini et al., 2005; Piat et al., 2009). Thirty nine out of 49 clients in Piat et al. (2009) study described mental health recovery in relation to wellness and affirmed self over illness. This includes beliefs that mental illness and recovery from mental illness are part of life and recovery from mental illness is possible. The consumers' views lead to a desire for finding normalcy or wellness-oriented identity, rather than an illness dominated identity, which relates to Goffman's (1973, p.132) suggestion '…that the stigmatized individual defines himself (sic) as no different from any other human being…' The consumer's desire to manage a normal identity also links with Anthony's (1993, p.15) definition of mental health recovery as '...developing a new meaning and purpose and growing beyond the catastrophic effects of mental illnesses…' Moreover, Slade (2009) personal recovery also correlates with these consumers' views. However, growing beyond illness domination demands responsibility, volition and courage from mental health consumers. Collaborative and transformational approaches from multidisciplinary professions and society are core elements to make this process of transformation easier for mental health consumers.

Mental health recovery - A cure

While many consumers see mental health recovery as a personal transformation, other consumers also acknowledged recovery as a cure from their mental illness. These views closely aligned to some carers and service providers views (S. Noiseux et al., 2010). Forty one out of 49 consumers in the Piat et al. (2009) study defined mental health recovery in relation to illness, which included the notion that recovering from mental illness is impossible, comparing mental illness to physical illness and the need for balancing the chemical imbalances, absence of

symptoms and identifying the right medication to cure the illness. These views also concur with some other consumers, who valued the contribution of medications and lack of symptoms to mental health recovery in many other studies (Happell, 2008a; Katsakou et al., 2012; Mancini et al., 2005; Ng et al., 2011; Ng, Pearson, Lam, et al., 2008), However, some consumers and service providers voiced their opinion that actual mental health recovery means there is no need for medications (Ng et al., 2011; Ng, Pearson, Lam, et al., 2008; Piat et al., 2009), which could be a reflection of society's view that being 'normal' means no need for medications. This dissonance among consumers' perceptions of recovery from mental illness call for collaborative and flexible practices in mental health settings, and is stated by Piat et al. (2009, p.205) as the need for 'rapprochement' between the medical and psychosocial perspectives of mental health recovery.

Impeding factors affecting service providers' performances

Among the mental health service providers, nurses play major roles in delivering services to mental health consumers and their families or carers (Bonney & Stickley, 2008; Connor, 1999; Fleming & Martin, 2011). Peplau (1994) asserts that psychiatric mental health nursing has developed and provides a wide scope of functions and activities. The major responsibilities of mental health nurses as identified by the Australian College of Mental Health Nurses Inc. are:

'…taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, *towards mental health recovery as defined by the individual'* (2010, p.5)

However, nurses are not taking a holistic approach towards mental health recovery, as defined by people with lived experience, when they focus on symptom remission and medication compliance, rather than personal choices and aspirations. McAllister (2007) found that clinicians

who were traditionally hospital-oriented were keen to change their mind-set towards mental health recovery-oriented care, however, they were struggling to maintain the shift in care due to lack of practical resources, such as frequent training, solution orientations, creative therapies and regular supervision, to support them to create new ways to approach challenges. These issues have been underscored by the findings by Marshall, Oades, and Crowe (2009). Since carers or family members were also seen as providers of crucial social support to people with mental illness (Pernice-Duca, 2010), collaboration among health practitioners, family networks and reconnection to society are essential factors that need to be addressed to overcome the barriers to mental health recovery.

Clinical Implications

Researching the views major stakeholders' on mental health recovery provides important insights, which allow for the development of better clinical practices in mental health settings. The themes from the literature review raise five key components to improve clinical practices in the Australian mental health settings, which are described below using the following headings: the need for rapprochement; recovery-oriented care; walk alongside the person; cultural change; and collaborative practices.

The need for 'rapprochement'

The need for 'rapprochement' between medical and psychosocial perception of mental health recovery (Piat et al., 2009, p.205) is indeed a necessity to broaden the current views of the medical model of care in the Australian Mental Health System (AMHS). While the Australian national and state mental health policies emphasise the importance of recovery-oriented practices in the day-to-day service delivery (Department of Health, 2011; Department of Health and Ageing, 2013a, 2013b), the over flowing acute mental health wards and emergency departments, lack of good housing, scarcity of skilled mental health staff are some of the major challenges in

the AMHS. These challenges can lead to early discharges with poor supports in place as identified by Happell (2008b). These factors force the Australian MHS's to generally adhere to a strategy of a 'quick fix' to meet the high demands and thus fail to uphold the recovery principles that enable rapprochement between medical and psychosocial perspectives.

Recovery-oriented practice

Recovery-oriented practices in mental health values the person with mental health issues, rather than focusing on symptom centred care practices (Browne et al., 2008). Recovery-oriented practices underpin the philosophy of person-centeredness. Mancini et al (2005, p. 54) stresses the importance of person centeredness in mental health services by underlining the need for '…considering strategies that address the whole person rather than isolating and targeting symptoms'. While Australian mental health policies and guidelines promote recovery-oriented practices, implementation of recovery-oriented practices is still not wide spread in the AMHS (Oades & Anderson, 2012). Therefore, implementation of recovery-oriented practices in the AMHS could only be possible by addressing any major impeding factors (as discussed under barriers).

Walk alongside the person

The need for service providers to step down from the 'hierarchical professional relationship to a side-by-side relationship with clients' is discussed by Mancini (2007, p. 40). This has a major implication to assist and support the people with lived experience to take control of their mental health recovery journey. In order to develop a 'side-by-side' relationship service providers with a cure-orientated attitude need to self-challenge their attitudes and practices and embrace the current notion of recovery that may transform the person with mental illness. Moreover, developing an in-depth understanding about what recovery means to a person

with mental illness will also help service providers. When service providers consider mental health recovery knowingly, they walk willingly with the person with mental illness.

Cultural change

The need for cultural change in mental health services to embrace the philosophical underpinning of mental health recovery is crucial to implement recovery-oriented practices in the day-to-day service delivery. This requires education and training of key parties involved in mental health system (Crane-Ross, Lutz, & Dee, 2006; Marshall et al., 2009). While education and training are important aspects of change process, developing and sustaining role models in the mental health services who foster the concept of mental health recovery is also imperative. This could only be achieved by the support from the government as it involves monetary expenses.

Collaborative practices

Collaboration is the key to successful recovery-oriented practices. The literature highlights the fact that recovery is a multidimensional process and need a multidisciplinary hand-in-hand approach to accomplish this process (Aston & Coffey, 2012; Oades & Anderson, 2012; Shanley, Jubb, & Latter, 2003). This involves collaboration among key agents involved in the AMHS, that is, consumers, carers or family members, service providers and policy makers. The approach of togetherness by these stakeholders should help to enact recovery-oriented practices in the AMHS as reflected in the national and state mental health policies (Department of Health, 2011; Department of Health and Ageing, 2008, 2013a, 2013b)

Conclusion

This review highlighted the gap in the current literature in relation to the views of mental health recovery among carers and service providers. Also, the review suggested that recovery from mental illness is a multidimensional process, which may include transformation to a new

self with new values and personal adjustment or remission of symptoms related to alternative treatments including medication and other therapies. These findings assert that mental health recovery cannot be defined in rigid terms and it needs openness from the key stakeholders to the philosophy of recovery. The concept of mental health recovery also emphasizes partnership; that is, handing over power to consumers. In order to enhance this process, an increased understanding is needed among consumers, carers and service providers about the meaning of mental health recovery and the importance of personal experience in the process of recovery. While the involvement of nurses and other service providers in a person's mental health recovery journey is crucial, it is essential to conduct studies among consumers, carers and service users to unravel their own personal meaning and perspectives of the concept of mental health recovery. Building such evidence serves as strong base for a recovery-oriented mental health system that upholds and enables personal values and choices in the process of mental health recovery.

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The above article provided an overview of the contemporary literature published in relation to mental health recovery between 2005 and 2013. Other factors influential in terms of MHR that were not discussed in the article include hope, empowerment, and stigma. These concepts are described in detail below.

Hope

Hope is a central theme in the journey towards mental health recovery. The future-oriented views of consumers are a reflection of their hope towards mental health recovery. Schrank, Stanghellini, and Slade (2008, p. 426) conceptualised hope as the:

> dynamic and changeable variable, future referenced (possibly linked to present negative conditions as a stimulus and to past experiences e.g. of successful coping), concerned with the attainment of individually valued positive goals, outcomes or states and judged by the individual as being at least potentially possible (p. 426).

Having a diagnosis of mental illness can be debilitating for consumers and carers. The current notion of MHR reflects hope as an underpinning philosophy. Many mental health systems have welcomed the notion of MHR with enthusiasm (Noiseux et al., 2010; Piat & Sabetti, 2012), because it embodies a hopeful view for the future and suggests modes of intervention that reflect humanistic values. Jacobson, Greenley, Breedlove, Roschke, and Koberstein (2003) define hope as the belief that recovery from severe mental illness is possible.

Stickley and Wright (2011) found two major themes aligned with the notion of mental health recovery – hope and optimism. Similar views are expressed by Rogers, Hemingway, and Elsom (2013) who suggest that therapeutic optimism – that is,

having a positive outlook in a specific situation and believing in a positive or favorable outcome – among nurses catalysis the belief that they can aid recovery in people who have mental health problems. Therapeutic optimism is characterised by a hopeful attitude. Numerous other authors also outlined the importance of hope in mental health recovery (Fleming & Martin, 2011; Houghton, 2007; Marshal, Oades, & Growe, 2010; Onken, 2007; Pilgrim, 2008; Pouncey & Lukens, 2010; Segal, Silverman, & Temkin, 2010; Slade, 2010; Stickley & Wright, 2011; Tee et al., 2007; Thornton & Lucas, 2010). This evidence highlights the responsibility of mental health services to provide avenues for the establishment of hope and optimism (Ramon, Healy, & Renouf, 2007) by augmenting traditional therapeutic interventions such as education, goal-setting, problem solving and by assisting the development of the spiritual and cultural identity of the person in order for them to find meaning in life (Schrank et al., 2008).

Empowerment

Empowerment is another important element that flourishes in the process of mental health recovery. Empowerment, for the mentally unwell, involves autonomy, courage, assuming control, demanding the same rights and assuming the same responsibilities as other citizens (Schrank & Slade, 2007). Additionally, empowerment is important to consumers and family, so they can be involved in decision-making in relation to their care and treatment (Crane-Ross, Lutz, & Roth, 2006). Cook and Chambers (2009) identified the development of an empowered sense of self as a key component in the recovery process. An important characteristic of a recovery-oriented mental health system should be the incorporation of the concept of empowerment and inclusion of consumers and families at every level of the service-planning for each individual (Crane-Ross et al., 2006). However, in order to promote

the empowerment of consumers in the service delivery, the core belief based on the biological assumptions of mental illness needs to be changed. Fleming and Martin (2011) assert that it is hard to instil hope and empowerment in service delivery when professionals hold a cure-oriented model of care. Sowers (2005) describes how family education and empowerment activities support recovery principles and strengthen attempts by consumers to establish recovery, and, thus, should be developed by providers of recovery-oriented services.

Stigma - an unhelpful factor for mental health recovery

There is a collective understanding supported by the literature that stigma is unhelpful to mental health recovery. People with mental illness are notoriously affected by stigma. Stigma can be a destructive factor in relation to mental health recovery (Arboleda-Florez & Sartorius, 2008; Corrigan, 2012). Goffman (1973) is well regarded for his work highlighting the concept of stigma. He describes stigma as a term "used to refer to an attribute that is deeply discrediting…" (1973, p. 13). He argues that "we believe the person with a stigma is not human" (Goffman, 1973, p. 15). Stigma affords differing facets; it can be internalised, or in other words, experienced within the person (Sibitz, Provaznikova, Lipp, Lakeman, & Amering, 2013) and it can be considered as a community stigma that is attributed by a particular society (Arboleda-Florez & Sartorius, 2008). Stigma can be exerted by private and government institutions; this is called 'structural stigma' (Corrigan et al., 2005). There are various consequences of stigma for a person's life, such as perceptions from the "public that persons with mental illness are dangerous, lazy, unreliable and unemployable" (Arboleda-Florez & Sartorius, 2008, p. 10).

However, compared to previous decades, activities to combat stigmatisation of people with mental illness are increasing. Some activities include: stigma-busting

educational undertakings such as national campaigns; Changing Minds campaigns; Community Awareness Program; Psychiatric Stigma Group; SANE Australia; World Health Organisation (WHO) Contact Programme; and political activism, which includes activities that draw the attention at public and government levels, such as 'Stop exclusion: Dare to care'(Arboleda-Florez & Sartorius, 2008, pp. 12- 14; Corrigan, 2012; Corrigan, Kosyluk, & Rüsch, 2013).

Recovery-oriented practices

The concept of MHR encourages applying recovery-oriented practices in mental health service delivery. Australian mental health policies describe recovery-oriented practice as "an approach to mental health care that encompasses principles of self-determination and individualised care. A recovery-oriented approach emphasises hope, social inclusion, goal-setting and self-management" (Department of Health, 2011b p,4). Davidson et al. (2010) attribute the origin of recovery-oriented practices at the turn of 18th century to the Tuke family who established The Retreat in York. This was a family-like space, which included a healing and spiritual environment for members of the Society of Friends.

During the last years of the 18th century and the beginning of 19th century, an increasingly segregated and centralised management style in mental health systems began to evolve in England. The emergence of psychiatry as a distinct discipline was cemented during the Victorian period, 1837-1901 (Lawton-Smith & McCulloch, 2011). In early Victorian times, legislation such as the County Asylums Act 1845 (UK) and the Lunacy Act 1890 (Victoria) to control the governance of lunatic asylums were introduced. The emergence of the Victorian asylum in England was paralleled in most developed countries to a greater or lesser extent, including France, Italy, the United States and the countries of the former Soviet Union (Davidson et al.,

2010; Lawton-Smith & McCulloch, 2011). Asylum-based care was the main model of psychiatric care for people with a mental illness until the de-institutionalisation movement in 1960s. This movement towards de-institutionalism was activated by a combination of advances in psychiatry and drug treatment, greater emphasis on human rights, and advances in social science and philosophy (Lawton-Smith & McCulloch, 2011). It became explicit government policy in the 1960s. This was paralleled in other countries which used administrative policy to gradually close institutions (Davidson et al., 2010; Lawton-Smith & McCulloch, 2011).

During the nineteenth century, European countries and the United States of America (USA) began a movement that resulted in establishing state hospitals for the mentally ill. The first psychiatric hospital in America at Williamsburg, Virginia, opened in 1773 marks the evolution of psychiatric mental health nursing (Antai-Otong, 2003). During the period of 1790-1890, families with financial means sent people with mental illness to an asylum to recuperate from the illness. Asylums were generally managed by a doctor and staff, who gradually restored patients to satisfactory functioning. It has been estimated by Davidson et al., (2010) that 90% of patients were successful in attaining functional ability; (Davidson et al., 2010) they argue that the 21st century notion of recovery is a return to the days of moral treatment practices that existed in the eighteenth century.

Compared to previous decades, there is an increased recognition of recovery-oriented practices in national and international policies. Current mental health policies encourage the implementation of recovery-oriented practices in service delivery. These include recognition of consumer's lived experience, hope-oriented practices, social inclusion, consumer empowerment, consumer and carer involvement in treatment development, and decision-making (National Institute for Mental Health in

England, 2005; New Zealand Minister of Health, 2005). Recovery-oriented practices respect consumers' decisions and allow them to pursue their goals (Salyers, Stull, & Hopper, 2011). The principles of recovery-oriented practices involve treating consumers as fully competent and equal individuals, being non-threatening, promoting self-help skills, breaking tasks down to be more simple, attending to individual needs, collaborative planning and treatment, recognising strengths and listening (Mead & Copeland, 2000). Crane-Ross et al. (2006) highlight other important characteristics of a recovery-oriented mental health system, such as service empowerment and inclusion of consumers and families at every level of the system, from inclusion in policy formulation, to individual service planning. Despite the literature applauding recovery-oriented practices of care, from anecdotal evidence and the researcher's clinical experience, recovery-oriented approaches to care are yet to be firmly established in the Australian mental health system.

Global responses to the concept of mental health recovery

Mental health recovery has been generally accepted among the western world and is slowly finding a place in the eastern world, including China (Ng, Pearson, Chen, & Law, 2011; Ng, Pearson, & Chen, 2008; Ng, Pearson, Lam, et al., 2008). In the USA, since the 1970s, the influence of mental health recovery endorses consumers' involvement in planning, engaging in mental health councils and state mental health agencies (Frese et al., 2009).

In Canada, mental health recovery is a consumer-driven paradigm with origins in the North American ex-patient liberation movement of the 1960s and 1970s (Piat & Sabetti, 2012); they state that long before recovery became a policy concern, ex-patients were promoting recovery as self-determination, empowerment and self-help group tradition. In Canada, Consumer/Survivor Initiatives (CSIs), such as self-help

groups and advocacy groups, were created as late as the 1990s, to draw attention to values such as caring and emancipatory functions focusing on both self-help, mutual aid and social change (Nelson, Janzen, Trainor, & Ochocka, 2008). Currently the recovery process has become the leading care model of the Canadian mental health system (Edeson, 2012; Nelson et al., 2008).

Similarly, in the UK, the current concept of MHR has gained relevance over the traditional cure-oriented model and has been guiding mental health care policy (Noiseux et al., 2010). A change management program called 'Implementing Recovery Organisational Change' (ImROC), developed by the Centre for Mental Health, is being implemented in mental health systems in the UK. The project involves the delivery of government-subsidised consultation, liaison, support and training to a number of pilot sites endeavouring to re-orient their services around recovery principles (Edeson, 2012).

The MHR movement is established in New Zealand (O'Hagan, 2008). A Mental Health Commission was established in response to the Mason inquiry in 1996. This commission highlighted wide-spread problems associated with under-funded, under-developed mental health services, and a demoralized workforce (O'Hagan, 2008). In 1998, the Mental Health Commission produced *The Blueprint for Mental Health Services in New Zealand* after consulting with a group of service users who were asked to describe a new philosophy of mental health services (Department of Health and Ageing, 2008; Gawith & Abrams, 2006). In 2008, the Ministry of Health in New Zealand developed *Let's get real: Real Skills for people working in mental health and addiction* (2008), which establishes workforce skills and competencies based on recovery. Alternative service models to acute inpatient and sub-acute units such as Recovery Houses were also established. Recovery houses are short-term

home-like services in the community that support people in acute distress and some of which are entirely run by people with lived experience of mental illness.

Concept of mental health recovery in Australia

Similar to other western countries, the Australian national and state governments encourage mental health services to promote and implement recovery-oriented practices in the service delivery (Department of Health and Ageing, 2008; O'Hagan, 2004, 2008; Oades & Anderson, 2012). However the MHR movement is scattered in Australia according to the uptake and emphasis of each State and Territory's government. The States and Territories are responsible for the funding and provision of the public sector mental health services that provide specialist care for people with severe mental illness in Australia. These include services delivered in inpatient and community-based settings. As the main source of funding for specialised mental health services, the States and Territories have occupied a central position in Australia's mental health system. Although, the Australian Federal Government is responsible for providing leadership to guide national action and monitor reform process, each State and Territory has its own frameworks and policies; this has divided mental health delivery and impeded a standardised distribution of mental health care across Australia.

Queensland, South Australia & Western Australia

The various mental health frameworks in the Australian mental health system result in some inconsistencies in mental health service delivery. For example, the implementation of a recovery-oriented framework varies in different states. The Queensland Alliance Mental Illness and Psychiatric Disability Groups promoted recovery as the basic ethos for the entire mental health system, emphasising that the

system should be focussed on consumer outcomes and consumer needs (Department of Health and Ageing, 2008). Similarly, the South Australian model of care has been rewritten to incorporate recovery principles into the service delivery and provide a significant amount of training on recovery, but there is still a lack of understanding about what recovery is. Mr. Wright, the Director of Mental Health Operations said, "clinicians who are of the view that once you have mental illness you will never recover … [clearly] we still have a lot of work to do …" (Department of Health and Ageing, 2008, pp. 17- 18). These views highlight that a radical change is required in both attitude and culture of staff, along with policies and system changes. In Western Australia, the need for recovery principles to be incorporated into policies, practice and procedures of entire organisations was also identified. The Chief Executive Officer of the Richmond Fellowship (Department of Health and Ageing, 2008) pointed to a critical gap between the rhetoric of recovery and the service delivery that actually facilitates recovery:

> Recovery is actually expensive. If you are going to do proper recovery work, it costs more money and so the gap that exists is between what the State recognises is the value of recovery and what it is prepared to pay for in contracts for the non-government sector to allow it to occur (Department of Health and Ageing, 2008, pp. 18- 19).

Tasmania, Victoria & New South Wales

In Tasmania, the concept of recovery is yet to be understood. One non-government source (Anglicare) emphasised that the recovery concept should not be used as a lever for reducing services, as many people will still need support "probably for the rest of their lives because of the illness that they are living with" (Department of Health and Ageing, 2008, p. 18). In 2011, the Victorian Government released the

policy framework for recovery-oriented care to "identify the principles, capabilities, practices and leadership that should underpin the work of the Victorian specialist mental health workforce", "to provide guidance to both individual practitioners and service leaders" and "to complement existing professional standards and competency frameworks" (Department of Health, 2011a, p. 1; 2011b). Recently, the Victorian Government published a discussion paper, which provides a long-term vision for mental health (Department of Health and Human Services, 2015). The discussion paper intends to capture the views of the community, which will be incorporated into the final strategy and will provide for a staged implementation of key actions. This 10-year strategy plan will compliment and build on important and immediate strategic work, including the review of mental health community support services, transitioning to the National Disability Insurance Scheme and the development of the next Public Health and Well-being Plan (Department of Health and Human Services, 2015).

The Department of Health in New South Wales (NSW) developed strategies that provide a strong focus on recovery-orientation. The *Community Mental Health Strategy Report 2007- 2012* (NSW Department of Health, 2008) aimed to ensure that consumer, family and carer participation were consistently available and included in the delivery, planning and evaluation of quality mental health services across the State (NSW Department of Health, 2008). The recent report by the Mental Health Commission in NSW laid out many directions and principles for reform, by which agencies and service providers must find ways to embed the supports they offer to people in the community (NSW Mental Health Commission, 2014).

These various strategies across the States demonstrate that the recovery-orientated approach is being welcomed in Australia and arguably great achievements

can be gained for the Australian mental health system. Nevertheless, it is also important that the approach needs to be driven at the national level to ensure the principles of recovery-oriented frameworks are practiced across all States and Territories without disadvantaging particular areas due to a lack of funding or other health burdens. At the commencement of this study in 2011, there was no national recovery-oriented practice framework in existence to guide the practice of the Australian mental health workforce. However, in 2013, the national framework for recovery-oriented practices was released in Australia (Department of Health and Ageing, 2013a, 2013b) to provide guidance to mental health practitioners and services. More recently, in November 2014, the report of the Mental Health Commission was released, which recommended the need to set clear roles and accountabilities to shape a person-centred mental health system in Australia. To achieve this, the Commission recommended the "… national leadership and regional integration, including integrated primary and mental health care" (National Mental Health Commission, 2014, p. 10).

The literature suggests that the meaning of mental health recovery and the consumer expectations of recovery are not yet firmly established in the Australian mental health system (Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013; Department of Health and Ageing, 2008; Happell, 2008b; National Mental Health Commission, 2014). Mental health services provided by major public organisations remain mainly focused on cure-oriented models and this highlights the gaps between theories, practices and government direction. Compared to New Zealand, the Australian policy documents have failed to incorporate recovery approach competencies for mental health professionals (Lloyd, Tse, & Bassett, 2004). The slow growth of literature on mental health recovery in the Australian context also suggests the lack of uptake of

the recovery concept in Australia. Therefore, in order to explore the concept of recovery among the Australian stakeholders such as consumers, carers, policy makers and professionals, more research is required.

This study aimed to gain a deeper insight and understanding regarding the essence of mental health recovery from the unique perspective of consumers, carers and mental health nurses. The framework of 'lifeworld existential' provided by van Manen aligns well with the various dimensions of mental health recovery. Hence, van Manen's hermeneutic phenomenological methodology has been chosen to gain a more comprehensive understanding of the concept of mental health recovery. It is also anticipated that this research will help to highlight barriers and enablers of MHR in the contemporary Australian setting. One intention is to provide an opportunity for the selected mental health stakeholders to express their views on the meaning of MHR, factors that are helpful and unhelpful to mental health recovery, and insights into a recovery-oriented mental health system. It is anticipated this research will narrow the existing gap in the current literature. Ultimately, this knowledge may aid the formulation of recommendations to improve the experiences of stakeholders around a clearer understanding of the concept of mental health recovery and the advancement of clinical practice.

Summary

This chapter provided an overview of the literature in relation to MHR and the national and international perspectives and responses with regard to this concept. To summarise, MHR is identified as a relevant topic in national and international mental health systems. However, from the anecdotal evidence and the researcher's clinical experience as a mental health nurse working in an Area Mental Health Service, the concept has not been established as a cornerstone within service delivery. Further

observation indicates that mental health recovery has been perceived differently by consumers, carers and service providers and these stakeholders do not demonstrate a deeper understanding or knowledge about the current notion of MHR. Additionally, to this end, no study has been conducted in Australia that incorporates inquiry into the views on MHR of consumers, carers, policy makers and professionals. The available literature (Happell, 2008a, 2008b; Noiseux et al., 2010) suggests the need for collaborative studies among service users, support workers and service providers, in order to develop a sound evidence base in relation to various stakeholders' understanding of the concept of mental health recovery.

From the available literature, the focus is primarily on consumers' views on mental health recovery. Consumers involved in various studies (Borg & Davidson, 2008; Browne et al., 2008; Happell, 2008a; Ng, Pearson, Lam, et al., 2008; Pernice-Duca, 2010) assert the importance of supportive carers and service providers for successful recovery. However, only a few studies (Ng et al., 2011; Ng, Pearson, & Chen, 2008; Noiseux & Ricard, 2008; Noiseux et al., 2010) explored carers' and/ or service providers' views of mental health recovery, highlighting a substantial gap in the current literature. Additionally, it is unclear from the literature whether the concept of mental health recovery is widely recognised and understood among the key mental health stakeholders, including consumers, carers and service providers. This lack of knowledge about other stakeholders' views is a major gap in the current literature. Therefore, this study undertakes to address the existing gap in the literature.

Chapter 3: Methodology

Hermeneutic phenomenology of van Manen

Phenomenology is more a method of questioning than answering, realising that insights come to us in that mode of musing, reflective questioning, and being obsessed with sources and meanings of lived meaning (van Manen, 2014b, p. 27)

Introduction

This chapter explores the methodological understandings pertaining to van Manen's hermeneutic phenomenology. The chapter includes a discussion about the origin of the phenomenological movement and describes three major approaches to phenomenology: Husserl's descriptive phenomenological approach; Heidegger's interpretive phenomenology; and van Manen's human science approach. The first two approaches are foundational pillars of this philosophical tradition. The third approach, which is utilised in this study, builds upon interpretive phenomenology and explores the 'lifeworld existential' and is therefore well-suited to this study. The chapter also outlines the development of phenomenology and nursing research and the suitability of van Manen's phenomenological method in mental health nursing research.

Phenomenology

Phenomenology is a philosophical framework that enables a researcher to search the essence/s of phenomena of interest. This framework allows the researcher to illuminate and experience the richness of a phenomenon. The search for the essence of a phenomenon requires the researcher to intentionally look through the phenomenon and to elicit the fundamental meaning. Many philosophers and phenomenologists have developed diverse methods to illuminate the purity of the phenomenon of interest. This researcher metaphorically expresses phenomenological methodology as an ocean of knowledge. To apply van Manen's phenomenological methodology to the study, the researcher has swum in the waters and found hidden

pearls which are illuminated in the findings chapters. Drawing upon the prominent discussions from the literature, the researcher provides an overview and some of the cornerstones of phenomenology's rich tradition.

Phenomenology emerged as a philosophy that was strengthened in the late 19th century and became one of several prominent contemporary research methodologies in the 20th century (Dowling, 2011; Moran, 2000). The advantage of phenomenology over the more dominant approach of empiricism, is that it focuses on human subjectivity and intentionality. This embraces the meaning of actions, and the freedom and responsibility that intrinsically belong to them, rather than focusing on physical nature, cause-effect analysis, impersonal forces and their manipulation and control (Giorgi, 2005). Many outstanding philosophers contributed and enriched this philosophical tradition[3]. Many researchers have defined phenomenology in various ways. For example, Moran (2000, p.4) defines phenomenology as:

> the radical, anti-traditional style of philosophizing, which emphasises the attempt to get to the truth of matters, to describe phenomena, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experiencer (p.4).

More simply, van Manen (1997b, p. 10) describes phenomenology as the study of 'essences', which aims at gaining a deeper understanding of the nature or meaning of our everyday experience. He suggests that phenomenology is "the study of the lifeworld, the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it" (van Manen, 1997b, p. 9).

[3] Edmund Husserl (1859- 1938- Transcendental Phenomenology), Martin Heidegger (1889- 1976- Ontological Phenomenology), Max Scheler (1874- 1928- Personalistic and Value Phenomenology), Edith Stein (1891- 1942- Empathic and Faith Phenomenology), Alfred Schutz (1899- 1959- Sociological Phenomenology), Hans-Georg Gadamer (1900- 2002- Hermeneutic Phenomenology), Jean-Paul Sartre (1905- 1980- Existential Phenomenology), Emmanuel Levinas (1906- 1995- Ethical Phenomenology) and Maurice Merleau-Ponty (1908- 1961- Embodiment Phenomenology)(van Manen, 2014b).

Phenomenological research is specifically designed to inquire about the lived experience. Auden (1986) states that "as persons, we are incomparable, unclassifiable, uncountable and irreplaceable" (para. 4). Auden is highlighting the uniqueness and the irreplaceable nature of lived experiences. This is what phenomenological inquiries are interested in because such inquiries attempt to return to the originality of a phenomenon and to interpret the original meanings of that phenomenon.

The essence of phenomenology is intentionality. The original philosophers of phenomenology, such as Brentano, Husserl and Heidegger, followed intentionality as a fundamental theme of phenomenology. They viewed intentionality as the "presupposition of the phenomenological method" (Crotty, 1996, p. 41). Van Manen (2014b), described Intentionality as:

> the ways we are 'attached' to the world and how consciousness is always being *conscious* of something. All our thinking, feeling, and acting are 'oriented to' or 'with' the things in the world . . . we are *au monde*, meaning simultaneously 'in' and 'of' the world (2014b, p. 62).

Van Manen expands intentionality further as it is "always being in the midst of things . . . means that the things around us always present themselves partially, perspectivally, seen from this side or with that aspect" (2014b, p. 62). For example, when we see an object, we are not only seeing the object, but also experiencing that object. We don't usually describe each aspect of the object, but rather we see the object as a whole. This means, when we look at a computer monitor and say it is a computer, in fact we are only seeing one aspect of a computer. The monitor is not the only central part, in fact the Central Processing Unit (CPU) is equally important.

Besides, we need a keyboard and a mouse to use a computer (if not a touch screen). Van Manen describes this process as "the intentional relations between the things" (2014b, p. 63). Intentional relations will be different for each individual depending on their unique experience with things or objects. Van Manen says that "when we focus our reflective awareness on our experience of the book [things], then we adopt a phenomenological attitude and we approach the book [thing] as a phenomenon"(2014b, p. 63). He asserts that:

> this thing-in-itself-as-it-shows-itself in consciousness is a phenomenon. Moreover, every distinct phenomenon is characterised by its phenomenality: the intentional ways that the phenomenon gives itself, shows itself, or appears in consciousness" (van Manen, 2014b, p. 63).

The phenomenality of a phenomenon may appear differently to each individual, meaning the intentionality can be different to each individual.

The origin

Gearing argues that "it is doubtful whether any article, or even a single book, could describe sufficiently all the nuances and complete evolution of phenomenology" (2004, p. 1430). Gearing's statement depicts the lack of clarity and complexity of the emergence of the phenomenological tradition. Even though the origin of this philosophy is nebulous, phenomenology has a unique and rich tradition. The origin of the word 'phenomenology' is derived from the Greek word of '*phainoemn'* (appearance) and '*logos*' (reason) (Gearing, 2004). However, Heidegger pointed out, in his provisional ontological formulation of the meaning of these Greek words, that *phenomenon* means "that which shows itself in itself"' and *logos* means "to let something be seen" (van Manen, 2014b, p. 27). The word phenomenology was

initially used by Johann Heinrich Lambert in 1764 (Spiegelberg, 1971). Phenomenology as a branch of philosophy emerged as a result of the influence of two intellectual pillars, Husserl and Heidegger, as described below.

Edmund Husserl

Edmund Husserl is considered the father of phenomenology (van Manen, 1997b). Husserl was inspired by Franz Brentano (1838-1917), a psychologist and a philosopher, whom he called his 'one and only teacher in philosophy' (Spiegelberg, 1971, p. 28). Brentano used the phrases 'descriptive psychology' or 'descriptive phenomenology' in his work (Moran, 2000). Husserl was a mathematician and changed his focus from mathematics to philosophy, as he was inspired by Brentano's lectures in Vienna (Cerbone, 2006; Crotty, 1996; van Manen, 2014b). Husserl's aim was to re-establish the science of philosophy from its "abstract metaphysical speculation wrapped in pseudo-problems" (Moran, 2000, p. 13). In order to achieve this, Husserl used his mathematical knowledge to better understand the foundations of logic and generate a theory of knowledge (Gearing, 2004). Husserl believed that a new way of undertaking philosophy needed to be established. He wanted to bring the philosophy back to the matters themselves, with a greater focus on living experience (Moran, 2000). Husserl defined phenomenology as a "descriptive philosophy of the essences of pure experiences . . ." (van Manen, 2014b, p. 89). His underpinning principle was that to experience the essence of a phenomenon, a researcher must be attentive only to what is given in intuition and not to be affected by suppositions. Husserl called this principle 'presuppositionlessness' and emphasised that this will capture the phenomenon in its primordial origin (Moran, 2000).

Husserl's phenomenological method included a central concept – that of intersubjectivity – found in his unpublished manuscripts (Crotty, 1996).

‘Intersubjectivity’ refers to a plurality of subjectivities which make up a community sharing a common world and lifeworld (*Lebenswelt)* – that is, the world of lived experience (Crotty, 1996). Van Manen states that phenomenology is intersubjective “in that the human science researcher needs the other (the reader) in order to develop a dialogic relation with the phenomenon, and thus validate the phenomenon as described” (1997b, p. 11). Another fundamental theory of Husserlian phenomenological reflection is the eidetic reduction; “The *eidos* is a phenomenological universal that can be described through a study of the structure that governs the instances or particular manifestations of the essence of that phenomenon” (van Manen, 2014b, p. 229). Eidetic reduction is the generation of “essential insight(s)” from the meaning of a phenomenon (van Manen, 2014b, p. 228) and illuminate the uniqueness of a phenomenon.

Husserl’s phenomenological method involved two attitudes, the natural attitude and the philosophical attitude (Walters, 1995). The natural attitude was primarily based on every experience and human relationship, whereas the philosophical attitude was about questioning the natural attitude of every experience. Husserl argued that, in order to understand the world, one needs to take a philosophical attitude and ‘requires *das unmittelbare schen* (direct seeing)’(Gearing, 2004, p. 1430). To attain this direct seeing and to reflect the phenomena, he introduced two methods – the method of *epoche* or transcendental reduction (bracketing of natural attitude) and the phenomenological reduction (constitution of meaning). These two processes are interconnected, continuous and cannot be separated. Gearing used transcendental reduction (*epoche* or bracketing) and phenomenological reduction interchangeably. Gearing (2004, p. 1430) defined phenomenological reduction as

> … the scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon. Bracketing, as in a mathematical equation, suspends certain components by placing them outside the brackets, which then facilitates a focusing in on the phenomenon within the brackets (p. 1430).

Husserl believed that by seeing directly and bracketing one's own preconceptions, the phenomena will be traced back to human consciousness as transcendental subjectivity. The multidimensional aspects of Husserl's philosophy are known as transcendental phenomenology, eidetic or descriptive phenomenology. Husserlian philosophy is practiced in the Duquesne school of phenomenology (Crotty, 1996).

Martin Heidegger

Heidegger was a student of Husserl and, once Heidegger was appointed as a *Privatdozent* (a teacher or lecturer who has attained his or her *Habilitation* and thereby has formal teaching status within a particular university faculty or department, but is not on its salaried staff) to the faculty, an intense philosophical and personal relationship began to develop between these philosophers (Spiegelberg, 1971). Even though Heidegger had a strong interest in Husserl's philosophy, both of them had two different styles to phenomenology. From Spiegelberg's (1971) writings, it appears that, in later years, the relationship between these two philosophers became strained, especially after Heidegger was appointed as the successor of Husserl in Freiburg.

Heidegger's philosophical approach expanded the concept of phenomenology beyond that of Husserl (Taylor & Francis, 2013). Heidegger's seminal work *Being*

and Time (1962) was a major re-interpretation of phenomenology (Walters, 1995). Heidegger saw the vital medium of being-in-the-world (*Dasein or* Being-there) and held the view that the fact of being is a more fundamental matter than human consciousness and human knowledge (Crotty, 1996). The explanation for *Dasein* given by Heidegger (1962) is as follows:

> Thus to work out the question of Being adequately, we must make an entity – the inquirer- transparent in his own Being. The very asking of this question is an entity's mode of Being; and as such it gets its essential character from what is inquired about –namely, Being. This entity which each of us is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term '*Dasein'* (Heidegger, 1962, p. 27).

Heidegger's approach replaced the study of the intentional structures of consciousness with a more fundamental study of the relation between *Dasein* (being-in-the-world) and *Being self* (Moran, 2000). Heidegger's philosophy was based on an existential perspective which considers that an understanding of the person cannot occur in isolation from the person's world (Walters, 1995). Heidegger argued that, in order to understand the person, the person's world also should be understood. Van Manen states that Heidegger's approach to phenomenology is ontological and requires the researcher to be in mindful attune to the "modes of being of the ways that things are in the world" (2014b, p. 105). Taylor and Francis (2013) assert that Heidegger viewed the philosophers as ontologists who seek to unravel the universal structures of Being as they manifest themselves in the phenomena. Taylor and Francis argue that Heidegger viewed "Being as the most universal concept", thus his phenomenology was "essentially hermeneutical" (2013, p. 81). Taylor and Francis

further explain that the basis of Heideggerian philosophy was existential, but his "emphasis on a hermeneutic . . . analysed the historically-situated self as a 'Being-in-the-world', thus it became an existential-ontological hermeneutic" (2013, p. 82). Heidegger believed that a question can only be raised by a questioner who has certain ideas of what to question. In order to demonstrate the need of a questioner, Heidegger developed a hermeneutical circle which enhanced the scope, meaning and significance of the hermeneutic phenomenology (Taylor & Francis, 2013). Heidegger's method was not about "looking at subjective everyday experience and discerning its visible meanings or even its hidden or implicit meanings . . . Heidegger is after the meaning of Being itself" (Crotty, 1996, p. 77). Heideggerian phenomenology is called interpretive phenomenology, and the school of Heideggerian hermeneutics and interpretive phenomenology is guided by Heidegger's philosophy (Crotty, 1996).

The literature suggests that Husserl's phenomenological reflection of the lived-world of experience was temporal, whereas the Heideggerian sense of the latter is both temporal and historical (Ray, 1985). Sukele (1976, as cited in Taylor & Francis, 2013) explains the basic differences between Husserl and Heidegger:

> It boils down to their different interpretation of the concept of 'world'. It was though there were two different levels; the level of the natural world and the level below the natural world from which all things sprang. Husserl was intent on reaching the world below, whilst Heidegger was concerned with Being-in-the-world, therefore, instead of trying to lay presuppositions to one side, Heidegger explored them as legitimate parts of Being (as cited in Taylor & Francis, 2013, p. 80).

While Husserl wanted to illuminate the essence of a phenomenon without external influence, Heidegger was more interested in illuminating the existence of a phenomenon, and argued the possibility of using researchers' assumptions to explicate the phenomenon. Unlike Husserl, who promoted the concept of *epoche*, Heidegger wanted the researcher not to be separated from the world, but to be present in the world. Heidegger argued that the presuppositions constitute the possibility of intelligibility or meaning (Munro, 2008). Spiegelberg explains that "Heidegger's fundamental wonder is objective Being, Husserl's subjective consciousness" (1971, p. 284). It could be argued that, for a novice researcher to apply *epoche* can be challenging, as it is an action requiring some skill; on the other hand, the Heideggerian approach requires the researcher to be aware of one's own presumptions and is an easier approach for a novice researcher to comprehend and apply in the research process.

Hermeneutic phenomenology

Spiegelberg (1971) identifies six types of phenomenology: descriptive; essential (eidetic); constitutive; reductive; hermeneutic; and, the phenomenology of appearances. This study has adopted hermeneutic phenomenology. The term 'hermeneutics' originated from the Greek verb *hermeneuein,* meaning to interpret, and relates to *Hermes,* the messenger-god (Apel, 1963). The origin of the hermeneutic method was developed by the theologian-philosopher, Friedrich Schleiermacher (1768-1834) and subsequently by Wilhelm Dilthey and Heidegger (van Manen, 2014b). Schleiermacher argued that texts should be read with an open mind, taking into consideration the historic temporality and rationality – a "reconstruction of the past" (as cited in van Manen, 2014b, p. 132). The foremost representatives of hermeneutic phenomenology are noted by van Manen as being

Gadamer and Ricoeur. Even though Gadamer was interested in Schleiermacher's theory, Gadamer debated the complexity and lack of possibility of reconstructing the past; rather, he argued that "hermeneutics means to place the interpretation of the ancient text in the context of one's own social historical existence" (as cited in van Manen, 2014b, p. 132).

Hermeneutics involves the "bringing to understanding of something obscure or foreign, the translation of the unfamiliar into a comprehensible form" (Gardner, 2010, p. 36). There are two processes attempted by hermeneutics – first, to interpret a given text, and second to theorize the condition under which such interpretation is possible. Gadamer distinguished these two processes as the process of 'pointing to something' and the process of 'pointing out the meaning of something' (as cited in van Manen, 1997b, p. 26). Cohen, Kahn, and Steeves (2000) state that hermeneutics is the interpretation that accompanies description within hermeneutic phenomenological inquiry. Van Manen concurs and states that "phenomenology becomes hermeneutical when its method is taken to be essentially interpretive and primarily oriented to the explication of texts" (2014b, p. 132). Van Manen (1997b) describes hermeneutic phenomenology as a writing activity that fundamentally leads the researcher to orient to the informer's experience of the phenomenon and interprets its meaning through the texts of life.

Van Manen's phenomenological approach

Van Manen's (2014a) approach to phenomenology further advanced this philosophical branch to human science research. Van Manen by focussing on human perception and experience (1997b), was able to bring together the European interpretive phenomenology and the North American methods-driven phenomenological philosophy. He described the aim of phenomenology as to gain a

deeper understanding of the nature or meaning of our everyday experiences (van Manen, 1997b). Van Manen argues that phenomenological philosophy is a theory of the unique and is interested in the irreplaceable aspect of a particular phenomenon (1997b). He clarifies the Husserlian view of the lifeworld that phenomenology is the study of world as we immediately experience it, pre-reflectively, rather than as we conceptualise or reflect on it.

Van Manen's approach to human science research is both phenomenological and hermeneutic (1997b). He asserts that pedagogy requires both "phenomenological sensitivity to lived experience" and "hermeneutic ability to make interpretive sense of the phenomena of the lifeworld" (1997b, p.2) to see the pedagogic significance. Van Manen used the terms phenomenology and hermeneutic interchangeably as he argued that "all description is ultimately interpretation" (van Manen, 1997b, p. 25). He cites Heidegger to support this notion, who argued that the meaning of phenomenological description lies in interpretation. This is inconsistent with the Husserlian phenomenological movement, which is based on pure description. The followers of Husserlian phenomenology critique hermeneutic phenomenology as being outside the realm of phenomenological research (van Manen, 1997b).

Distinguishing features of van Manen's method

Van Manen identifies many distinguishing factors of his hermeneutic phenomenological human science research approach that elucidate rigorous and rich data (1997b). He delineates phenomenology as the study of lived experience and holds that, unlike other philosophical traditions, phenomenology offers the possibility of credible insights that bring the researcher into more direct contact with the world (1997b). This allows the researcher to understand the essence of the experience of the lived-world and interpret the deeper meaning of the phenomenon (van Manen,

1997b). Phenomenological research is an "explication of phenomena as they present themselves to consciousness" (van Manen, 1997b, p.9) and enable a researcher to "systematically uncover . . . the internal meaning structures, of lived experience" (1997b, p. 10). Phenomenology is distinguished from other sciences, as it enables the researcher to "explicate the meanings as we live them in our everyday existence" (van Manen, 1997b, p. 11).

Van Manen describes the central characteristic of phenomenology as thoughtfulness: "a mindful wondering about what it is like to live a life" (1997b, p.11). Phenomenology leads the researcher to become fully oneself by searching what it means to be human (van Manen, 1997b). Phenomenological text uses poetising expressions and metaphors to invoke the phenomenological intuition (van Manen, 1997b, 2014b). This rich description of texts brings the lived experience alive and makes explicit, for the reader, the experience of the 'phenomenological nod' as the phenomenological texts may have an effect on one's understanding and may arouse an "ah ha! moment" or 'epiphany' (van Manen, 1997b, p. 12).

Methodical structure of van Manen's approach

Many researchers, such as Colaizzi, Giorgi and van Kaam, have developed step-by-step methodical structures for approaching phenomenological research. Methodical structures have pros and cons; they are useful tools for a novice researcher and can provide the researcher with clarity as to what to do at each step of data analysis. However, methodological structure can also limit the scope of the researcher's potential to think outside the boundaries. Van Manen (1997b) established a methodical structure for his research methodology (Table 1). Though van Manen's methodical structure is not a step-by-step process, it guides a novice researcher by giving some parameters (van Manen, 1997b, p. 30). These parameters orientate a

novice researcher on how to conduct human science research, and provide clear indication about what the researcher should consider before even turning to a phenomenon of interest. He states that in order to pursue human science research, the researcher should find an interesting phenomenon and commit to exploring that phenomenon. The researcher should live the phenomenon as part of investigation, rather than conceptualise the phenomenon (van Manen, 1997b). He also provides various ways for thematic analysis, which can be utilised according to the researcher's preference. Van Manen asserts the importance of writing and rewriting, and the strong need for maintaining a pedagogical relation with the phenomenon. Van Manen's methodical structure provides academic freedom, where the novice researcher does not have to abide with a formula, but is allowed to explore the phenomenon of interest.

Table 1 Van Manen's methodical structures

<table>
<tr><td colspan="3">• Identify a phenomenon that seriously interests and commits the researcher to the world</td></tr>
<tr><td colspan="3">• Investigate the experience as the researcher lives it rather than as the researcher conceptualises it</td></tr>
<tr><td colspan="3">• Analysis of text by using any of the below three method</td></tr>
<tr><td><u>The wholistic reading approach:</u> Attend to the text as a whole and capture the fundamental meaning of the text as a whole and try to express that meaning by formulating a sententious phrase</td><td><u>The selective or highlighting approach:</u> Listen to or read a text several times and ask 'what statements or phrases seem particularly essential or revealing about the phenomenon or experience being described and highlight such statements.</td><td><u>The detailed or line-by-line approach:</u> Look at every single sentence or sentence cluster and ask what does this sentence or sentence cluster reveal about the phenomenon or experience being describe</td></tr>
<tr><td colspan="3">• Describe the phenomenon through the art of writing and rewriting</td></tr>
<tr><td colspan="3">• Maintain a strong and oriented pedagogical relation to the phenomenon</td></tr>
<tr><td colspan="3">• Balance the research context by considering parts and whole</td></tr>
</table>

Lifeworld existentials & mental health

Van Manen identified six fundamental lifeworld themes that can guide reflection in the research process and is applicable to human beings, regardless of their historical, cultural or social background (Munro, 2008). Application of van Manen's method can be very useful to various disciplines of enquiry. This study focused on mental health research, where the primary question explored the meaning of mental health recovery. The lifeworld themes are called 'existentials', by which all humanity experiences the world in different modes (van Manen, 1997b). These are: 'lived space' (Spaciality); 'lived body' (Corporeality); 'lived time' (temporality); 'lived self-other' (Relationality) (van Manen, 1997b, pp. 102- 105), 'lived things' (Materiality); and, 'lived cyborg relations' (Experiencing Technology) (van Manen, 2014b, pp. 306- 308). Any experience under investigation in mental health research has a close relation with the lifeworld existentials, as these six concepts feature in one's living world. The lifeworld themes are fundamental and interrelated. In a majority of cases, all aspects of lifeworld existentials will be affected for a person with mental illness. Reflecting on this framework will assist a mental health novice researcher to contemplate the deeper meaning of the phenomenological texts.

Lived space (Spaciality): van Manen called this 'felt space' and described it as a space where one finds themselves, such as a home or special place (van Manen, 1997b, p. 102). A person with mental illness may find themselves moving in and out of that comfortable space, not only the comfort of a house, but also the comfort of belonging in a community. Being admitted into a mental health unit may place a person in an awkward and uncomfortable space. Similarly, a person's sense of lived space can be threatened by internalised (van Manen, 1997a) and externalised stigma (Sibitz et al., 2013). A person with mental illness may also find the usual comfortable

spaces as no longer comfortable, especially if one suffers paranoid fears about their lived spaces.

Lived body (Corporeality): Refers to "how one [is] bodily present in the world" (van Manen, 1997b, p. 102). Van Manen argues that one may reveal or conceal certain aspects of oneself when being surrounded by others. For example, a person may behave differently to a work colleague compared to a close family member. A person with mental illness may find that one's usual self is being replaced by something else, a feeling of being alienated. For example, one's usual self could be neat, organised and logical, but when affected by illness, one may find it hard to look after oneself and be organised. Thus, a person can become illogical in conversation or identify themselves as another person: for example a 'celebrity' or a 'millionaire'.

Lived time (Temporality): Van Manen termed 'subjective time' as lived time and described it as the way in which one might experience the speeding up and slowing down of time, depending on certain situations (1997b, p. 103). A person affected by mental illness will also be affected by this subjectivity of time. One may find a loss of certain periods in their lifetime, correlating to the onset of their mental illness. For example, if one was affected by mental illness in their early teens, they may lose some aspects of their adolescence, such as missing schooling, struggling at university or struggling with work; rather, they may find that they are spending some of their time in hospital or other health services. They may find this time as long and tedious, compared to a healthy person, whose adolescent period has not been interrupted by periods of hospitalisation or illness. Similarly a person may lose certain periods in their life, such as adulthood, motherhood and so on, due to the effects of mental illness.

Lived self-other (Relationality): Lived self-other is the "lived relation we maintain with others in the interpersonal space that we share with them" (van Manen, 1997b, p. 104). The relationship one develops and keeps has significant effects on one's mental health. For example, a detrimental relationship may push one into acute distress, whereas a fruitful relationship may give hope to live a happy life.

Lived things (Materiality): Many things, such as objects, personal belongings, other possessions, and external objects, influence our lives. These things directly and indirectly affect our existence. Van Manen states that "it would be difficult to overestimate the significance of 'things' in our life" (2014b, p. 306). Van Manen states that, since things have significant effects on our existence, in almost every research study we could ask the question "how are things experienced?" and "how do the experiences of the things and world contribute to the essential meaning of the phenomenon?" (2014b, p. 306). Things have an influence in our lives more than we might think. Things can influence us not only internally, but also externally. For example, van Manen states that "things can disappoint us or reflect our disappointments back to us" (2014b, p. 307). In the context of mental health, many things in life can affect the mental health of a person. For example, for some people, an event such as loss of a loved one can trigger a depressive episode.

Lived cyborg relations (Technology): van Manen adds 'lived cyborg relations' as an addendum to the existential theme as we are living in a technological era. He states five kinds of lived cyborg relations in the human experiences.

1. ***Experiencing technology as taken for granted:*** Most of us have the taken-for-granted attitude and use technology as tools or techniques. For some people who can take advantage of technology, it enhances comfort; for those who are not interested in technology, it can be painful. Van Manen suggests that, when

reflecting on the phenomenon, the question is "are we taking our cyborgian existence for granted"? and "how"? (2014b, p. 308).

2. ***Experiencing technology ontically:*** Van Manen briefly explains the work of various scholars, such as Ihde, Dreyfus, and Achterhuis, who are trying to understand technology. He states: "with respect to the computer, several experiential relations may be distinguished that the person maintains with this empirical or ontic dimension of technology" and asks "in what ways are we cyborg?" (2014b, p. 308) to understand how people use and experience technology in this modern world.
3. ***Experiencing technology ontotheologically:*** "Technology is a way of revealing" (van Manen, 2014b, p. 308). Technology reveals the "cyborgian existence", provides useful resources for humans and "lets things reveal themselves" (van Manen, 2014b, p. 308). A simple example could be the usefulness of the internet, which reveals a glut of resources to people according to what they are looking for.
4. ***Experiencing technology as technics:*** Van Manen briefly describes how Stiegler brings the cyborgian nature of being human to consciousness. Technology has an enormous effect on our ways of life, especially in the way younger people are "caught up" in the technological innovations (2014b, p. 309), such as in preoccupation with online games and social medias.
5. ***Experiencing technology aesthetically:*** Van Manen draws upon Perniola, who argued that contemporary sensibility is transforming the relations between humans and things or technology. In this section, van Manen raises some important questions, such as: "How is technology overcoming the constraints of the physical body?", "What does it mean to feel things as in the

cyborgian experience of the body increasingly consisting of organic and inorganic parts?", "How do humans identify with or become extensions of computerized technologies?", and "Can we speak of things as having feelings?" (2014b, p. 309).

***Textual features*:** Van Manen describes five other parameters that enhance phenomenological data. These are "lived thoroughness, evocativeness, intensity, tone and epiphany" (1997a, p. 350). Van Manen utilises these features to explain how phenomenological texts enable the reader to recognise and experience the phenomenon (thoroughness) and to allow the lived experience to be brought vividly into the presence and evoke thoughtful reflection (evocation). He asserts that silences and spaces between words also have meaning, which gives full value to the key words in the phenomenological text (intensity) and resonate meanings. Van Manen argues that the tone of the phenomenological texts also conveys greater meaning and re-creates a mental image of humanness, thereby touching the understanding of life's meaning. This epiphany or realisation of a meaning may push the reader to think more and search for deeper meaning and understanding.

Phenomenology and nursing research

Nursing research is largely interested in understanding the experience of health, illness and the treatment of patients, carers and nurses. Understanding the various experiences of patients has been discussed by many nurse theorists since Florence Nightingale (Cohen et al., 2000). Polit and Beck (2008) define nursing research as a systematic inquiry designed to develop trustworthy evidence about issues of importance to the nursing profession, including nursing practice, education, administration, and informatics. Researchers in nursing enhance the profession by utilising knowledge underpinned with evidence. While there are various

methodologies in practice within nursing research, Liamputtong (2009) notes that phenomenology is the most commonly used qualitative methodology in nursing. Similarly, Holloway and Wheeler (2010) indicate that phenomenology has become a popular method in healthcare research.

The use of phenomenology as a method in nursing research opens an era that allows the nurse researcher to gain a deeper understanding of the phenomena experienced by others. Nursing research is largely interested in experiences which embrace a holistic perspective, therefore using phenomenology as a methodology to explore lived experiences provides a basis on which to develop insights into these experiences. Crotty, a psychologist, (1996) argues that nurse researchers do not follow the authentic phenomenological approach to research that is objective and critical; rather, nurse researchers follow a new phenomenology, which is descriptive, subjective and lacks critique. However, it needs to be understood that, if an inquiry is to explore the subjective experience of a phenomenon, then the subjectivity of the phenomenon will be illuminated. Lindseth and Norberg (2004) justify their position on nursing research by arguing that nursing research is often about understanding the subjective experience of a phenomenon from the participants' perspective. They believe that, in such cases, employing this new phenomenological approach is appropriate (Lindseth & Norberg, 2004).

Phenomenology and mental health research

Phenomenological philosophy is emerging in the study of mental health. Recently, the perspectives of lived experiences of people with mental illness have been influential in the planning and development of mental health service delivery (Barkway, 2001). Due to the significance of the lived experiences, mental health care is adopting qualitative methodologies to explore the encounters of mental health

participants (Kutney, 2006). In addition, researching the lived experiences of mental health stakeholders, such as consumers, carers, professionals and policy makers, may provide greater insights into the advancement of clinical practice. Van Manen describes the notion of lived experience as "to explore *directly* the originary . . . life as we live it" (2014b, p. 39). Therefore, understanding mental illness through the eyes of the people who experience mental illness is crucial in mental health care. The growing use of phenomenology in mental health research enables insights into the lives of people with mental illness, thus making a significant contribution to assist in the definition and development of person-centred outcomes (Kutney, 2006).

Mental health nursing is less affected by advancements in technology and is largely focused on the principles of human interaction (Cutcliffe & Ward, 2007). Thus, research in mental health care should ideally take a human science approach that is capable of exploring the world of the participants being studied. Examining the subjective experiences of the lifeworld of mental health clients enhances service providers' knowledge about how participants experience their world. In so doing, the service providers may be better equipped to understand and translate the subjective knowledge to education and clinical practice, thereby ultimately improving clinical care. Van Manen's human science approach expands the scope of phenomenology to this level, enabling the researcher to explore the lifeworld of the participants under study.

Mental illness can be a chronic debilitating condition, like any other serious chronic disease that affects the person's world – that is, their sense of self, sense of time, relationships with the environment in which they live, their sense of space, sense of objects that they possess (van Manen, 1997b). Van Manen's rigorous work of lifeworld existentials – lived space, body, time, self-other, things, cyborg relations

and textual features (van Manen, 1997a, 1997b, 2014b) – provides a means for the researcher to reflect on the phenomenon under investigation and enables the illumination of the essence of the event of interest. The lifeworld theme is closely aligned to many mental health phenomena and provides a structure for the mental health researcher to explore further. Additionally, van Manen's (1997b) methodical structure helps a novice researcher adopt a systematic style to analyse data, without hindering the academic freedom of the researcher.

The question as to the meaning of recovery from mental illness was a pivotal force that brought this researcher into the world of research. As an experienced mental health clinician, I was aware that mental health recovery, as it intentionally appeared, was different to other forms of recovery from illness, and wanted to know what the experience means to consumers, carers and mental health nurses. Therefore, in order to explore the phenomenality of mental health recovery, the researcher chose van Manen's methodology to explore this concept, due to the various distinguishing features of van Manen's methodology elucidated here and the appropriateness of this methodology to the research area of this study.

Summary

This chapter provided the methodological background of phenomenology chosen for this study. Phenomenology is a useful methodology which provides a suitable framework to explore individual participants' experiences of a phenomenon of interest. Understanding the unique experience of participants enhances the evidence-base of the body of nursing knowledge, and augments the advancement of clinical practice and policy development. As Gearing (2004) highlights, it is not at all an easy task to comprehensively and accurately articulate the philosophy of phenomenology from its origin to the current period. To return to the analogy already raised in this

chapter, phenomenology is a philosophical tradition and a research methodology that resembles an ‘ocean’. The huge beings in the ocean are the intellectual personalities in phenomenological tradition. Like an ocean filled with its own immense resources, phenomenology holds its own treasures and shares its wealth in the world of research. In applying this methodology, this researcher experienced the delight of a novice swimmer wading into the ocean's shallows; through the completion of this project, the wonder and richness of the ocean's depths were revealed.

Chapter 4

Phenomenology as the research method

Introduction

This chapter details the diligent application of the methodology to the research. Van Manen's (1997b) methodological outline for phenomenological research and hermeneutical phenomenological writing guided the design of this research. This chapter includes the research design, ethical considerations, recruitment strategies, method of data collection, the process of data analysis and the authenticity of the research process. At the end of the chapter a brief background of the participants is provided.

Ethical considerations

The study received ethics approval from the AMHS's Human Research and Ethics Committee (Ref: HREC/12/PH/17) and from the Monash University Human Research Ethics Committee (Ref: CF12/2022–2012001088). This study was carried out according to the *National Statement on Ethical Conduct in Research Involving Humans*, produced by the National Health and Medical Research Council of Australia (Australian Government, 2007). This research was considered as a high-risk research area, due to the vulnerability of consumer participants involved in the study. In this research, possible ethical issues were explored, such as: the risk of unanticipated harm; protecting the participant's information; effectively informing participants about the nature of the study; and, the risk of exploitation. The researcher was also aware of relevant ethical principles such as: beneficence, non-maleficence, fidelity, justice, veracity, confidentiality, as well as the rights of the participants (Connor, 1999). The researcher anticipated that some problems affecting the confidentiality of

the participants might arise when interviewing them, which might need to be reported to relevant authorities, according to the seriousness of the disclosed information. This was an anticipated challenge; however no participants disclosed any challenging information that required the escalation of further protective action, and there were no other issues encountered during the data collection period.

Informed consent and voluntary participation

The concept of 'informed consent' is a valuable one that serves to protect those who participate in research studies. DiCicco-Bloom and Crabtree (2006) state that informed consent acts on the principle that individuals should not be coerced or persuaded or induced into research against their will, but that their participation should be voluntary. The researcher assured participants their involvement in the study was voluntary, and that they had the right to withdraw from the study at any stage without any compromise until the de-identification of the data. Participants were also informed that they were able to stop at any time during the interview if they wanted to, and were given options to turn off the recorder if they wished not to have certain aspects of the interview recorded. During the interviews, the recorder was turned off once as per the participant's request due to their heightened emotional state and resulting outburst.

Considering the vulnerable population involved in the study, three types of participant information and consent forms (See Appendix C) were developed for each of the participant cohorts using the relevant template. The consent form contained the following information: a thorough explanation of the study; details of the researcher's and participants' roles; advice as to what happens to the information collected; the steps to be taken if any adverse events occurred; and the process for reporting any

adverse effect/s from the interview. During the consent procedure, the researcher explained the study in simple language, and an opportunity was provided to ask questions and clarify any doubts associated with the study. The researcher explained that, once the interview was transcribed, these transcriptions would be returned to participants to ensure the trustworthiness and accuracy of the data. Once the participants had no further questions, the consent form was signed and the interview was carried out according to the agreed time and venue. Written informed consent was obtained from all interviewees who participated in the study.

Minimising harm to participants

Process to manage any potential distress that might be caused by the study was developed relevant to each cohort (Appendices D). The Mental Health Triage Manager and the Chief Nursing Officer of the AMHS supported this process. The consent forms also included access numbers to mental health triage; however, following the interviews, there was no indication that any participants required these services. Many consumers, carers and mental health nurses were grateful for the opportunity to discuss their experience with the researcher and offered the researcher their support for recruitment, which had a snowballing effect; one carer, two consumers, and two nurses were recruited to the study as a result of this effect.

Privacy, anonymity and confidentiality

To ensure the privacy and confidentiality of participants, certain strategies were put in place, such as: the coding of data; the use of pseudonyms of the researcher's choice; and, the secure storage of data. Coding numbers were given to all participants, as follows: consumers P1- P9; carers C1- C8; and, mental health nurses N1- N9. Once the interviews were professionally transcribed, the participants were

given pseudonyms and these were consistently used throughout the thesis and in all other publications. Permission was sought from participants to use the de-identified data for education purposes.

Data storage, access and disposal

According to the university's requirements, the collected data is stored in a locked space for five years for verification if required and will be destroyed after five years. These strategies were explained to participants to assure they were aware of how their information was managed and that anonymity at all times was assured. The consent forms were stored separately from the transcripts and the supervisors did not know the identity of participants.

Selection and recruitment of participants

Site*:* There was no restriction placed on which site was selected. However, the majority of participants were recruited from the local AMHS, due to accessibility and the AMHS's focus on the concept of mental health recovery. One nurse participant and one consumer participant were recruited from outside the catchment area of the AMHS. The carers were recruited from the catchment area of the AMHS, but the majority of carers' (6/8) loved ones were not actively followed up by the AMHS. Their loved ones were receiving care from primary health care settings. One carer involved in this research is related to one consumer who participated in this research.

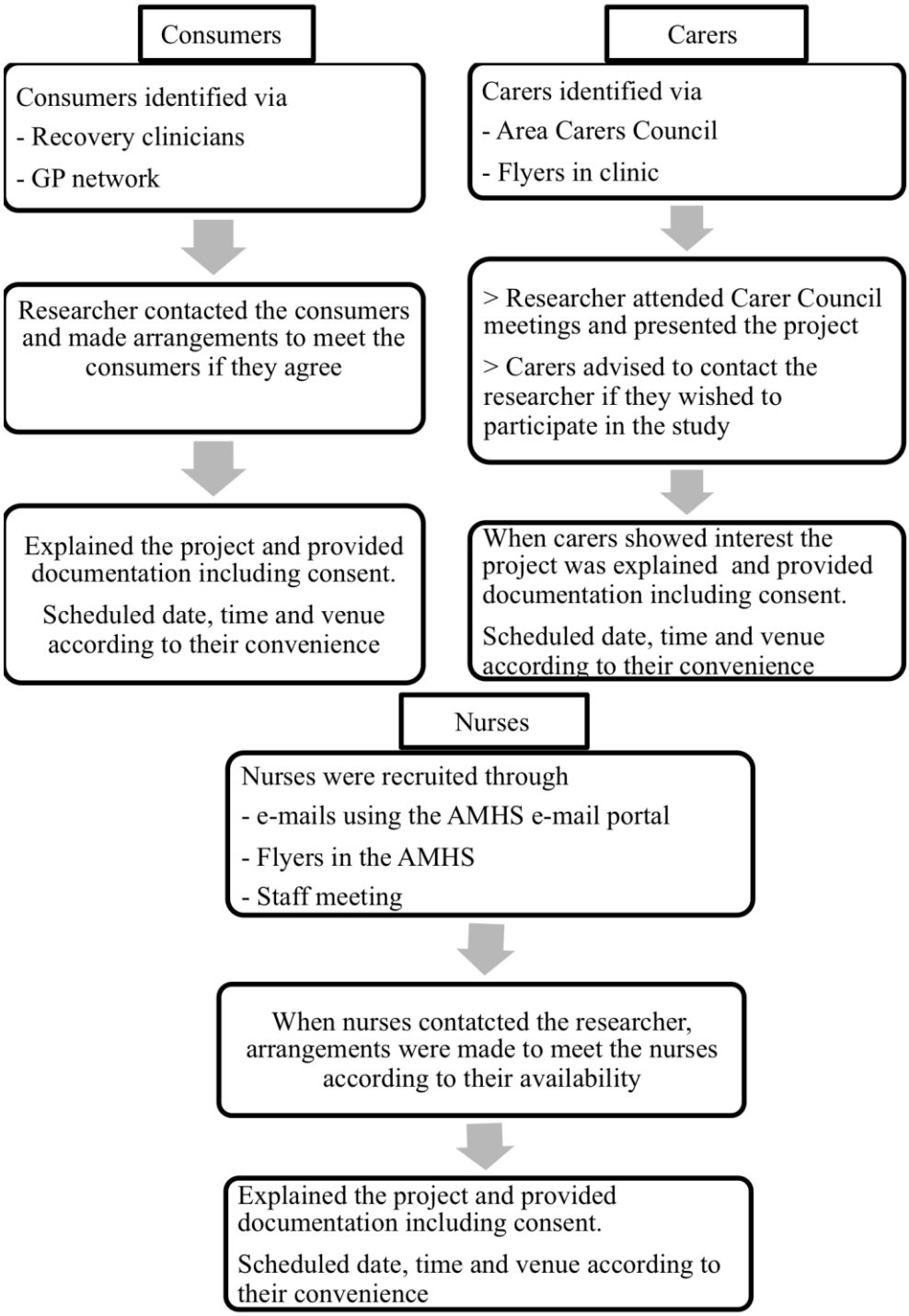
Sample as example*:* Van Manen (2014b, p. 352) argues that "the use of the notion of sampling presupposes that one aims at empirical generalisation, and that is impossible within a phenomenological methodology". He suggests the term 'sample' can be related back to the French root word 'example'. He reiterates if the notion of sample is necessary to be used, "it is best to do so with reference to the attempt to

gain ‘examples’ of experientially rich descriptions” (van Manen, 2014b). In phenomenology, the size of the sample is insignificant and the saturation depends upon the phenomenological questions (van Manen, 2014b). The research question for this study sought to explore the meaning of mental health recovery among consumers, carers and mental health nurses. In order to select appropriate health professionals, the following considerations were deemed important. Given mental health services have many disciplines working with clients, it was thought that this diverse focus might fragment the sample. Mental health (MH) nurses are the largest health care providers in mental health settings; therefore, the decision to focus upon MH nurses was taken. This enabled the collection of a homogenous sample and enhanced the advancement of mental health nursing by giving insights into the day-to-day care. The decision to exclude other professions also made this study feasible for the specified period.

Participant recruitment*:* To recruit participants for each cohort, a strategy was used involving an inclusion and exclusion criteria (Schneider, Whitehead, & Elliott, 2007). A recruitment flowchart was also developed (Figure 3) to efficiently plan the recruitment strategy. The researcher asked participants about a preferred date, time and a preferable space in the hospital or clinic setting to conduct the interview. Choosing a preferable space in a hospital or clinic setting or a public place was directed by the senior research team of the University in line with the University’s preference, as at times, home environments of participants can be risky environments for the researcher (Green & Thorogood, 2009; Holloway & Wheeler, 2010; International Council of Nurses, 1996). The researcher was conscious of the potential interruption when conducting the interviews in a hospital or clinic setting (Green & Thorogood, 2009, pp. 68- 69). Therefore, a meeting room was booked and a ‘Do not

disturb' sign was posted to avoid any potential interruptions (Green & Thorogood, 2009, p. 85).

Figure 3: Recruitment flowchart



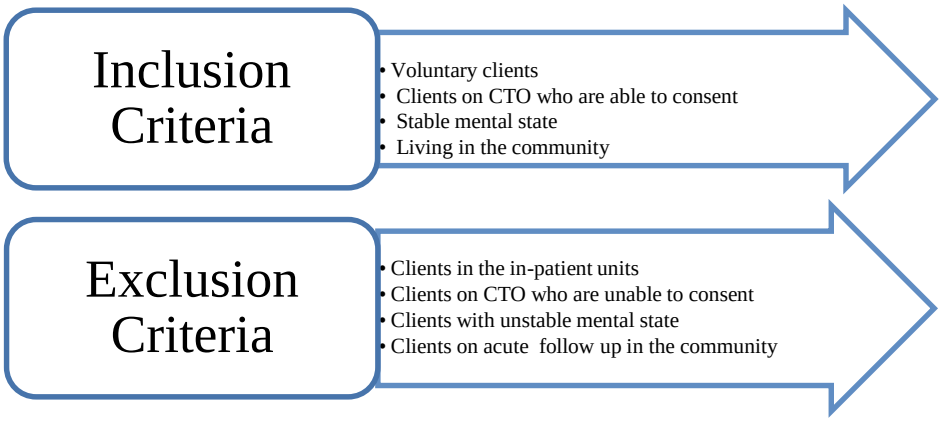
Initially, twenty-nine participants expressed their interest in joining the study. However, two consumers and a MH nurse withdrew from the study and did not give a reason for withdrawal. The remaining twenty-six participants included nine consumers, eight carers and nine MH nurses. All participants were selected from the community settings. Inclusion and exclusion criteria were created for each cohort; these are discussed below.

Mental health consumers: The notion of mental health recovery is seen as a subjective journey, which is commonly defined by the individual affected by mental illness (Slade, 2009). Therefore, the central definition of MHR is provided by the perspectives of consumers; hence they formed an important group in this study. The consumers were notified about the study through their recovery clinicians, General Practitioners (GP), and by flyers placed around mental health clinics. The recovery clinicians are those who support consumers in the community settings of the AMHS. The recovery clinicians screened consumers to ascertain their suitability for participation in the study before final selection. This was to ensure that consumers were participating voluntarily in the study, were mentally stable and were able to consent. The inclusion criteria for the latter group included consumers who were: receiving voluntary treatment; designated as having an Axis 1 diagnosis[4]; and, who were living in community settings. Consumers in the acute in-patient units, on a Community Treatment Order (CTO) and/or on acute follow-up in the community were excluded from the study due to vulnerability (Figure 4). When a consumer showed interest in participating in the study, their relevant recovery clinicians contacted the researcher and, having obtained permission, provided the consumer's

[4] DSMV: Axis 1 diagnosis: All psychological diagnostic categories except mental retardation and personality disorder.

contact details. The researcher then contacted the consumers, explained the project and answered any questions they raised. Post interview, some consumers indicated they would recommend participation in the study to their friends and, through this snowballing effect, two consumers contacted the researcher and were recruited to the study.

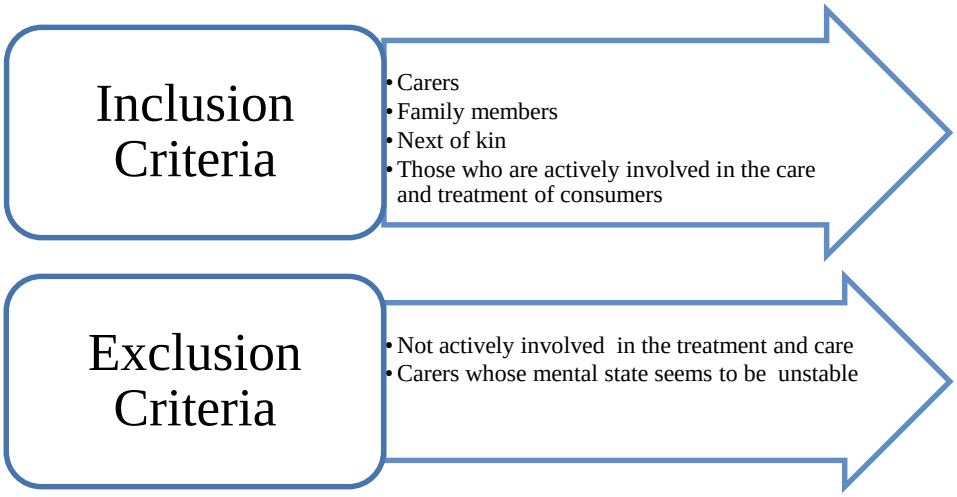
Figure 4: Inclusion and exclusion criteria for consumers



Carers: Carers of consumers play a crucial role in consumers' lives in terms of their recovery and re-connection to the community (Slade, 2009). Carers have a close and personal relationship with consumers. They provide support and a degree of balance to those with mental illness. Understanding carers' views about mental health recovery is vital, as this has a direct impact on the care of consumers. Therefore, their inclusion was deemed important to the study. Carers were informed about the study via the local Carer Council and flyers were posted in community mental health clinics, and an in-patient mental health unit. The researcher conducted an oral presentation at the Carer Council as part of the advertising strategy. The inclusion criteria for carers included those who were actively involved in the care and treatment of a consumer. Carers who were not currently supporting a consumer and those carers who had unstable mental health, as assessed by the researcher, were excluded from the study (Figure 5), as this could be distressing for the carer. All participants were

asked about their experience with mental illness and none of the carers who participated in the study disclosed they had a formal diagnosis of mental illness. Some carers informed the researcher there was a growing interest from the Carer Council to join the study, but many carers found themselves trapped within the busy schedule of caring for their loved ones and had difficulty in finding a reliever to enable time to participate. Some carers expressed struggle in taking time for themselves, since their loved ones were scared to be alone and the carers needed to be around constantly.

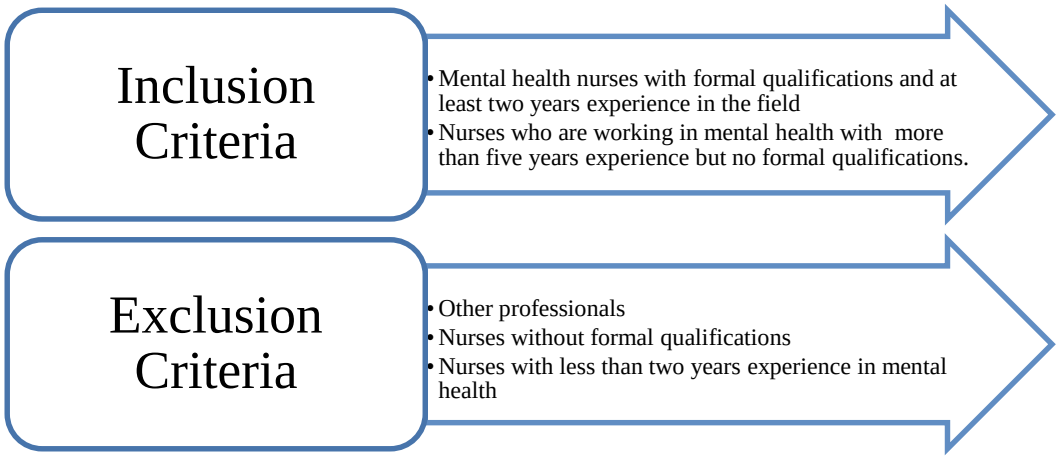
Figure 5: Inclusion and exclusion criteria for Carers



Mental health nurses: The majority of the mental health workforce comprises MH nurses**,** who play a major role in delivering day-to-day services to consumers and carers. In this study, the term **'**MH nurse**'** refers to both Registered Nurses and Enrolled Nurses working in mental health services. Collaborative practices between MH nurses and consumers improve the effective participation of consumers in the ever-changing field of mental health**,** which has an impact upon recovery (Lakeman, 2010). Thus, it is essential to obtain their views in relation to the concept of recovery from mental illness. MH nurses were invited to participate in the study through the e-mail portal of the AMHS, following permission from the Operational Director. Flyers were displayed in staff rooms within the health service and five oral presentations

were conducted at handover times, both in in-patient and community settings. The inclusion criteria for nurses included MH nurses with formal mental health qualifications[5] and at least two years' experience**,** or those who were working with no formal qualifications in mental health with more than five years of experience (Figure 6). Other health care professionals were excluded from the study. All interested nurses recruited to the study were community mental health nurses.

Figure 6: Inclusion and exclusion criteria for mental health nurses



Data collection process

Developing rapport: As this researcher is a MH nurse, the vulnerability of participants in terms of power relationships was carefully considered and measures were taken to build rapport. These strategies included provision of a warm welcome and non-judgemental demeanour (Holloway & Wheeler, 2010) in order to make participants comfortable (Hansen, 2006). Green and Thorogood (2009) suggest that, in order to build the trust of participants, personal sharing and a friendly approach would be helpful. Otherwise, a fast-paced or rushed interview can generate an impression of 'data raid', as described by Schneider et al. (2007). Therefore, the

[5] Postgraduate Qualification: Diploma or above

participants were initially orientated to the environment by the researcher and had an initial informal chat to develop rapport and a relaxed environment.

Interview venue: The participants selected the time and place for the interviews; the majority of participants chose the hospital or MH clinical setting for the interviews. Two carers were unable to attend the hospital or clinic settings, due to the unavailability of a reliever to take care of their loved one. These two carers were interviewed at an agreed site closer to their house, where privacy and confidentiality were assured. Carers told their own stories, indicating at times that their interview was somewhat cathartic in relation to the burden of caregiving.

Interview style*:* An in-depth interview style is considered the best method to collect data from vulnerable populations (van Manen, 2014b). In-depth interviews are open and exploratory. Similarly, a semi-structured interview style is also considered as a useful method in the interview process. Liamputtong (2009, pp. 240-241) argues that "semi-structured interviews guided by a short series of broad open-ended questions allow exploration of people's experiences". Liamputtong suggests that, in order to keep focus for the interviewer, developing a 'theme list' would be beneficial (2009, pp. 240-241). This study used a semi-structured in-depth interview style to ensure adequate exploration of the experience and to maintain the research focus during the interviews.

Interview techniques: Many researchers such as Liamputtong and Ezzy (2005), Liamputtong (2009), and Hansen (2006) suggest that practicing in-depth interview techniques beforehand is useful for novice researchers. As a MH nurse, the researcher has conducted many interviews with consumers and carers. However, as a novice researcher, the researcher sought to gain a good understanding of conducting semi-structured, in-depth interviews. Hence, the researcher practiced in-depth

interview techniques with colleagues and listened to the recorded conversations to improve interview skills. Holloway and Wheeler (2010) suggests that in hermeneutic phenomenological research a conversational style of interview could be used to generate data. However, Schneider et al. (2007) asserts that interview process should be disciplined by the fundamental question when using various interview techniques. Van Manen described the specific purpose of hermeneutic phenomenological interviews as exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon and to develop a conversational relation with the interviewee about the meaning of an experience (2014b).

This researcher sought to gain a rich and unique description of the meaning participants attributed to mental health recovery as they perceived it. The initial informal discussion helped the researcher to build up a conversational rapport with participants and, when participants were settled and comfortable, permission was then sought to start the interview. The tape recorder was turned on to capture their story and the interview commenced, initially, with the question: *"What is it like to recover from mental illness?"*. Many times, participants detailed their knowledge about MHR, whereas the researcher wanted to know what mental health recovery meant to them, on a personal level, as they lived through it. For that reason, the question was reformulated as: *"In your experience as a mental health consumer, what does mental health recovery mean to you?"*

With carers and mental health nurses, the researcher reiterated the phrase: *"In your experience as a carer or mental health nurse"*, in order to stress the aim of the question. Carers were more inclined to tell their loved one's story of recovery, rather than describing how they experienced the process of mental health recovery.

Therefore, further probing questions were used, such as: *"What did that experience feel like?"* and/or: *"Can you tell me a story that comes to mind to illustrate what you are describing?";* van Manen (1997b, p. 66) guides the researcher, as they need to be aware of eliminating the 'why' questions, and, rather, asking 'how?', or 'in what way?' to illuminate the experience of participants. Therefore, additional minor prompting questions, such as *"Could you tell me more about that"* were asked. These open-ended and exploratory questions were also related to their experience with mental illness, barriers and enablers to MHR and their experience of a recovery-oriented mental health service. The open-ended questions enabled a free flow of conversation. The interviewees had opportunities to talk about related topics that were relevant to the open-ended questions. Interviews lasted between half an hour and one and a half hours, with total time with the participants averaging around one hour, which included the initial orientation phase.

There were times when participants were moved by emotions, when their responses included long silences, tearfulness, and deep sighs. These emotions were more prominent among consumers and carers. At times, the researcher was also empathically moved by the experience of these participants and, on two occasions, tears welled within the researcher. Unlike consumers and carers, nurses tended to be emotionally detached from the subject matter. It appeared that they had their 'professional hat' on when they described their experience of MHR. When participants were emotional, the researcher asked them if they wished to discontinue the interview and reminded them they had the option to withdraw from the study at any time. One carer requested to halt recording when she was tearful and was unable to speak for a few minutes and this was permitted. Later she asked to continue with the interview and the recording was re-commenced.

Interview sessions: The data collection method was applied through a series of single session, audio-recorded, semi-structured, in-depth interviews. There are various views among researchers in relation to the collection of data using one single interview session per participant, as opposed to multiple interview sessions. For example, Liamputtong and Ezzy (2005, p. 62) suggest that more than one interview might be required at times to re-examine the issues, though they acknowledge that many novice researchers use one-off interviews due to factors such as time constraints. On the other hand, Langford and Young (2013, p. 137) state that the "nature of follow-up depends upon each study". This flexibility of qualitative research methods, in terms of depending on the group of participants being interviewed, has been supported by Liamputtong and Ezzy (2005). These views convey that, ultimately, the researcher makes the decision to conduct one or more interviews depending on the situation and the richness of the data. However, both methods have limitations; for example, with multiple interviews there is a possibility of participants' ongoing dependency (Holloway & Wheeler, 2010) and, for one-off interviews, there is the possibility of gaining insufficient in-depth information (Hansen, 2006). Considering these factors and the attainment of rapport and the richness of data, the researcher decided to conduct one-off interview sessions for this study. This was preferable for some participants, as they found it difficult to attend the first session due to their personal responsibilities. Before commencing the interviews, the general demographic data, including clinical diagnoses of consumers, was obtained (Table 2). Additionally, field notes were written when specific situations were encountered, such as those involving emotional vulnerability.

Table 2: Demographic data of participants

Demographic Data of Consumers, Carers and Nurses

	Consumers	Carers	Nurses
Number of participants	9	8	9
Males	6	2	6
Females	3	6	3
Average age	48 years	63.2 years	42.5 years
Average years of experience with mental health	17.7 years	22.6 years	17.5 years
Consumers with Schizophrenia	7		
Consumers with Bipolar	2		

Trustworthiness of data

The data collection continued until saturation was attained. Once the data collection was completed, a professional transcriber transcribed the data. The transcribed data was sent back to the participants to validate the accuracy of their recollections and to ensure the trustworthiness of the data. In the initial session, participants were explicitly informed about this process of checking the data for accuracy and about the period allotted to make amendments and return the transcripts. If the data was not returned within that time, it was to be assumed that the data was correct and did not need any amendments. One consumer, one carer and one nurse made slight amendments to their data for clarification purposes, such as slight modifications to the words, but no major changes were made to the transcripts. However, the downside of doing this is that data is temporal, the words chosen as a specific time to describe thoughts and feeling should not be changed post interview, as the impact could also change.

Reimbursement

Various arguments exist in relation to paying informants for participating in

research projects. Some researchers argue that it might unduly induce participants (Hansen, 2006), whereas others argue that participants should be paid for their participation to ensure they are not disadvantaged regarding their expenses (Holloway & Wheeler, 2010). The researcher reimbursed $20.00 to the consumer cohort to meet any out-of-pocket expenses, as it is a financially disadvantaged group and might be relying on disability support pensions. The carers and nurse participants were not reimbursed, as they were not considered as a financially disadvantaged group.

Data analysis

Data was analysed in accordance with van Manen's (1997b) hermeneutic phenomenological method. These techniques were used to generate accurate interpretations and to gain access to the lived experience of participants in relation to their understanding of mental health recovery. While undertaking data collection, the researcher was mindful of the data analysis process and the need to reach saturation of the data. Langford and Young (2013, p. 143) state that data analysis generates a "thick description that accurately captures and communicates the meaning of the lived experience".

In order to capture and communicate these meanings, a novice researcher needs to understand what these meanings are. Therefore, to understand and to identify themes, the following points by van Manen (1997b) guided the researcher to appreciate the constituent parts comprising a 'theme'.

> Theme is the experience of the focus, of meaning, of point.
>
> Theme formulation is at best a simplification.
>
> Themes are not objects one encounters at certain points or moments in a text.
>
> A theme is not a thing; themes are intransitive.

Theme is the form of capturing the phenomenon one tries to understand. Theme describes an aspect of the structure of lived experience" (p. 87).

These points assisted the researcher in understanding what to look for in the data. The researcher was also aware that isolating these themes constituted the initial steps in the data analysis process and that the illumination of the phenomenon would lie in the writing and re-writing process (van Manen, 1997b, p. 77). To generate the themes from the data, van Manen (1997b, pp. 92- 93) suggests three approaches: the *wholistic or sententious approach*, in which the researcher attends to the text as a whole, asking what sententious phrase may capture the fundamental meaning or main significance of the text as a whole, and then trying to express that meaning by formulating such a phrase; the *selective or highlighting approach*, in which the researcher listens to or reads a text several times, asks what statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described, and then circles, underlines, or highlights them; the *detailed or line-by-line approach*, in which the researcher looks at every single sentence or sentence cluster and asks what this sentence or sentence cluster reveals about the phenomenon or experience being described?

Analysing the texts

In order to generate themes from the data, the above process was employed by the researcher. Firstly, the data was professionally transcribed and the transcripts were checked against the tape recordings. This approach allowed the researcher to highlight existing transcripts for the salient emotionally-driven features, such as silences, deep sighs, pauses and significant phrases, thus capturing the fundamental features. The data was then read as a whole, to obtain a contextual understanding. The researcher used field notes to highlight any additional special features noted from each interview.

Major themes were identified, highlighted and clustered (Table 3). This clustered data was analysed according to the lifeworld existentials template introduced by van Manen (1997b) to reflect on and gain an in-depth understanding of the phenomenon of MHR (Figure 7 & Figure 8). This process helped to conduct a structured analysis of the data (van Manen, 1997b). The emergent themes from each cohort were clustered under headings and subheadings (Figure 9). Similarly, the differences in the views were identified and integrated into an understanding of the phenomenon of MHR. These findings are described in detail in the following chapters.

Table 3: Developing themes and weaving the lifeworld existentials

Texts	**Subthemes**	**Themes**	**Lifeworld existential**
"The community group that I attended did not welcome people with mental illness" (Carer) "People in the community are still fearful of mental illness" (Nurse)	Social factors	Theme of rejection	Lived space Lived self-other
"I was on a CTO and pretty much had to go to the hospital when MH staff said" (Consumer) "We're [mental health staff] coming up and coming to grab her . . ." (Carer)	Staff factors	Theme of control	Lived space Lived self-other

Figure 7: Process of data analysis

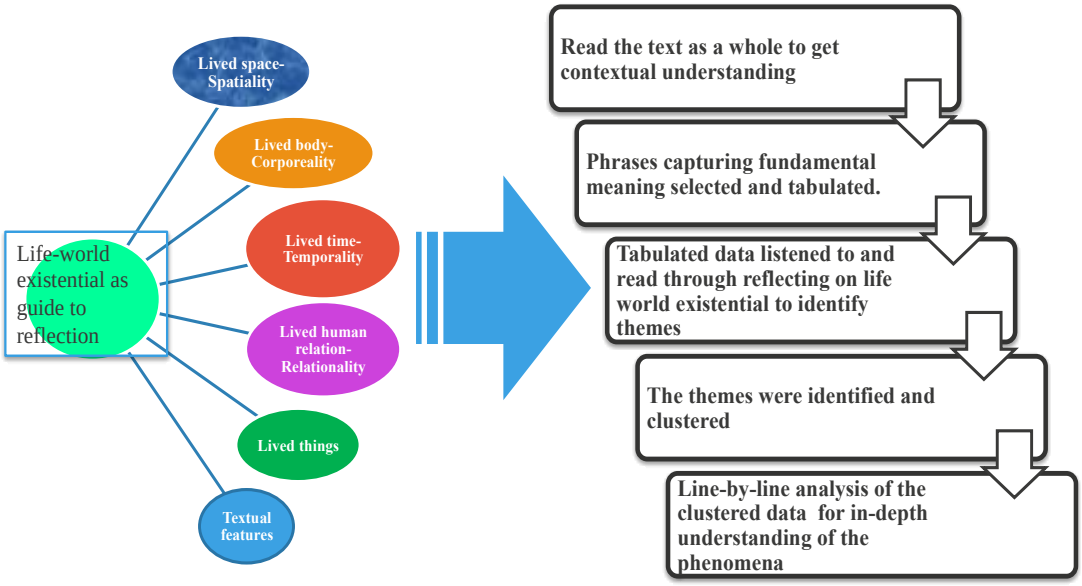


Figure 8: Lifeworld in a recovery-oriented MHS

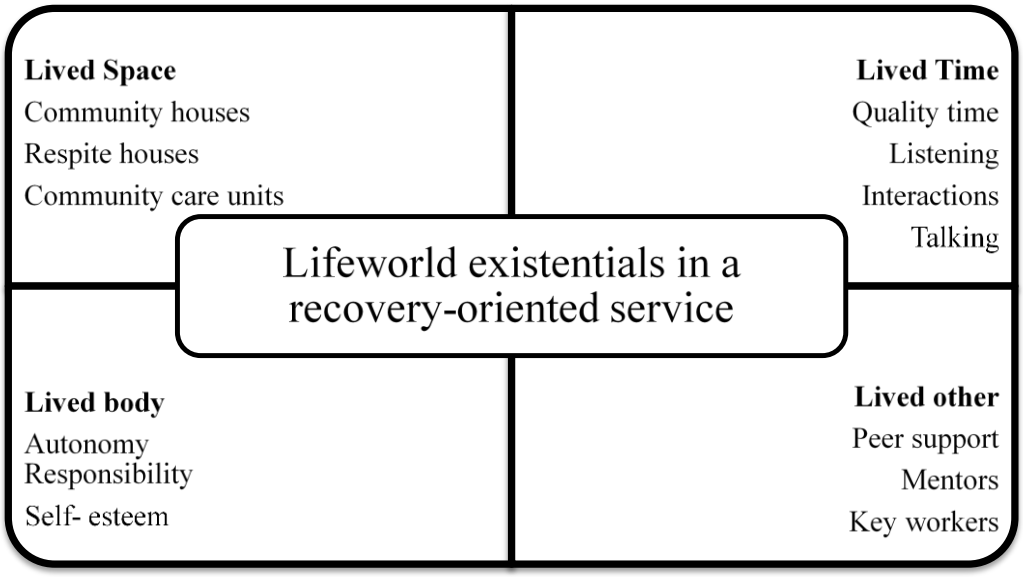
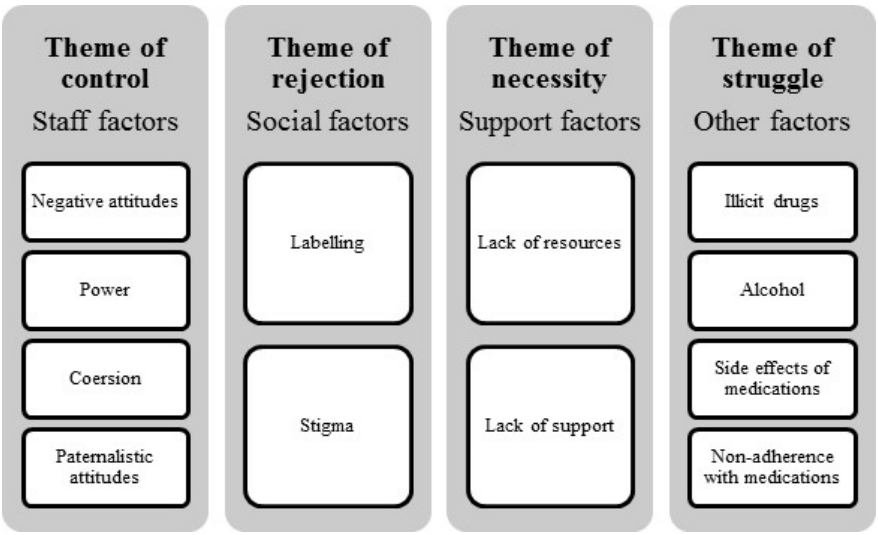


Figure 9: Thematic development: Impediments to mental health recovery



Van Manen's position on validity and reliability

Validity

Van Manen argues that "measures such as content validity, criterion-related validity, and construct validity apply to tests and measures that are not compatible with phenomenological methodology" (van Manen, 2014b, p. 347). He emphasises that these various checkpoints can be applicable to other types of qualitative research studies, but are not able to be applied to phenomenology, because of the difference between the purpose of phenomenological inquiry method and other methodologies. The primary aim of the phenomenological method is "to gather prereflective experiential accounts" (van Manen, 2014b, p. 311). He asserts that "a common problem for phenomenological researchers is to be challenged in defending their research in terms of references [such as sample criteria, members' checking and empirical generalizations] that do not belong to the methodology of phenomenology" (van Manen, 2014b, p. 347). Van Manen argues the following four questions might be

applied when assessing the validity of phenomenological studies (2014b, pp. 350-351):

- *Is the study based on a valid phenomenological question?*

In this research, the researcher wanted to understand the phenomenon of MHR as it is experienced by MH consumers, carers and MH nurses. Therefore, the phenomenological question, *What is it like to recover from mental illness*? was formulated by this researcher.

- *Is analysis performed on experientially descriptive accounts, transcripts?*

The analysis for this study used descriptive accounts of the participants transcribed by a professional transcriber. The thematic analysis (Table 3) was performed as described above and the interpretive writing follows in the results chapters.

- *Is the study properly rooted in primary and scholarly phenomenological literature?*

In this study, a wide range of primary and scholarly work of the original phenomenological philosophers and researchers was explored to understand the philosophical tradition. The researcher primarily focused on van Manen's methodological outline for phenomenological research and hermeneutical phenomenological writing, as it was the design for this study.

- *Does the study avoid trying to legitimate itself with validation criteria derived from sources that are concerned with other (non-phenomenological) methodologies?*

Various researchers indicated different methods to measure trustworthiness in qualitative research. Holloway and Wheeler (2010, p. 302) claim that "researchers make judgments of trustworthiness possible through developing dependability, credibility, transferability and confirmability". However, these measures cannot be used for phenomenological studies, as the methodology does not fit those criteria. In this study, the transcripts were returned to the participants for confirmability, but, the researcher did not use any other validation criteria such as that found to measure the

trustworthiness of other qualitative studies, as in, for example, that carried out by Guba and Lincoln (1989, (as cited in Annells & Whitehead, 2007, p. 149).

Reliability

Reliability of a study focuses on generating the same results each time a study is repeated. Van Manen (2014b, p. 347) states that, for phenomenological studies, inter-rater reliability will not be involved because "phenomenological studies of the same "phenomenon" or "event" can be very different in their results . . .. A phenomenologist may study a same phenomenon that has already been addressed repeatedly in the literature, but strive for new and surprising insights." For example, the experience of recovery from mental illness can be different at any given point in a person's life. Recovery is a subjective experience and is therefore influenced by many factors. Exploring the experience of recovery from one point to another can be different, and a researcher can receive new insights each time the same questions are repeated. For instance, Ryan, who participated in this study, described that, during the early stage of mental illness, he was affected by stigma and was non-adherent with medication. He believed that people in recovery do not need medications. Therefore, recovery for him, at that given time, was the ability to get off medication. However, later in life he accepted the need for medication and now believed that 'recovery' meant "staying well". Ryan stated that finding the "right medication" and being "compliant with it" were important aspects of his recovery.

Van Manen distinguishes empirical evidence from phenomenological evidence. He argues that phenomenological evidence is based on "interior intuitive understanding and is meaning-based and based on the logic of eidetic reduction . . . and is ambiguous and never complete" (2014b, pp. 350- 351). While empirical evidence is based on objective data, phenomenological evidence is solely based on the

subjective experiences of participants and the researchers' interpretations of those experiences. For instance, Peter, who participated in this study, did not consider improvement in his symptoms of mental illness or the improvement in functioning (objective experience) as his experience of recovery. Conversely, for Peter, understanding the concept of 'who am I?' (subjective experience) was a major turning point in his recovery journey. This meaning-based, self-understanding process is the underpinning principle of phenomenological evidence.

Phenomenological evidence cannot be generalised. Van Manen (2014b) criticises qualitative researchers who try to generalise evidence. He argues "the only generalisation allowed in phenomenological inquiry is never generalise" (van Manen, 2014b, p. 351). In the context of this study, the experience of mental health recovery for participants is unique to this cohort; another cohort will have their own unique experiences of recovery. Thus, the meaning of recovery elicited in this study cannot be viewed as the meaning of a generalised sample. However, van Manen suggests that, to make phenomenological generalisations possible, "one can adopt existential and singular generalisations" that understand a phenomenon in an existential sense and in a unique sense (van Manen, 2014b, p. 351).

Summary

This chapter discussed the research method used in this study to illuminate the phenomenon of mental health recovery. The researcher conducted this study in line with van Manen's human science approach of hermeneutic phenomenology. The processes described above, which are examples of that trail comprised: the phenomenon of interest; ethical considerations; the selection and recruitment of participants; the data collection processes, and, the data analysis. After examining this study against van Manen's (2014b, p. 351) questions pertaining to validity, the

researcher believes that this study has achieved the degrees of trustworthiness and credibility necessary to constitute a phenomenological study as it may generate an in-depth understanding in the reader, where the description and interpretation can be experienced (van Manen, 2014b). For example, many participants from the three cohorts explained how negative and paternalistic attitudes and coercion by mental health clinicians hinder the process of recovery. The researcher interpreted these factors relating to mental health staff as the 'theme of control' that took over the consumers' lived bodies and lived spaces and disadvantaged the process of recovery for many consumers. Although each individual is unique, it is anticipated that, when reading through this text, the reader will interpret in ways similar to that of the researcher and will experience the 'phenomenological nod'. Below a brief background of the participants is provided.

Participants in the research

Mental health consumers

P 1 is called Ryan. Ryan (45 years) was the first participant interviewed among consumers. He was born in Victoria and lived with his parents until he was 28. He was 21 when he had the first 'breakdown'. He moved to an outer suburb after being diagnosed with schizophrenia, though the decision as to his accommodation was made by his parents. He said they believed living in an outer suburb would be better for his health. Ryan felt that he found the right medication and has as 'close to a normal lifestyle' as he can with the illness.

P 2 is called Michelle (30 years) and has a diagnosis of schizophrenia. Michelle was first admitted into the hospital when she was 20. She used marijuana for a while and then started using ice (methamphetamine). She described the first day of her admission as 'one night when things went a bit bad'. She said that drugs took a long while to leave her body and it was lot harder than she thought. Eight years later, she got her life back, but there was still some sort of mental illness that occurred when she took drugs and she wondered whether the illness had already been there. She explained the fluctuations she experiences with symptoms; she said: 'Sometimes I go through this hole and I can feel as terrible as I could ever feel, and a few weeks later I will be normal and acting normal'.

P 3 is called Steve (32 years) and has a diagnosis of schizophrenia. He experienced mental illness over a decade. He described his recovery journey and the various treatments he tried as recommended by doctors. He said that he was diagnosed with various mental illnesses and that he lost hope for recovery. He thinks he should be able to claim insurance as this is a lifelong condition. Steve described that at times, he 'falls back into schizophrenia' but on the last two occasions, he experienced

depression and anxiety. He stated there is no warning when he relapses; therefore, he is worried that the illness might come back again.

P 4 is called Jodie (55 years) and she has a diagnosis of bipolar disorder. She was from England and her parents lived in England. She was affected by mental illness when she was 20, soon after the birth of her first child. At this point, she couldn't sleep for seven days and one day she saw blood in the bathroom, which she felt was from the devil. She was extremely unwell and did not respond to various treatments, including Electro Convulsive Therapies (ECT). Jodie described extensively her experience with mental illness, how it affected her family and her parents. She believed that her mother in-law 'pushed her to the edge' and her husband was not very helpful. He sent her back to England, without her baby, when her baby was 6 months old and told her parents that he only wanted her back once she was cured. She felt better on Lithium, but once a doctor told her: 'as you get older you tend to get more depressive episodes'. Jodie believed that such a comment made by a doctor "is a very bad thing to say to anyone'. Jodie was tearful when she described her experiences.

P 5 is called Peter (60 years) and he was diagnosed with schizophrenia when he was 28. He was in and out of hospital for around 10 years. He received various antipsychotic medications and ECT. He described being diagnosed with schizophrenia because he heard horrible voices and was admitted to inpatient and community facilities for many years. He considers himself an ex-consumer and advocates for and conducts training about the mental health recovery movement.

P 6 is called Liz (50 years). She was diagnosed with bipolar disorder when she was 32 and had a second episode when she was 35. She remembered that both those episodes were preceded by extreme trauma on various levels in her life. During that time, each major person in her life, such as her sister and her parents, were having trauma. Liz related a terrible incident that occurred in 1994 while she was overseas with her family. Liz had to give cardiac compression for her sister for an hour who was trapped under a bus. Her sister died and everyone who had been involved in the incident 'was just falling apart and continued to for a few years after that'. Liz was very tearful when she told her story and her story was emotionally moving.

P 7 is called Mark (28 years) and he was first admitted to hospital when he was 18 years. He was diagnosed with schizophrenia and could remember the difficulties he experienced throughout schooling. He went into crisis when his relationship broke down, and he felt that he had 'too much on' on his 'plate' and had a 'mental breakdown'.

P 8 is called Mike (28 years) and he was diagnosed withs when he was 18. He felt that a lot of help is needed for those suffering from mental illness. Mike said that he was lucky that he had a very supportive family and that having to care for someone with a mental illness is hard for the families.

P 9 is called John (33 years) and he was diagnosed with schizophrenia when he was 24. John didn't believe that he had mental illness in the first couple of years and spent four years trying to figure out a way to get out of the MH system. He remembered those times were very hard, and then eventually he wanted a better life and accepted

the diagnosis of mental illness, rather than fighting it. He still feels the ups and downs of the illness, but senses that he is able to understand it all better now than in the past.

Carers

C 1 is called Lucy (73 years) and she was the first participant who attended the study. She has a son who was diagnosed with schizophrenia and said that she has quite a lot of experience with mental illness. She disclosed that she had suffered from an episode of depression when she was twenty or twenty-five, and having to look after a son who was quite agitated from the age of about three or four was not helpful. Later, her son developed schizophrenia. Currently she does not suffer from depression.

C 2 is called Emily (59 years) and she has a daughter who suffers from schizophrenia. Now looking back, Emily feels that her daughter was not like other children. She didn't make friends easily, she was very self-disciplined and she 'seemed older in her head than other kids'. Emily said her daughter didn't give her any troubles and was very academic. Emily described the symptoms of mental illness showed when her daughter joined the Army. Emily thinks that various factors such as the stress of the Army, being away from home and the rigid and strict Army life might have been factors that contributed to her illness.

C 3 is called Kristy (65 years) and her son was diagnosed with Asperger's when he was young, but later was diagnosed as having schizophrenia. She felt scared and was very reluctant to seek help from mental health services. She felt her journey as a carer was very stressful.

C 4 is called Jack (68 years) and his wife is suffering from a schizoaffective disorder. He has been married to his wife for forty-two years and his wife has been sick for thirty-five years. He said that she has been through most of the 'labels' [diagnosis] and this hasn't been helpful, but he takes care of her.

C 5 is called Cathy (70 years) and she has cared for her mentally-ill husband since 1998. Her husband was suffering from bipolar disorder and she initially didn't know what was going on. She recollected the initial days of her marriage and her husband said that he had sleep problems and she thought many people experienced those. But at 2 o'clock every morning, he got up and left; he did this for six weeks and Cathy felt that 'that can't be normal'. Cathy said that she spoke with a psychiatrist and later realized that her husband had a lot of energy and was 'trying to wash off the energy'.

C 6 is called Maureen (60 years) and her son has a diagnosis of schizophrenia. She recollected that, from the early days, her son was 'a pain' in her life, right from infancy until now. Maureen felt that her son was unusual, and as a toddler, he was always the cause of naughty incidents. She had to change his schools more than six times, thinking every time that it would be helpful, but eventually realized the problem was with him. When he was eight he was prescribed Ritalin (Methylphenidate) but, after seeing the effects of Ritalin, Maureen decided to stop the medication and said to her mother that she would rather have her naughty child. Maureen said that her son was doing very well and had held a job for five years continuously. When he was eighteen years, he had a hiccup at work and resigned his job and took up drinking alcohol and taking drugs. Maureen felt she 'always walked on egg shells' and 'knew something was wrong'.

C 7 is called Mary (58 years) and her son is suffering from schizophrenia. She noticed her son's increased anger when he was a teenager. She described her son as a beautiful and loving boy with some impishness. She felt that her son got his nasty anger from his father and described that the relationship with her son is very stressful.

C 8 is called David (52 years) and his wife was diagnosed with bipolar disorder twenty years ago. They both had difficulty understanding 'what is going on'. He feels her illness is seasonal and around September, she becomes elevated, excited, and this continues till about mid- January. He feels the illness comes and goes, but his wife doesn't acknowledge the illness much. He described that admission into the inpatient unit was a traumatic experience for both his wife and the family.

Mental health nurses

Nine mental health nurses joined the study. All are currently working; eight of them are working in a community setting and one is an educator. Three of them had received education about the current concept of mental health recovery.

N 1 is called Simon (48 years) and he was the first mental health nurse I interviewed. He is a Manager of a Mental Health Service (CMHS) and has both local and overseas experience in mental health systems. He has 30 years of experience as a nurse, out of which he has spent 16 years as a mental health nurse.

N 2 is called Norman (50 years) and he has had 21 years experience as a mental health nurse for. He has worked in a variety of settings, including community and in-patient settings. He was previously a general nurse.

N 3 is called Aaron (24 years) and he has been working as a mental health nurse for five years. He completed a Masters degree in mental health and has both in-patient and community experience.

N 4 is called Zac (35 years) and he has 15 years of experience in nursing. He has 10 years experience in mental health nursing and has completed postgraduate studies. He has worked as a senior clinician in both in-patient and community mental health settings, and is a Manager in a CMHS.

N 5 is called Kim (50 years) and she has 8 years experience in mental health work. She is currently working as a mental health clinician in a community setting. She has attended education in mental health recovery and is passionate about the concept.

N 6 is called Russell (45 years) and he was hospital trained in the UK. He had twenty-five years of experience in a variety of mental health settings, both in Australia and overseas. He came to Australia in 2002 and worked with people who were diagnosed with borderline personality disorder. He has had education in mental health recovery and currently participates in recovery education of staff at the AMHS.

N 7 is called Tony (48 years). He was hospital trained in the UK and has 25 years of mental health experience, both in Australia and overseas. He has in-patient and community mental health experience and is a senior clinician who has been working in the AMHS since 2006.

N 8 is called Rosie (42 years) and she has 22 years of experience in mental health work. She has also worked in both in-patient and community settings and is currently a senior clinician in a community setting.

N 9 is called Melissa (50 years) and she had her initial training in 1984 in the UK. She has worked in mental health services for 16 years and now conducts education in mental health recovery.

Chapter 5

Illuminating the phenomenon of interest: The meaning of mental health recovery

Introduction

Chapters Five to Eight illuminate the phenomenon of mental health recovery. Four aspects of the phenomenon of MHR were explored in this research. The meaning of MHR; enablers to mental health recovery; impediments to MHR; and, views about a recovery-oriented mental health system. In this chapter, the meaning of MHR is explored. This chapter includes a manuscript published in the journal, *Contemporary Nurse*. The final paragraphs of this chapter discuss the findings from this study and compare them to those presented in contemporary literature.

The meanings attributed to MHR by study participants were explored in this published paper. Participants described two major processes involved in the MHR journey. Firstly, they highlighted internal processes, which involved regaining various aspects of themselves, such as: self-understanding, self-belief, self-acceptance and self-control. These internal processes are called 'Internal Recovery'. The other process delineated by participants was an external one, that involved how one presents bodily in the external world; for example, without being affected by symptoms of mental illness, or succeeding in living life within the community like everybody else. This external process is termed 'External Recovery'. The published paper details the similarities and differences in the views of the three cohorts. The major difference between the themes was in that many carers believed that mental health recovery was impossible. Addtionally, the paper discusses a person's sense of self as the essence of MHR and suggests implications for practice in mental health service delivery.

Mental health recovery: lived experience of consumers, carers and nurses

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Declaration for Thesis Chapter Five

Declaration by candidate

In the case of paper entitled: Mental health recovery: lived experience of consumers, carers and nurses, which appears in Chapter Five, the nature and extent of my contribution to the work was the following:

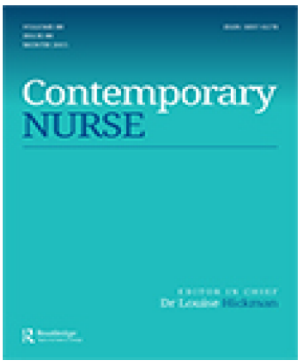
Nature of contribution	**Extent of contribution (%)**
Concept development, research, original ideas, writing up	70

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Dr. Ian Munro	Draft review and editing	
Prof. Beverley Taylor	Draft review and editing	

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date: 02/11/2015**
Main Supervisor's Signature	[redacted]	**Date: 02/11/2015**



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Mental health recovery: lived experience of consumers, carers and nurses

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Mental health recovery: lived experience of consumers, carers and nurses

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Background Mental health recovery is a prominent topic of discussion in the global mental health settings. The concept of mental health recovery brought about a major shift in the traditional philosophical views of many mental health systems.
Aim The purpose of this article is to outline the results of a qualitative study on mental health recovery, which involved mental health consumers, carers and mental health nurses from an Area Mental Health Service in Victoria, Australia. This paper is Part One of the results that explored the meaning of recovery.
Methods The study used van Manen's hermeneutic phenomenology to analyse the data.
Findings Themes suggested that the cohort had varying views on recovery that were similar and dissimilar. The similar views were categorised under two processes involving the self, an internal process and an external process. These two processes involved reclaiming various aspects of oneself, living life, cure or absence of symptoms and contribution to community. The dissimilar views involved returning to pre-illness state and recovery was impossible.
Conclusion This study highlights the need for placing importance on the person's sense of self in the recovery process.

Keywords: carers; consumers; lived experience; mental health recovery; nurses

Background

The concept of mental health recovery brought about a major shift in the traditional philosophical views of many mental health systems globally. This shift includes but is not limited to placing an importance on the lived experience in mental health care and empowering mental health consumers (Mancini, Hardiman, & Lawson, 2005). The concept of recovery has been put forward as a guiding vision for mental health service practices (Anthony, 1993). This vision invites considerable collaboration among mental health service providers and service users. However, there remains dissent among the views of service users and service providers on recovery (Anthony, 1993; Piat et al., 2009; Slade, 2009; Slade, Amering, & Oades, 2008). The discord includes, seeing recovery as a process with transformation of self with or without symptoms, or as a cure or absence of symptoms (Deegan, 1988; Marshall, Oades, & Crowe, 2009; Schrank & Amering, 2007; Slade, 2009).

The vision of recovery calls for change from symptom-centredness to person-centredness (Browne, Hemsley, & St. John, 2008; Mancini et al., 2005). While many Western countries have embraced this radical change (Schrank & Slade, 2007), confusion exists among service

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providers and service users regarding the concept (Department of Health and Ageing, 2008; Ng, Pearson, Chen, & Law, 2011; Piat et al., 2009). Surprisingly, there have been limited studies conducted among these stakeholders to establish more understanding on mental health recovery. This article presents the findings of the meaning of recovery from a study in which the authors explored the views of mental health consumers, carers and mental health nurses on mental health recovery in Australia.

Mental health recovery

The concept of mental health recovery has been defined and discussed extensively by consumers and service providers in various ways, such as recovery as a unique process or recovery as the absence of symptoms (Lloyd, Waghorn, & Williams, 2008; Piat et al., 2009; Slade, 2009; Slade et al., 2008). Anthony defined mental health 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. (1993, p. 15)

Moreover, Slade (2009) and Lloyd et al. (2008) also conceptualised mental health recovery. Slade (2009) distinguished mental health recovery as 'personal recovery' versus 'clinical recovery'. According to Slade (2009), the notion of personal recovery emerged from people with lived experiences of mental illness, which may or may not include symptom remission or return to the pre-illness state, but it involves personal growth and development. Whereas, the notion of clinical recovery, emerged from the expertise of service providers and it involves the removal of symptoms or getting back to normal (Slade, 2009).

On the other hand, Lloyd et al. (2008) argued that support from society, including supported employment, housing, groups and education, result in recovering the damaged social relationships and calls it social and functional mental health recovery. Lloyd et al. (2008) suggested that functional mental health recovery not only reflects the lack of symptoms, but it also reflects the ability to function well in society, which includes successful return to work and education.

Methods

Design

A qualitative hermeneutic phenomenological method was chosen as the methodology for the study. Phenomenology is the 'study of the life world … which aims at gaining a deeper understanding of the nature or meaning of our everyday experiences' (van Manen, 1997, p. 9). Hermeneutics is the 'interpretation of experience via some 'text' or via some symbolic form'(van Manen, 1997, p. 24). The authors were guided by van Manen's life-world existential in the data analysis process. The life-world existential are 'lived space' (spatiality), 'lived body' (corporeality), 'lived time' (temporality), 'lived other' (relationality) (van Manen, 1997, pp. 102–104) and 'textual features' (van Manen cited in Munro, 2008, p. 59). This research approach was carefully considered due to the nature of the study, as it enquired into the in-depth meaning of recovery from mental illness.

Ethics

The study received ethics approval from the Area Mental Health Services Human Research and Ethics Committee (Ref: HREC/12/PH/17) and from the Monash University Human Research

Ethics Committee (Ref: CF12/2022–2012001088). Written informed consent was obtained from all the interviewees who participated in the study. Pseudonyms were used to anonymise the participants.

Sample

The participants were selected from the community mental health services of an Area Mental Health Services in Victoria, Australia. The process of recruitment for each cohort is described in detail below.

Mental health consumers

The mental health consumers were notified about the study through their recovery clinicians and by flyers around the clinics. The recovery clinicians are those who support the mental health consumers in the community settings of the Area Mental Health Service. The mental health consumers were screened for the suitability to participate in the study by recovery clinicians prior to the selection. This is to ensure that the consumers were voluntarily participating in the study and were able to consent. The inclusion criteria for consumers were those receiving voluntary treatment, having Axis 1 diagnosis and living in the community settings. Consumers in the acute inpatient units, those on Community Treatment Order (CTO) and on acute follow-up in the community were excluded from the study.

Carers

The carers were informed about the study through the Carers' Council and flyers posted in clinics. An oral presentation was conducted at the Carers' Council as part of the advertising strategies. The inclusion criteria for carers were those who were actively involved in the care and treatment of the consumers, such as carers, support workers and family members. Carers who were not currently supporting the consumers and those who had unstable mental health were excluded from the study. None of the carers who participated in the study had a formal diagnosis of mental illness.

Mental health nurses

Mental health nurses were invited to participate in the study through the Area Mental Health Service's e-mail portal with permission from the Operational Director. Flyers were displayed in the staff rooms and presentations were conducted. The inclusion criteria for nurses were that they were mental health nurses with formal qualifications and at least two years' experience, and those who were working in mental health with more than five years of experience with no formal qualifications. Other professionals were excluded from the study. All the interested nurses recruited to the study were community mental health nurses.

Data collection

The interested participants were prompted to contact the researcher and were recruited if they met the inclusion criteria. The selected participants were given options for an interview venue and time. The researcher met with the participants according to their availability and gave verbal and written information about the study. The participants were assured their involvement in the

study was voluntary. The participants were informed that he/she had the right to withdraw from the study at any stage without any compromise until coding of the data. Once participants gave informed consent, general demographic data including clinical diagnosis for consumers were obtained (Table 1), after which qualitative interviews were conducted with the participants. At the end of the interviews of consumers, they were given a gift voucher of $20, to reimburse any costs associated with participation in the study, such as travel, because many of the consumers depended on disability pensions. Carers and nurses were not given reimbursement to avoid biases.

Table 1. Demographic data of consumers, carers and nurses.

	Consumers	Carers	Nurses
Number of participants	9	8	9
Males	6	2	6
Females	3	6	3
Average age	48 years	63.2 years	42.5 years
Average years of experience with mental health	17.7 years	22.6 years	17.5 years
Consumers with Schizophrenia	7		
Consumers with Bipolar	2		

Qualitative interviews

A semi-structured interview schedule was developed and in-depth interviews were conducted using the core questionnaire, which was slightly amended according to the cohort. The semi-structured interviews were guided by flexible, neutral and open-ended questions. All the participants were asked to describe their experience with mental illness, the meaning of recovery from mental illness, the barriers and enablers to mental health recovery and their recommendation towards a recovery-oriented reform. The interviewees had opportunities to talk about related topics that were relevant to the open-ended questions. The interviews lasted between 30 and 125 minutes. The data collection continued until saturation was attained. The saturation of data was determined until themes were extensive and well described. All interviews were recorded using a digital recorder and transcribed by a professional transcriber. The transcribed interviews were sent back to the participants to check for accuracy. This process of checking the data for accuracy and the period of time allotted to make amendments was explicitly stated in the initial meeting to all the participants. If the data were not returned within that time period, it was assumed that the data were correct and did not need any amendments. One consumer, one carer and one nurse made slight amendments to their data.

Data analysis

The initial data analysis was ongoing during the data collection process until the saturation of the data. The second in-depth data analysis was guided by three approaches proposed by van Manen (1997) to uncover themes. The three approaches were slightly modified as follows. The data were initially read as a whole to get the contextual understanding. The significant phrases capturing the fundamental meaning of recovery were identified and tabulated. The tabulated data were then listened to and read through simultaneously and were reflected on deeply for the essential phenomenon of the meaning of recovery. The themes were identified, highlighted and clustered. A line-by-line analysis of the clustered data was carried out using the life-world existential introduced by van Manen (1997) to reflect on the phenomenon of recovery to gain an in-depth understanding.

This process helped to conduct a structured analysis of the data (van Manen, 1997). The emergent themes from each cohort were clustered under headings and subheadings. Similarly, the differences in the views were identified and integrated into understanding the phenomenon of recovery.

Results

Twenty-nine eligible participants initially agreed to participate in the study. Out of these, two consumers and one nurse later declined. The remaining 26 participants involved nine consumers, eight carers and nine nurses. These participants were interviewed and the demographic and clinical characteristics of the participants are presented in Table 1.

Consumers, carers and nurses had various views on mental health recovery, which will be described in the sequence below. There was a consistency in the views of the consumers. Similarly, carers' views were akin but were slightly different to consumers' and nurses' views. However, nurses' views differed according to their knowledge on the concept of mental health recovery. Consumers and nurses had some similarities in their views. The data suggested that two overarching processes involved in mental health recovery, an internal process involving the self and an external process of presentation of the self. This is illustrated in Figure 1.

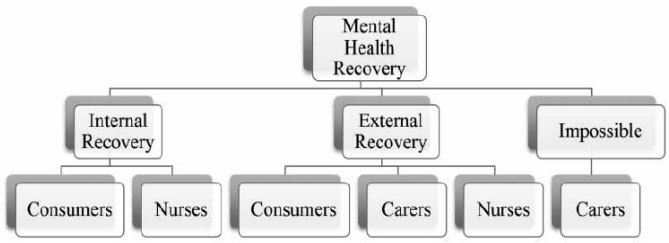

Figure 1. The overarching themes.

Internal recovery

Recovery as an internal process included reclaiming various aspects of the self and is described in detail with examples under consumers and nurses views. These views on mental health recovery were prominent among consumers and nurses. These notions of reclaiming or regaining various aspects of the self were described as one's need for learning about the self, and thereby gaining the strength to overcome the effects of mental illness. The internal process is temporal (van Manen, 1997) and may result in transformation of oneself from an illness-dominated identity to wellness-dominated identity (Piat et al., 2009). The internal process of reclamation of oneself may lead to external manifestations, such as living a productive life in the community.

External recovery

Recovery as an external process involved how one presented bodily in the external world, for example, without being affected by symptoms of mental illness, or living life in the community like everybody else. The external presentation of the self also involved spatial and relational aspects (van Manen, 1997), such as being at home or having a home, staying out of the hospital and enjoying life with friends and family and are described with examples in the subsequent paragraphs.

Consumers' views on mental health recovery

From the consumers' views, mental health recovery appeared as involving both the internal and the external process involving the self. These two processes involved several subthemes. The internal process involving the self included: self-understanding, self-acceptance, self-control and self-belief. The external process of presentation of the self involved living life, transcending the need for services, absence of symptoms and contribution to community.

Self-understanding

Peter defined mental health recovery as the ability to understand the self. Self-understanding was seen as helping him learn to live with oneself. Peter described the recovery process as follows: 'For me, recovery has never been about getting rid of all the symptoms or so called symptoms, but being able to understand who am I, then learn to live with me rather than any kind of cure.' Similar views were expressed by John who said that: 'Recovery is about learning that life is about ups and downs and learning to just go along with things.' Mark realised that he has to grow out of his comfort zone to start the process of recovery; he described: ' … continuing the same behaviour and staying in my comfort zone I have come to realise [that] I won't improve myself … getting outside of my comfort zone is helping me to grow as a person and do better.'

Self-acceptance

Self-acceptance involved acceptance of the illness and the need for medication. Ryan described the process as: 'You have got to accept that it's [schizophrenia] a lifelong illness, and have a mindset to accept that you do need medication. You can't stop medication when you feel better.' The statement by Mick also reflected acceptance of illness as paramount: ' … it's definitely a case of accepting your illness before you accept medication.' Mick described psychological relief when he accepted the need for medication in his life. Mick explained it as:

> 'I guess it's all psychological. Before I was put on medication, I was just angry with myself and would get upset and kick things. Now I am on medication it helps heaps. It brought me a lot further than I have ever been.'

Self-control

Consumers felt part of recovery was having control over their own affairs and emotions, which reflected taking ownership and responsibility for one's recovery. Ryan stated that: 'There's just so much the doctors and nurses can do for you, but there's a large part you have to do for yourself.' The statement by Jodie also suggested a notion of control: 'There are number of things that I can't control … I just think feeling more in control means recovery.' Whereas, Liz described recovery as 'being able to pre-empt and pre-manage stressful situations and not have the extreme reactions to things … and I am in control of my emotions and therefore, able to function well.'

Self-belief

Self-belief involved believing in one's capacity to recover. John stated that recovery is: ' … about believing in yourself and building on your confidence.' Peter described an epiphany in his

recovery as: 'For me, the turning point was a worker who believed in my capacity to recover. She believed that I could recover, she held the hope for me.'

Living life

As Ryan described, living life involved looking after oneself and having a 'normal routine' in life in the community. This normal routine involved managing one's own life, doing everyday business and being able to enjoy leisure activities without being fearful. Ryan described part of recovery as: 'learning to do things for yourself and trying to resume a normal lifestyle. A normal lifestyle involved running a house, having certain leisure activities and task-oriented activities such as paying bills and shopping, etc.' Similar views were expressed by Michelle, who said:

> 'Recovery means maintaining some sort of normality I suppose … years ago I couldn't watch TV, because I couldn't take in what I was watching. I don't take those things for granted now, being at home, having dinner and sitting in front of the TV enjoying myself.'

While recovery was seen as living life in the community, Peter expressed a more inspiring view as: 'I believe recovery is the ability to live my life, not my existence.'

Transcending the need for services and absence of symptoms

Some consumers saw transcending the need for services or absence of symptoms as recovery. Steve stated recovery is: ' … where I am not hearing voices, not having nightmares and being agitated and anxious in the morning. I suppose where I don't feel a weight on my shoulders would mean recovery.' Whereas, Ryan said: 'Recovery firstly means staying out of hospital … I have been out of hospital several years now. My job is to stay out of hospital and save taxpayers' money.' For Mick recovery meant a great deal; he described: 'Just clearer thinking. It means a great deal to me I would like to be fully recovered.'

Contribution to community

Some consumers saw recovery as the ability to function in the community, such as having a job and managing life independently. Part of recovery for Michelle was getting a job she enjoyed, she explained: 'Recovery to me, a part of it will be getting a job – hopefully one I enjoy.' Likewise, Mick declared: 'I am not aiming to go back to my former self, I am aiming to go forward … I will do what everyone else does, get work, family, a house – that's what I am working towards.'

Carers' views on mental health recovery

Unlike consumers and nurses, carers' involved in this study did not acknowledge the internal process involved in recovery. Many carers stated recovery was impossible. Even so, the external process of presentation of oneself was important to many carers, such as absence of symptoms, returning to pre-illness state, functioning well in the community and having the ability to be independent. Carers also expressed spatial and relational aspects (van Manen, 1997) as important to recovery. For example, some carers explained the importance of having stable accommodation and healthy relationships to one's recovery.

Recovery was impossible

Some carers stated recovery was not possible. Emily stated: 'I know she won't ever fully recover back to where she was before mental illness.' Whereas, Jack said: 'I haven't seen any recovery as such … you can't call it recovery, only stabilisation.' Cathy could not understand what the researcher was asking, because she questioned: 'I don't understand what you mean by recovery from mental illness, there isn't one … we went to the psychiatrist the other day and she said [that] the illness will never go, it's just controlled.' Maureen also expressed the similar views: 'If there really was a complete recovery I don't think I would be sitting here … I can see there is relief, but no recovery.'

Cure or absence of symptoms

Some carers saw recovery as a cure to the illness or absence of symptoms. For Lucy recovery meant: 'a settled mind', which involved the ability to live peacefully and communicate with the person without being fearful. Lucy described how living with her son who suffers mental illness was very hard. Whereas David explained recovery as a balanced mental state where his loved one was not suffering the extremes of mental illness. David stated: 'Short answer to recovery, I guess, is happy wife, happy life … I guess for bipolar it's very much the two poles … I would say recovery, for example, she is on some medication and she levelled out.'

While David accepted the need for some medications in one's recovery, Jack described how medication affected his loved one. He stated:

> 'I think the medication she takes has detrimental effects on her mental illness and physical being, so I am a bit negative on the medical treatments available … there is treatments such as trans cranial magnetic stimulation, which is non-invasive and no side effects. I believe a lot of people have recovered without having any medications whatsoever.'

David also explained how alternative therapy such as open dialogue in Finland (Institute for Dialogic Practice, 2013) is used to treat not only the person, but also the whole family, to investigate the reason for mental illness.

Living life

Like consumers and nurses, carers also saw recovery as living life, not just existing. Living life meant the ability to deal with symptoms of mental illness and functioning well, such as having one's own place and independence. Mary said: 'Recovery means learning how to deal with it [mental illness], learning how to make you happy.' Whereas Emily stated: 'Recovery for me is having her able to function as she is … to be able to do things for herself, live her own life … to live independent of us.' Kristy described recovery as an empowering process as follows: 'Well, it means to me a process, a journey rather than an end point … to determine his own life.'

Nurses' views on mental health recovery

Like consumers and carers, many nurses also saw recovery as living life and attaining an optimum level of functioning in the community, which is described as the external process of presentation of self. However, some nurses who were trained in the current concept of mental health recovery expressed views akin to some consumers who identified the internal process involving the self to recover from mental illness.

Reclaiming self

Nurses who were trained in the concept of mental health recovery viewed the internal process involving oneself as an important aspect of recovery. Melissa questioned the existence of mental illness. She asserted that people have a distressed 'self' rather than mental illness. This mental distress can be around life issues or spiritual issues. She stated: 'Those who have been seriously traumatised or abused have a real loss of sense of self, a real questioning of humanity … issues with trust … people become very damaged during their life and [this] leads to mental distress.' Melissa talked about the importance of having open dialogue with these people to work through their issues. She described that the open dialogue may lead to a chance to transform the person.

Similar views were expressed by Russell, another nurse trained in mental health recovery, who said: 'It's a rediscovery or reclaiming of oneself, a big emphasis is placed on the self … it is about the self, coming together again, and from that a person gets stronger.' Kim asserted the importance of discovering self:

> Recovery is to achieve optimum level of functioning as a human being. To have a fullness of life and the mental illness to be secondary to whom the person is. It's like the focus is off mental illness and its discovering the self and reaching maximum potential.

Living life

Some nurses saw recovery as attaining optimum levels of potential, in terms of achieving goals with or without mental illness. Nurses' views reflected how one might be able to live his/her life without being affected by the effects of mental illness. For example, Simon stated: 'I think of recovery as a way of fulfilling one's potential despite the illness, in terms of achieving goals and living one's life.' Melissa expressed similar views, she said: 'The simplest definition of recovery is living the life, not existing.' Some nurses saw recovery as one's ability to function well in society. Aaron mentioned how difficult it is for people with mental illness to get back to their former self, he stated: ' … with mental illness it's difficult to get back to their original level of functioning … [recovery] is an attempt to try to get to the highest level of functioning one can.' Similarly, Zach said: 'I don't think recovery means a cure from mental illness, it means learning to live with a diagnosis, and working out ways to live the life to the best of their ability.' Rosie also had similar views: 'I believe recovery is returning a person to their best level of functioning that's not impacted daily by their mental illness.'

Return to pre-illness state

While some nurses perceived recovery as regaining one's level of functioning despite symptoms, other nurses viewed it as a return to the pre-illness state. Norman stated: 'Recovery means a full recovery back to the person of themselves, a way of living and coping.' Similarly, Tony said: ' … means that someone [is] becoming well, [there is a] decrease in symptoms, increase in functioning and returning to their pre-morbid state or as close to that state as possible.'

Discussion

The themes from this study revealed that views on mental health recovery vary among consumers, carers and nurses. This variance ranges from being able to reclaim the sense of self to being able to

be free from mental illness. The participants in this research had varying knowledge about the notion of mental health recovery, including nurses who were trained in the concept of mental health recovery and carers who have never attended any formal training in recovery.

The lived world forms mental health recovery

Themes from this study suggested that for some people recovery started by an epiphany (van Manen, 1997). For example, as Peter said the turning point in his life was when one worker believed that he could recover. Moreover, all the above views on mental health recovery can be clustered under van Manen's (1997) life world existential. Recovery requires improvement in body functions, for example, in having the motivation and ability to live like everybody else, thus it is corporal. Recovery is temporal, because people in recovery rebuild their sense of self and transform into a new self. The spatial aspect of recovery related to having the ability to live in one's own place in the community, without being transferred to other services, such as hospital or community care settings. Likewise, recovery involved improved relationships with family and community, thus it is relational. These four aspects form the lived world of a person in recovery (van Manen, 1997).

The essence of mental health recovery

Themes from this study also suggested that the 'sense of self' is very important in mental health recovery. Participants, including consumers and nurses who were trained in the current concept of recovery, highlighted the importance of the sense of self for persons with lived experience of mental illness. This is closely aligned to a well-noted theory by Goffman (1973) who depicted the importance of sense of self for people affected by stigma. When one regains the sense of self, the transformation of self happens, as described by Melissa. Findings from the study by Piat et al. (2009) also found similar views from consumers that 'self' is the driving force to recovery.

Major divergence and similarities in the views

Even though carers are the closest people that many consumers have in their life, carers had major divergence in their views on mental health recovery. Contrasting to consumers and nurses, none of the carers described regaining one's sense of self as an important aspect to mental health recovery. The carers' views on mental health recovery closely related to the traditional views of remission of symptoms. The above views also correlate with findings from Noiseux et al.'s (2010) study which involved consumers, carers and service providers that carers' views of recovery were based on outcome orientation, such as absence of symptoms and improved functioning. These views might be due to the carers' unconditional desires to see their loved ones not being affected by mental illness. Alternatively, it could be suggestive of carers' lack of knowledge on the current concept of mental health recovery due to lack of active participation and education in mental health care (Goodwin & Happell, 2007).

Nurses' views on recovery correlated with consumers' and carers' views. For example, nurses defined recovery as both an internal and external process involving the self. Related findings were reported by Noiseux et al. (2010), where service providers' views reflected those of both consumers' and carers' views. Some nurses saw returning to the pre-illness state as recovery, which aligns with the views of community mental health nurses, who participated in a study by Cleary, Horsfall, O'Hara-Aarons, and Hunt (2013). Clear divergences were present in the views of nurses who were experts in the current notion of recovery compared to those who

were not. This finding is similar to the findings of a survey conducted by Tsai, Salyers, and McGuire (2011) ($n = 318$) that staff who had recovery training had positive attitudes towards mental health recovery and had higher consumer optimism, compared to staff who had no recovery-related training. Similar views were also expressed in the study by Marshall et al. (2009), where consumers who received services from recovery-trained workers identified significant changes to service delivery and they were encouraged to take responsibility in their mental health recovery. The findings from Tsai et al. (2011) and Marshall et al. (2009) suggest that training and education of staff on recovery-related services have a positive effect in promoting optimism, responsibility and empowerment for consumers.

The overall themes suggested that two overarching processes were involved in recovering from mental illness, i.e. the internal and the external processes involving the self. Many consumers emphasised the internal process of regaining various aspects of oneself. Similarly, some nurses, who were trained in the concept of mental health recovery, also asserted the internal process involving oneself. The notion of internal process of the self closely aligned to Slade's (2009) notion of personal recovery, which involves personal growth and development. The internal process enables the person to understand the person's being and helps the person to 'live the life rather than existing' (Peter). Consumers involved in many other studies also expressed similar views towards recovery, such as transformation of self and/or finding personal meaning (Aston & Coffey, 2012; Davidson et al., 2005; Hipolito, Carpenter-Song, & Whitley, 2011; Lakeman, 2010; Mancini, 2007; Mancini et al., 2005; McEvoy, Schauman, Mansell, & Morris, 2012; Piat et al., 2009; Windell, Norman, & Malla, 2012).

Consumers, carers and nurses had consistent views on the external process of recovery. The external process of recovery involving cure and functioning well in the community are closely aligned to the notion of clinical and functional recovery portrayed by Slade (2009) and Lloyd et al. (2008). Similarly, the external process involving living life and/or contributing to community were reflective of Anthony's definition (1993, p. 15) that ' … [recovery is] a way of living a satisfying, hopeful, and contributing life … .' Moreover, consumers in many other studies valued similar views, such as the ability to engage in meaningful activities as an important aspect of recovering from mental illness (Browne et al., 2008; Drake et al., 2006; Katsakou et al., 2012; Mancini et al., 2005; Siu et al., 2012). Similar to this study many consumers in various other studies (Borg & Davidson, 2008; Drake et al., 2006; Lakeman, 2010; Ng et al., 2008; Piat et al., 2009; Ridge & Ziebland, 2006) identified recovery as getting rid of symptoms or going back to the pre-illness state.

Strengths and limitations

Many themes from this study echoed the existing themes of mental health recovery (Cleary et al., 2013; Lloyd et al., 2008; Ng, Pearson, & Chen, 2008; Ng et al., 2008; Noiseux et al., 2010; Piat et al., 2009; Slade, 2009). However, this study was able to accentuate the 'essence' of mental health recovery through a hermeneutic phenomenological lens. The three-dimensional approach used in this study helped to identify similarities and differences in the views of three major stakeholders on mental health recovery, thus enabling the researchers to identify the gaps. The above findings contributed to the existing knowledge and generated more evidence based on mental health recovery concepts. However, in line with qualitative epistemological assumptions, the sample only represents a local area and does not represent the generalised views of the Australian population. Although other professionals were excluded to make this study feasible, it is also a limitation of the study. Further comparative studies involving various major stakeholders across Australia would be beneficial to gain wider, generalisable evidence on mental health recovery.

Conclusion

This study highlights the need for placing the importance to the person's sense of self in the recovery process. According to these participants, recovery is a combination of internal and external processes, which involve corporal, temporal, spatial and relational aspects of the lived world. The internal process of reclamation of self may lead to transformation of oneself, resulting in a change of the external presentation of self. This transformation may or may not involve symptom remission as described by Slade (2009). Even though people had divergent views on recovery, the prime importance needs to be placed on the person with lived experience of mental illness. This is because mental health recovery is the business of a person with lived experience of mental illness; others are facilitators who join the person to support the journey.

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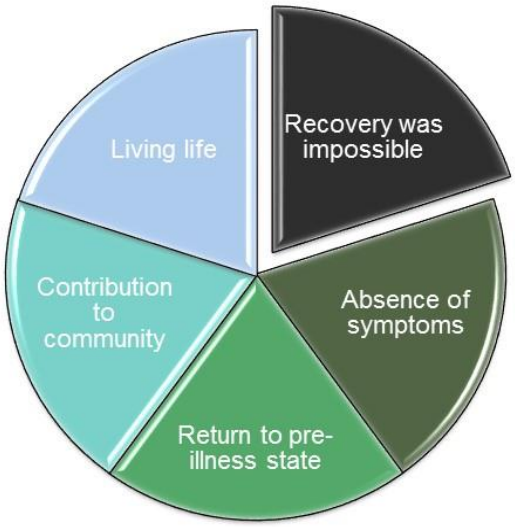
Discussion

The above article highlights the major themes from the participants' views. The following paragraphs discuss some additional themes and dialogue that are not included in the article.

Mental health recovery as an unfamiliar concept: The views of many participants indicate that the current notion of MHR is an unfamiliar concept (Figure 10).

Figure 10: Various views about mental health recovery



Even though the AMHS has a focus on the concept of recovery, this is not embedded into the understanding of many staff, consumers and carers. For example, Aaron (Nurse) states:

Well it's the way that mental health has been for the last 200 years. We have just come out of institutions in the last 20 years. You have got all these staff with old idealisms about how to treat people . . . not relapsing was enough, they would call it recovery. I think [with] a lot of staff that's still how they are seeing it. It's about

keeping their patient out of hospital. As long as they are medicated [and] they are not coming to the attention of anybody.

Aaron also thinks that many consumers are only accustomed to the practice of receiving medication on a regular basis from mental health services. Many consumers do not have high expectations, such as setting goals for recovery, living an independent life and/or productive engagement with staff. Therefore, they only engage with staff on a needs basis, such as to receive medication. Aaron said: "You do get a lot of people with chronic illnesses . . . that's the way they have been treated their whole life, so they don't expect anything different. It makes [it] hard for staff to really engage". Aaron's views highlight that the focus of the AMHS remains underpinned by a medical model of care with limited outcomes for consumers. Aaron's opinions suggest an urgent need for a focus on recovery and education for both mental health staff and clients in the AMHS, based on the principles of trauma-informed care and open dialogue.

Views of carers also underscored these statements that demonstrate that the concept of recovery is less understood in current practice. An overwhelming sense of sadness is embedded in the carers' views, as they believe that the person will not recover, leading to a feeling of loss and disappointment for the person. These views are explored in the above article under the paragraph entitled, '*Recovery is impossible*'. These carers' views concur with the findings of Hungerford and Richardson (2013), who found that seven of the ten carers interviewed had not heard of recovery or the implementation of recovery-oriented services. Nine out of the ten carers had noticed no recent improvements in the way services were delivered.

The above views indicate that consumers, carers and staff require an immediate and revolutionary system of education regarding the concept of recovery

and the values, such as hope and optimism it can bring to their lives. Recovery practices are for all, and should be available for all, including those consumers who have been in the mental health system for many years (Atterbury, 2014). Perkins (as cited in Edeson, 2012) argues that health services have essentially de-skilled the community's ability to manage people's distress, because services have aimed to fix people, removing the need for communities to accept and help people experiencing distress. Getting the concept of recovery out there for people to understand and work towards will equip the community to accept and de-stigmatise mental illness. The National Mental Health Consumer and Carer Forum (NMHCCF) (2010) Position Statement critiques the lack of progress around recovery, seeing it as linked to the barriers to effective consumer and carer participation in mental health services. The NMHCCF argues that the workforce identified in relation to mental health consumers and carers has the potential to be a key resource in the implementation of recovery in mental health services (2010). The needs of carers and consumers are also identified in the National Mental Health Consumer and Carer Forum (2011). Such needs include: an expansion of Commonwealth Carelink services to provide information on mental health supports for both consumers and carers; carer peer support; information; advice; mentoring; help with navigating systemic supports available to carers and to consumers; education and training; and tips on caring for oneself.

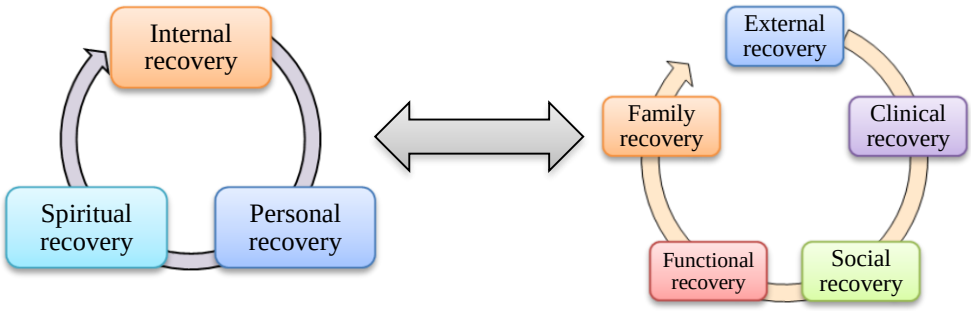
Encapsulating various concepts of MH recovery

The concept of MHR has been defined in various ways, as detailed in Chapter Two; this concept includes personal, clinical, social, functional, family, and spiritual recovery (Lloyd et al., 2008; Slade, 2009; Watkins, 2007). This research identified two major processes involved in MHR; internal recovery and external recovery. These two processes are interrelated; for example, the internal process of reclamation

of oneself may lead to external manifestations. Internal recovery consists of the transformation of the person and this includes transformation of various aspects of oneself, as explained in the above paper. These two processes are temporal and are aligned with the findings of Kidd, Kenny, and McKinstry (2015) that recovery takes time.

Internal recovery is a subjective process and is closely aligned to the notion of personal recovery (Slade, 2009) and spiritual recovery (Gomi et al., 2014; Watkins, 2007); in contrast, external recovery involves how one presents oneself to the external world and involves an objective process, such as living life in the community, functioning well (Lloyd et al., 2008), returning to pre-illness state (Slade, 2009), and recovering social (Lloyd et al., 2008) and family relationships (Watkins, 2007). Therefore, these two definitions encapsulate the various modes of recovery, as illustrated in Figure 11.

Figure 11. Encapsulating various concepts of mental health recovery



Both internal and external recovery are important for consumers as they lead to the total transformation of a person. For example, a person who experiences internal recovery overcomes the effects of mental illness by self-awareness, self-understanding and believing in one's capacity to recover from mental illness (Coleman, 2008). This process of overcoming the effects of mental illness can lead to

clinical, social, functional and family aspects of recovery, and therefore a more productive life in the community. Participants stated that 'living life rather than existing' is an important aspect of mental health recovery. Maslow's model of the hierarchy of needs proposes that people seek to satisfy progressively higher human needs, starting with physical needs like food and shelter, and advancing through safety and security, belonging and love, esteem, and self-actualisation (as cited in Rowan, 1998).

Even though the basic physiological needs are satisfied for many consumers, they might feel that they are still existing and not living because of not meeting other needs such as safety, security, belongingness and love, esteem and self-actualisation. Therefore, aspects such as the ability to return to pre-illness state (Clinical recovery) (Aston & Coffey, 2012; Lakeman, 2010; Slade, 2009), to engage in meaningful activities in the community (Functional recovery) (Katsakou et al., 2012; Lloyd et al., 2008; Windell, Norman, & Malla, 2012), to enjoy supportive and loving relationships (Social & Family recovery) (Happell, 2008a; Pernice-Duca, 2010) and to find meaning and purpose in life (Personal & Spiritual recovery) (Lakeman, 2010; Noiseux & Ricard, 2008; Siu et al., 2012) are also important for a person with mental illness in order for them to live their life rather than merely to exist.

Summary

This chapter explored the meaning of MHR in line with the available contemporary literature. In this chapter, a published paper is included which discusses the meaning of MHR from the perspectives of MH consumers, carers, and MH nurses. MHR involves two processes – internal and external recovery. The various existing definitions of recovery can be captured under these two definitions of recovery. The essence of recovery is a person's sense of self and the process of internal recovery can

lead to the process of external recovery. Both the internal and external processes of recovery are temporal and important aspects of recovering from mental illness. There are various helpful factors that lead to internal and external recovery of a person with mental illness. These are described in the next chapter.

Chapter 6

Factors assisting mental health recovery

Introduction

In this chapter, factors that aid in mental health recovery are examined. This chapter comprises a paper under review by the International Journal of Mental Health Nursing. This paper explored findings in relation to factors that are helpful in mental health recovery from a three-dimensional view encapsulated in the participant data. Consumers' personal attributes, such as hope, acceptance, belief, and a positive change in language by mental health professionals, were categorised under the theme of *optimism*. The theme of *safety* applies to social elements such as accommodation, safe environment and meaningful activity, such as having a job. Data that described the inter-personal dynamics were clustered under the theme of *belongingness*. The themes such as safety and belongingness are explained by Maslow in the hierarchy of needs (as cited in Rowan, 1998) as basic human needs. Exploring and assessing various alternative therapies to address one's mental health, provides the consumer with a multitude of strategies, rather than a sole reliance on medication. These elements were classified under the theme of *choice* and were identified as treatment factors. At the end of this paper, concluding paragraphs were added to draw dissimilar elements elicited by participants; such elements are discussed in light of the existing literature.

Mental health recovery: Views of consumers, carers and nurses

Part 1: What aids recovery?

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Dr. Ian Munro
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Under Review

International Journal of Mental Health Nursing
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Monash University

Declaration for Thesis Chapter Six

Declaration by candidate

In the case of Paper entitled: Mental health recovery: Views of consumers, carers and nurses: Part 1: What aids recovery? Which appears in Chapter Six, the nature and extent of my contribution to the work was the following:

Nature of contribution	**Extent of contribution (%)**
Concept development, research, original ideas, writing up	70%

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Dr. Ian Munro	Draft review and editing	
Assoc. Prof. Debra Griffiths	Draft review and editing	

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date: 02/11/2015**
Main Supervisor's Signature	[redacted]	**Date: 02/11/2015**

Mental health recovery: Views of consumers, carers and nurses

Part 1: What aids recovery?

Introduction

The philosophical underpinning of mental health recovery portrays a multidimensional process, with a central focus on hope, self-determination, self-management, empowerment and advocacy (Department of Health and Ageing, 2013a; Williams et al., 2012). For many mental health systems, this ethos of mental health recovery has become a guiding vision to deliver person-centered services that adapt to the aspirations and needs of people. In a bid to guide recovery-oriented practice and service delivery, the emergence of policies outlining these principles for those employed in the mental health services are growing (Department of Health and Ageing, 2008, 2013a; Department of Health and Human Services, 2015; National Institute for Mental Health in England, 2005; New Zealand Minister of Health, 2005).

Mental health recovery is an individual and subjective process influenced by various factors. Many helpful factors enhance the recovery process, such as: hope (Noiseux & Ricard, 2008; Pernice-Duca, 2010; Siu et al., 2012); support (Davidson et al., 2005; Lakeman, 2010; Ng, Pearson, Lam, et al., 2008); respect and empowerment (Cohen, 2005; Happell, 2008c); social connectedness (Cohen, 2005; Happell, 2008c); medications and alternative therapies (Happell, 2008c; Mancini, Hardiman, & Lawson, 2005); meaningful activities (Davidson et al., 2005; Mancini et al., 2005; Siu et al., 2012); and, family and friends (Cohen, 2005; Ng, Pearson, Lam, et al., 2008; Pernice-Duca, 2010). Consumers involved in many studies reported that service providers, carers and families have a major influence in the recovery process (Happell, 2008a, Happell, 2008b, Pernice-Duca, 2010); however, to this end, studies that have explored and compared the views of consumers,

carers and service providers on mental health recovery are scant (Kidd et al., 2015a, Kidd et al., 2015b, Noiseux and Ricard, 2008, Noiseux et al., 2010). The available studies explicitly examined the meaning and process of mental health recovery (Noiseux and Ricard, 2008, Noiseux et al., 2010, Kidd et al., 2015b) and the meaning of recovery-orientated care (Kidd et al., 2015a). While findings of these studies are important, it is also crucial to explore, from multidimensional perspectives, the factors enabling and impedingmental health recovery; this is necessary in order to understand the potential factors that influence recovery-oriented service delivery outlined in the policy documents. The literature review revealed that there is a dearth of research that specifically examines and compares the views of key stakeholders, such as consumers, carers and service providers, on factors influencing the recovery process. This two-part article serves, to some extent, to bridge this gap, as this study has gained insights from consumers, carers and mental health nurses. While this article discusses the various factors that aid mental health recovery, the second article focuses on factors that hinder the recovery process.

Methods

A qualitative research methodology guided by van Manen's hermeneutic phenomenology was employed for the study to gain an in-depth understanding of the meaning of recovery from mental illness and the factors influencing mental health recovery. Van Manen argues that phenomenological philosophy is a 'theory of the unique', and is interested in the 'irreplaceable aspect' of a particular phenomenon (1997b). Van Manen used the terms 'phenomenology' and 'hermeneutic' interchangeably, as he argued that "all description is ultimately interpretation" (van Manen, 1997b, p. 25). Van Manen's 'lifeworld existentials' were central to the data analysis process. These lifeworld existentials are: 'lived space' (spatiality); 'lived body' (corporeality); 'lived time' (temporality); 'lived other' (relationality) (van Manen, 1997b, p. 102-104); 'lived things' (materiality); 'lived cyborg

relations' (experiencing technology) (van Manen, 2014, p.306-309); and, 'textual features' (van Manen, 1997a, p. 350).

This research was considered as a high-risk research study due to the vulnerability of consumer participants involved in the study. Therefore, ethics approval was sought from the relevant organisations. Participants were given written and verbal information about the study prior to obtaining the informed consent. In order to ensure the anonymity of the participants, pseudonyms were used. Initially, twenty-nine participants expressed their interest in joining the study. However, two consumers and a nurse withdrew from the study and did not explain a reason for withdrawal. The remaining twenty-six participants included nine consumers, eight carers and nine mental health nurses. The majority of participants were living in the catchment area of an Area Mental Health Service (AMHS). The authors used the help of recovery clinicians, staff who support consumers in the community, and flyers posted around the clinics to recruit consumers into the study. Carers were recruited through advertising the study at the Carer's Council and by flyers posted around the clinics. The nurses were recruited by e-mail communication and by flyers displayed in the staff room, in addition to oral presentations at the staff meetings and handover meetings.

The authors used a semi-structured interview schedule with flexible, neutral and open-ended questions to conduct in-depth interviews. The data collection continued until themes were extensively explored and well described. A digital recorder was used to record the interviews and the data was transcribed by a professional transcriber. In order to check the accuracy, the transcribed data was sent back to the participants, as discussed in the initial meeting with each participant. No changes to transcripts were made by the participants, except in the case of one consumer, one carer and one nurse, who made slight modifications to the words for clarification purposes. The three approaches suggested by van Manen (1997b, pp. 92- 93) – the wholistic or sententious approach, the selective or highlighting

approach, and the detailed or line-by-line approach – were used in the data analysis process. These techniques were used to generate accurate interpretations and to gain access to the lived experience of participants in relation to the meaning of mental health recovery. The emergent themes from each cohort were clustered under subthemes and themes (Table 1).

Table 1: Developing themes

Texts	Sub themes	Themes	Lifeworld existential
"I think when people hold that hope you get that hope eventually" (Peter- Consumer) ". . . but if you really believe and support them [consumers] where they are at, they are more likely to take a step forward [towards recovery]" (Kristy- Carer) "people want to embrace life . . . it really is about giving the person back a sense that they [consumers] have a future . . ." (Russell- Nurse)	Personal factors- Hope	Theme of Optimism	Lived body
"secure family relationships" and having other healthy relationships are cornerstones to recovery (Liz- Consumer) "I think it [the facilitating factor] is a loving relationship . . . if he feels secure and loved I think that makes a difference" (Lucy- Carer) "[when] taking a life history, the worker is looking for things they want to know about . . . [the] story, its listening to where the person has been and what they have gone through"(Melissa- Nurse)	Interpersonal factors Relationships	Theme of belongingness	Lived self-other

Results

Participants in this study identified many factors that assist recovery from mental illness. From these factors four major themes were drawn and identified as: theme of optimism that included personal factors; the theme of safety which incorporated social factors; the theme of belongingness that involves interpersonal factors, and the theme of choices, which encompasses treatment factors.

Theme of Optimism: Personal factors

Personal factors are hope, belief, acceptance of illness, self-knowledge, spiritual health and independence. Many participants identified that these factors accelerate a person's journey to recovery. They identified that these elements help individuals with mental illness to overcome the effects of their illness and enable them to live a satisfying life.

Consumers' views: Hope

Peter described the turning point in his recovery journey was when a key worker demonstrated a sound belief in his capacity to recover and held hope for him. He stated that service providers conveying hope that one will recover from mental illness is a major facilitating factor to mental health recovery. Peter said: "I think when people hold that hope, you get that hope eventually" . . . . He asserted that ". . . the premise should be not [that] you *might* recover or recovery is possible, but you will recover".

Acceptance and abstinence

Some consumers felt that acceptance of mental illness and abstinence from alcohol and drugs significantly fosters mental health recovery. For example, deliberately abstaining from taking drugs and alcohol are key actions. John stated: ". . . I didn't realise how dangerous alcohol could be . . . I had accepted [that] I had an illness . . . and I haven't had an alcoholic drink for more than a year".

Carers' views: hope & belief

A hopeful attitude that the consumer will recover from mental illness helps the family to move forward in the recovery journey. Kristy, who cares for her son, stated: "if you really believe and support them [consumers] where they are at, they are more likely to take a step forward [towards recovery]". Kristy added: "Patiently waiting in the recovery journey required hope and belief for both consumers and carers".

Nurses' views: language of hope

To generate hope in mental health, a change in language is vital. Russell stated the belief that "when mental health services promote illness domination by focusing on symptom remission and relapse profile, it is hard not to be pessimistic about it." Changes in language that promote mental wellness and the individual's strengths are essential. Russell asserted that, in his experience, "people want to embrace life . . . it really is about giving the person back a sense that they [consumers] have a future". In addition, people who hold an attitude of hope and belief can rebuild a person's life. Melissa stated: "A good recovery worker uses their own experiences in their work . . . to show that you can get through this."

Theme of safety: social factors

Social factors include external factors such as stable accommodation, connections and support in the community, and meaningful activities such as work. The importance of accommodation to maintain one's recovery has been well explored (Browne et al., 2008, Browne and Hemsley, 2010). Having a stable space where consumers feel at home and in touch with the community tend to assist consumers to combat internalized and externalized stigma. The ability to work and contribute to the society increases self-esteem and decreases social isolation.

Consumers'' views: environment

Having a safe space in the community was considered as an important element to recovery. Steve said: "I was living in a different environment in the country in a rainforest and nature helped me out a lot, that was one of the main things I felt helped me recover the most". Ryan preferred his "own accommodation rather than a shared house" in order to avoid the influence of other people with mental health issues.

Carers' views: environment

Some carers disclosed that hospitalisation was detrimental to the mental health of their loved ones. David said "If she [his wife] gets what she wants and gets her space and . . . gets a good book to read and some sunshine and some quiet time and all of those things that she loves, then that levels her a lot more". An environment where the consumers had loving family around who listened and understood was considered a better option than admission into hospital. David revealed how hospitalisation traumatised his wife and himself. David felt that the acuity of the hospital environment itself "pushed them [consumers] right over the edge". David felt that his wife could cope better in the home environment and believed that recovery is "on-going" and getting his wife into her own comfort zone [home] was paramount in that journey. David said that hospitalising his wife was "the dark side" of that journey.

Nurses' views: accommodation & support

Nurses also identified stable accommodation as vital to one's recovery. Norman was very clear that "I am a great believer [that] if someone has stable accommodation it's the most important thing . . . it's very stressful and traumatic living in rooming houses with other people."

Support

Melissa was confident that supporting consumers to make decisions and to take responsibility empowers and equips them to face challenges of everyday life. She said: "As long as nurses do for people [and] make decisions . . . the person doesn't stand a chance of recovery. In order to recover the person needs to take control and have ownership of their experience". Melissa's thoughts reflected that consumers need to be empowered from a dependant role to an independent role. Similarly, Aaron felt that "Linking and educating consumers with various community services enable them to re-enter into the society".

Supporting the family to withstand the effect of mental illness and educating them how to deal with mental illness, also plays a pivotal role in facilitating recovery. Tony stated: "Providing adequate support for the carers will enable them to look after their loved ones within the community. The idea is to look after the carers [and] the carers then look after the client".

Service providers also need to be supported to be able to work in partnership with consumers. Simon asserted that the whole mind-set of "Tasks, safety, efficiency, getting the boxes ticked needs to be changed to . . . being more open to risk . . . [and] changing policies and paperwork . . .".

Work

When a consumer is able to work and contribute to society it may increase a sense of self-esteem for that person (Jacob et al., 2015, Munro and Edward, 2008). Melissa emphasised: "I think it's really important [for] people [to] feel they are citizens and when people are on long term benefits there is a sense where they feel less than other people, less worthy."

Theme of belongingness: interpersonal factors

Interpersonal factors have a major influence on one's mental health. Many participants identified that positive relationships with various allies helped the recovery process. These included understanding and caring relationships with key workers, carers and friends. Factors such as empowerment, listening and collaboration on the part of these allies were identified as actions of respect that catalysed one's recovery.

Consumers' views: supportive relationships

Close relationships with family and friends helped some consumers to move forward. For Liz, "secure family relationships and having other healthy relationships were cornerstones to recovery". On the other hand, Ryan felt the right key worker can positively influence the process of recovery. He described how "some key workers can spur us on . . . it's a combination of the right medication and the right key worker". According to Peter, key workers who "model relationships and friendships help consumers to learn and develop good relationships and friendships".

Carers' views: loving relationships

Some carers described how understanding, acceptance and keeping peace facilitated recovery. Lucy depicted how careful she was to avoid "pressing the wrong trigger" and that she "used to tread on glass a lot", meaning that she was cautious to avoid a volatile situation with her son. Lucy affirmed how she and her daughter supported her son to feel secure and hopeful. She said: "I think it [the facilitating factor] is a loving relationship . . . if he feels secure and loved I think that makes a difference". Similar views were expressed by Cathy who disclosed: "I submerged a lot of my own principles for my husband, who has bipolar disorder; however, I received greater benefit in doing so".

Nurses' views: therapeutic relationships

Therapeutic relationships facilitated mutual understanding, respect, listening, tolerance, rapport, empowerment and commitment from both parties. Melissa asserted that listening to consumers and their life story has a pivotal role in recovery. She stressed: " [when] taking a life history, the worker is looking for things they want to know about . . . [the] story, it's listening to where the person has been and what they have gone through". Melissa believed that "many consumers have carried that story as a secret for many years and just being able to tell their story can be enough to lift the weight off their shoulders of keeping that secret".

Additionally, working collaboratively with, rather than dictating care to consumers was seen as important. For instance, Tony reflected that "years ago, it used to be what we [mental health clinicians] want . . . we will do this and make you recover without asking the client." Tony's reflections highlight the fact that the concept of mental health recovery revolutionised the long-practised process of 'doing things *to* the consumers' to 'doing things *with* the consumers'.

Theme of choice: treatment factors

Various forms of treatment factors, such as medications and alternative therapies, were identified as factors helpful to mental health recovery. Some participants identified that the effects of medication had a positive outcome for them in terms of their recovery. However, others favoured alternative therapies, such as massage therapy, group therapy and narrative therapy over prescribed medications.

Consumers' views: 'right' medications

'Right medications' were described as those which controlled the effects of mental illness and had fewer side effects. Ryan described how "mental health recovery is sped up light years ahead when you find the right medications". John also had a similar experience and said: "It's [medication] not something that I would ever attempt to stop taking on my own. [It] just makes me feel normal".

Carers' views: medications

Medication was seen as helpful by some carers for their loved ones' recovery. David said that with "some medications, she levelled out"; likewise, Lucy also agreed that, when her son was off medications, "he was pretty hard to live with or communicate with". She affirmed: "It's a relief to see my son now; he's gone back on medication".

Nurses' views: medication adherence

Some nurses said that adherence to medications was important in promoting mental health recovery. Norman said "If service providers develop good rapport with consumers, that can actually facilitate medication compliance" (*sic*). Aaron shared a similar experience; he was able to develop rapport with his clients and discuss their treatment plans with them. He explained: "After spending some time with him [consumer] and educating him . . . he was happy about that [accepting medication]".

Alternative therapies

Nurses discussed group therapies as open opportunities for consumers to create new relationships within the community and reduce reliance on medications. Tony suggested various resources such as "talking therapy [counselling] and or walking groups enable

consumers to trial (and error) various methods of treatment until the person finds the right treatment for oneself".

Discussion

Factors helpful to recovery for gaining a sense of lifeworld

The participants raised many factors they considered helpful in the process of mental health recovery (Figure 1). These themes are closely aligned to van Manen's (1997b) lifeworld existentials (Figure 2). The themes from the data suggested that the positive influence of lifeworld existentials facilitates mental health recovery; that is, mental health recovery evolves when a person feels hope and belief within themselves (lived body) and have a peaceful environment or stable accommodation (lived space). Supportive relationships (lived other) with various allies promoted mental health recovery. For some carers, living with their loved ones was at times traumatic and they had to patiently wait (lived time) for their loved ones to recover.

Figure 1: Factors helpful in mental health recovery

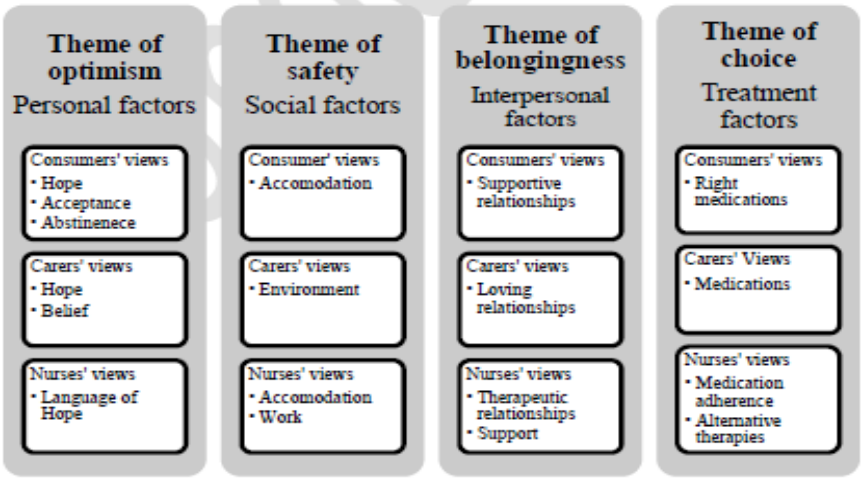
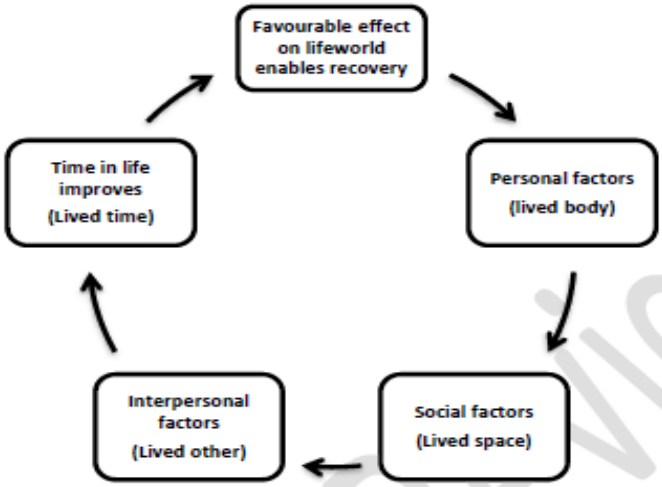


Figure 2: Mental health recovery and lifeworld



Participants in each cohort identified personal factors such as optimistic thoughts, and attitudes such as hope and belief, as factors helpful to recovery. Jacobson et al. (2003) defined hope as the belief that recovery from severe mental illness is possible. Similarly, Stickley and Wright (2011) found that one of the major themes of mental health recovery is hope and optimism. Hope promotes healing and personal well-being (Corrigan, 2014) and recovery grows when hope and opportunity co-exist (Slade et al., 2012). For many consumers, having a diagnosis of mental illness can be a debilitating process. A notion that reflects hope as a central theme and as an underpinning philosophy helps the consumers to transform from debilitation to revival. Many mental health systems have received the notion of mental health recovery with much enthusiasm (Noiseux et al., 2010; Piat & Sabetti, 2012) because it embodies a hopeful view of the future and suggests modes of intervention that reflect humanistic values.

Social factors such as stable accommodation, a safe environment and the ability to work enhances recovery and were well regarded among many participants. Stable accommodation and stability in social situations are critical elements that can prevent decline in mental health (Browne and Hemsley, 2010, Browne et al., 2008). Stable accommodation is a major element of mental health recovery. The lack of stable support and accommodation can result in further decline of mental health and lead the person to homelessness. Zac asserted that: "I think there is a lack of resource for people with mental illness not only in public mental health but in housing options and a lot of people are forced to live in conditions that are pretty awful or end up being homeless…". Castellow, Kloos, and Townley (2015) argues that the experience of homelessness is inherently traumatic and thus has the potential to affect the mental health of a person. In their study of 424 people diagnosed with serious mental illnesses living in supported housing programs in South Carolina, the following points were concluded that: ever experiencing homelessness as well as the amount of time spent homeless were related to higher levels of psychiatric distress, ever experiencing homelessness was related to higher levels of reported alcohol use, and total amount of time spent homeless was related to lower perceived recovery from mental illness. These findings suggest the strong link between experiencing homelessness and the psychosocial vulnerability to negative mental health outcomes. Therefore, as part of recovery-orientation housing for people with mental illness need to be considered as a priority by the Australian Government.

The inability to work increases distress and social isolation (Brice, 2011, Waghorn, 2013). Consumers involved in various studies (Siu et al., 2012, Browne et al., 2008, Mancini et al., 2005) identified that meaningful activities such as employment was helpful to their recovery. Clarke et al. (2012) found that many participants in their study attached greater importance to employment and career goals. Both nurses and consumers in this study raised

the importance of employment for positive mental health. Meaningful work is important in the lives of all people including people with mental illness. Leff and Warner (2006, pp. 138-139) suggest various approaches that have been used to increase employment among people with mental illness including "sheltered workshops, skills training, supported employment, the clubhouse model, and the social firm model". They argue that "effective employment programs have multiple benefits, including reducing hospitalizations and health care costs; decreasing positive and negative symptoms; increasing quality of life, self-esteem, and level of functioning; and expanding social networks" (Leff & Warner, 2006, p. 110). They also view employment as a primary avenue to social integration and insist on the importance of job programs and supports in any system of care. These views compliment well with the Position Statement by the National Mental Health Consumer and Carer Forum (2010) that advocate for consumers and carers to work in partnership with mental health services providers to focus on recovery.

Positive interpersonal relationships encourages recovery from mental illness. Many studies (Katsakou et al., 2012, Pernice-Duca, 2010, Siu et al., 2012, Noiseux and Ricard, 2008, Noiseux et al., 2010) have found that supportive and nurturing relationships are central to the promotion of recovery. Collaborative partnerships with service providers and peers (Mancini et al., 2005, Happell, 2008a) demonstrate empowerment and promote recovery. Similar views were expressed by participants from this study; that having service providers who 'hold the hope of recovery' (Peter) instil hope in consumers. Nurses involved in this study also suggested, not only consumers, but carers and service providers' also need to be supported to embrace recovery principles.

Some participants in this study identified that medication adherence and alternative therapies as helpful factors to recovery. Participants from other studies also expressed similar themes (Happell, 2008a, Mancini et al., 2005, Ng et al., 2008, Piat et al., 2009). For

example, Happell (2008a) found that recovery is enhanced by medications, as well as spiritual and counselling therapies. In addition, the effectiveness of alternative therapies in mental health has been explored by many researchers (van Lith et al., 2009, Van Lith et al., 2011, Solli, 2013). The availability of choices for alternative therapies in the treatment of mental illness should be considered and supported in mental health services, rather than relying only on pharmacological therapies.

Clinical Implications

Providing opportunities for consumers

Offering opportunities for consumers to grow and develop, such as a peer support worker, will improve their self-esteem. Slade et al. (2012) suggest that providing such opportunities brings benefits to both parties – the care receiver and peer support worker, enables growth and development of both parties and increases the experience of finding meaning in their lives. Ehrlich-Ben Or et al. (2013) found that people with a high level of internalized stigma reported experiencing less meaning in life. Thus, involving consumers in opportunities that generate hope, optimism and belief in their capacities can be a strategy that reduces internalized stigma and helps to make life more meaningful. Slade et al. (2012) state that England has adopted the strategy of transforming the mental health workforce by employing a greater proportion of people with lived experience. Implementing similar strategies will be useful in other countries to promote recovery-orientation in mental health service delivery.

'Increase participation in the community'

Carr and Waghorn (2013,p. 696) argue that the next mental health reform goals in Australia should be "increased participation in the workforce and increased participation in community life". Many consumers identified in various studies that engaging in meaningful activities is an important goal in relation to mental health recovery (Browne et al., 2008; Katsakou et al., 2012; Mancini et al., 2005; Munro & Edward, 2008; Siu et al., 2012;

Windell et al., 2012). Engaging in meaningful activities can instill meaning and purpose in one's life (Lakeman, 2010; Siu et al., 2012). Therefore, practical achievements such as completion of education and employment should be encouraged and supported and should be set as priority strategies for consumers in mental health services.

Setting recovery competencies for mental health services

A change in values and culture within the organisational ethos is required to enhance recovery-orientated practices in mental health services. Lakeman (2010) discusses five top recovery competencies for mental health workers, such as: the ability to recognize and support personal resourcefulness; reflecting a belief that recovery is possible; listening and respecting consumers' views; respect for the expertise of the lived experience; and helping consumers to develop self-belief. The authors of this paper concur with Lakeman (2010) and assert that, while many mental health services wish to promote mental health recovery, it is useful, as a service change strategy, to set recovery competencies for services to implement recovery principles,.

Strengths and limitations

The views of participants in this study reveal some similarities to the existing literature around consumers' views on promoting recovery. Similar to this study, consumers involved in many other studies (Mancini et al., 2005, Siu et al., 2012, Lakeman, 2010, Ng et al., 2008, Happell, 2008a, Browne et al., 2008, Borg and Davidson, 2008) voiced various factors they considered important to mental health recovery such as: self-belief, relationships, family, accommodation, work, social connectedness, medications and alternative therapies. This study was able to identify and compare the views of three major stakeholders in relation to factors seen as helpful to mental health recovery. However, the local and purposeful sampling was posed as the limitation of this study. Further comparative

studies involving various major stakeholders across Australia would be beneficial to gain wider, generalizable evidence on mental health recovery (Jacob, Munro, & Taylor, 2015).

Conclusion

The process of implementing recovery-oriented service delivery is contingent on many factors. This article explored the views of three cohorts to identify and highlight the factors deemed helpful in the process of mental health recovery. The findings suggest that positive influences of several factors including personal, interpersonal, social and treatment factors, considerably assisted the journey towards recovery from mental illness. These factors included hope, belief, accommodation, work, supportive and loving relationships, medications and alternative therapies. The overall findings demonstrated some similarities to those in the existing literature. The study recommends the implementation of various strategies that will further enhance recovery-orientation in mental health settings, such as: greater involvement of consumers in service delivery; improvement in stable and safe accommodation; enhancing employment opportunities for consumers; availability of various alternative therapies; and, setting recovery competencies for the mental health workforce.

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Minor Themes

There were many similarities in the views of participants' regarding factors that are helpful to recovery. The above article captured those similar themes. Some further themes emerged and are described below, grouped according to the particular participant cohort.

Mental health consumers

Spiritual health

Spiritual health was seen by Liz as a major helpful factor. She offered the opinion that a balance is imperative in the various aspects of life, such as the personal, social, occupational and spiritual. She stated: "one of the biggest [factors] is having a good spiritual sense in your life and nurturing that". Liz described that nurturing these aspects are important in balancing one's life. Many consumers identified that finding meaning and purpose in life was an important aspect to mental health recovery (Lakeman, 2010; Siu et al., 2012). Spirituality is considered as an essential component of holistic care and the healing process, and many consumers described having spiritual or mystical experiences (Watkins, 2007). Therefore, a holistic approach to care should drive a system of mental health care that encompasses the physical, mental, social, cultural and spiritual needs of consumers.

Client-led goals

Part of mental health promotion is equipping consumers from dependence to independence. Setting the premise "you will recover" (Peter), rather than "recovery is possible", is stronger and augments the hope of recovery. Peter stated that "the premise should not be one of 'you might recover' or 'recovery is possible', but one of 'you will recover' [Thus] high expectations of recovery should be placed on staff, consumers and family" in order to affirm the certainty of recovery. In short, this premise should be the foundation of the recovery journey. Peter said: "we set goals

that are too small that people can't be bothered. If you are shooting for the moon, you have got to work harder than if you are trying to brush the kitchen once a day". He asserts that high expectations about working hard for recovery are inevitable, though these are not exercised in the current mental health services. He explains this by saying: "we have got it to such a low base that the goals are service-led rather than client-led . . . which would stick out in the system". Peter asserts that service-led goals are a reflection of the medical model of care and raise a major challenge for many contemporary mental health practices that are not recovery-orientated. Edeson (2012) discussed the importance of co-production in mental health service delivery; this notion refers to an equitable and reciprocal partnership approach between people who deliver and people who access services, such as consumers and carers, in the design, delivery and evaluation of mental health services. A key element of mental health system reform should relate to implementing the notion of co-production in policy-making, service design and delivery, research and evaluation (Edeson, 2012).

Carers

Social connectedness and inclusion

Some of the carers delineated social connectedness as an important aspect of recovery. For example, Lucy acknowledged that her son became isolated when he was unwell. She stated: "he is a very creative person . . . up until eight months ago he was very isolated". Lucy is referring to a period when he relapsed. Kristy shared similar thoughts: "now he is able to, and willing to go into shops, he can go in and chat to the butcher about the football team. I nearly fell over the first time I heard him make a comment like that". Consumers involved in other studies have identified similar thoughts in relation to re-engaging with community – an important part of the

recovery process (McEvoy, Schauman, Mansell, & Morris, 2012; Windell et al., 2012).

Leff and Warner (2006) discuss the barriers to full citizenship that are, for consumers, partly due to the disabilities produced by their illnesses, and partly due to the stigmatising and discriminatory attitudes of the public. Lack of motivation due to effects of illness and the lack of interest of the community to encourage the inclusiveness of consumers can act as a double-edged sword. As "most of a person's recovery occurs at home, so their family, friends, neighbours, local community, church, clubs, school and workplace have an important part to play" (Department of Health and Ageing, 2013a, p. 26). Therefore, practices that promote motivation and inclusiveness of consumers are crucial to establish social relationships and to promote responsibilities as citizens (Wong, Stanton, & Sands, 2014). In Australia, the government's social inclusion agenda aims to make sure every Australian has the capability, opportunity and resources to participate in the economy and their community, while taking responsibility for shaping their own lives (Department of Prime Minister and Cabinet, 2009). While a person-centered focus is important for social connectedness, it is also imperative to include families and carers who are often blamed for and are worried about their loved ones' care (Watkins, 2007). The guiding principle of the Victorian Department of Health and Human Services (2015) – that is, to place consumers, carers and families at the centre of mental health planning and service delivery – is a great vision that needs to be implemented with urgency within the Australian mental health system.

Nurses

Positive risk-taking

Risk-aversion is a contrary feature of a recovery-oriented mental health service. Staff reported the importance of positive risk-taking for a person's mental health recovery. Various staff drew many examples of high-functioning persons in recovery being prevented from making a risky decision. Staff thought that positive risk-taking was essential in the recovery journey to build on confidence. Russell works in a Community Care Unit (CCU) where the recovery-oriented framework of care is established. Russell said: "Mental health services are very good at getting in the way of [consumers' recovery journeys] by saying, because of risk-related issues, we are going to define it [recovery goals] for you. What we've had to do here is take some risks and give the person back the responsibility". Russell asserts that giving the person back some responsibility will allow the person to take the next step of recovery. Russell described a story of a consumer who was admitted to the CCU. He said:

> A man who had come from a locked facility and was having his medications crushed, had been on a Community Treatment Order (CTO) for 15 years. It was very difficult to see how we can progress beyond that, but by creating a really good recovery plan in various layers which started off with connecting with him and then listening to him and then allowing him to articulate his life goals and then building on his achievements and then eventually taking the leap of faith to take him off the CTO and give him back the control of his medications within a supportive environment. It led within a year to him now moving out and living independently. That's a very, very significant series of events and

> they all needed to be in place there including the courage of the Consultant Psychiatrist and the Manager to endorse this approach, but the alternative was probably that this man would never leave a supervised environment.

Russell's story is a powerful example of positive risk-taking and emphasise the need for change in the attitude and courage of mental health professionals towards positive risk taking. In order to allow a person to grow and take the next step of recovery, it is imperative to give the person back his responsibilities. Tickle, Brown, and Hayward (2014) argue that the existing culture of mental health services emphasises the need to avoid harmful consequences of taking risks, which in turn limits innovations in implementing recovery-oriented approaches. In order to promote positive risk-taking in mental health services, a whole team approach and the support of management is required (Yuen, 2012). As part of recovery-orientation, the Department of Health (2011b, p. 5) encourages mental health services to "articulate the threshold of risk appropriate to the particular setting . . .[and] provide guidance, training and support to staff".

Strengths-based approach

Melissa asserted the need for a strengths-based approach to enable recovery, rather than watching out for return of symptoms. She said: "We . . . taught people how to look out for signs and symptoms so they're constantly on this look out for symptoms". Melissa thinks that, rather, mental health clinicians should reiterate that if "you have a bad day it doesn't [indicate that] it's the restart of your mental health distress, it's just a bad day". Reiterating the notion that life has ups and downs can reduce anxiety for consumers. Melissa asserted that every person has "gifts and strengths" and focusing on and enhancing these will enable the recovery process. The

principles of a strengths-based approach is that it focuses on individuals' attributes that promote health, instead of focusing on symptoms and pathologies that induce sickness (Huiting, 2013). The strengths-based approach aligns well with the recovery framework and could be utilised in both acute and community mental health settings. However, it can be challenging for mental health services that emphasise the medical model of care to move towards an individualised, strengths-based approach.

Huiting (2013) argues that practitioners are often comfortable and confident in their role as experts and believe that an accurate diagnosis helps to institute the appropriate medical treatment for consumers A strengths-based approach requires practitioners to acknowledge that they may not be all-significant in the life of consumers and rather to use practitioners' knowledge to help consumers to utilise their strengths and integrate these into the recovery process (Huiting, 2013). In order to practice within the realm of the strengths-based approach, an optimistic and positive attitude should be developed by mental health clinicians to look at a specific situation and to believe in a positive and favorable outcome. Such a positive outlook is called 'therapeutic optimism' by Jackson (as cited in Rogers et al., 2013). Therapeutic optimism in mental health clinicians enables them to identify the strengths of consumers and work collaboratively with them. Therapeutic optimism strengthens the hope and belief that mental health recovery is possible (Rogers et al., 2013)

Summary

In this chapter, the factors aiding mental health recovery were discussed. The four major themes that evolved from the data included: optimism, safety, belongingness and choices. These four themes were consistently evident from the data across the three cohorts. Other themes included: spiritual health, client-led goals,

social connectedness, positive risk-taking and a strengths-based approach. The overall findings demonstrated some similarities to the existing literature. This chapter proposes various recommendations to further enhance the recovery of consumers. These are: greater involvement of consumers and carers in service delivery; improvement in stable accommodation; enhancing employment opportunities; availability of various alternative therapies; setting recovery competencies for the mental health workforce; a holistic approach to care; positive risk-taking and a strengths-based approach. There are many factors that are unhelpful in the mental health recovery process; these are described in the next chapter.

Chapter 7

Impediments to mental health recovery

Introduction

This chapter presents findings relating to the factors deemed to be unhelpful in terms of mental health recovery. The chapter contains a paper under review, which explores the factors seen as impeding mental health recovery, drawn from the views of consumers, carers and nurses. Four major themes were identified as barriers towards mental health recovery: control, rejection, necessity and struggle. Elements that comprise the theme of control include: staff factors, such as negative attitudes; use of power or coercion; and, paternalistic attitudes. The theme of rejection included social factors, such as labelling and stigma. Lack of resources and a lack of support were classified under the theme of necessity. Other issues including illicit drugs, over-use of alcohol; side effects of medications and non-adherence to medications were clustered under the theme of struggle. The themes identified as barriers to recovery by the participants had many similarities. At the end of this chapter, further findings have been included that address the existing impediments to recovery, as well as recommendations for the enhancement of mental health recovery.

Mental health recovery: Perspectives of consumers, carers and nurses

Part 2: Impediments to recovery

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Under Review

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Declaration for Thesis Chapter Seven

Declaration by candidate

In the case of Paper entitled: Mental health recovery: Perspectives of consumers, carers and nurses: Part 2: Impediments to recovery, which appears in Chapter Seven, the nature and extent of my contribution to the work was the following:

Nature of contribution	**Extent of contribution (%)**
Concept development, research, original ideas, writing up	70%

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Dr. Ian Munro	Draft review and editing	
Assoc. Prof. Debra Griffiths	Draft review and editing	

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date: 02/11/2015**
Main Supervisor's Signature	[redacted]	**Date: 02/11/2015**

Mental health recovery: perspectives of consumers, carers and nurses

Part 2: Impediments to recovery

Introduction

The foremost concept in discussions relating to mental health recovery is that recovery is not merely the absence of symptoms; rather, it is about living a satisfying life, even with the presence of mental illness (Anthony, 1993, Slade, 2009, Deegan, 1988). The practices that promote mental health recovery resting on this definition as a basis have been endorsed by western mental health systems (Department of Health and Ageing, 2013a, Department of Health and Ageing, 2013b, New Zealand Minister of Health, 2005, Sowers, 2005). However, the establishment of recovery-oriented practices (RoP) is, in reality, yet to be achieved in many contemporary mental health settings. Therefore, an examination of the barriers to mental health recovery is necessary to understand the various factors that impede the process of recovery.

The literature review suggested that barriers to mental health recovery have been inadequately explored among consumers and other key stakeholders. The available studies (Happell, 2008b, Mancini et al., 2005) explored only the views of consumers and did not examine and compare the views of service providers and/or carers. While support for consumers from various allies such as carers and service providers is an important contributor in recovery process (Happell, 2008a, Mancini et al., 2005), it is essential to explore the views of other stakeholders such as carers and service providers in relation to factors that are unhelpful to mental health recovery. This knowledge will enable understanding, rectify the barriers of recovery and also bridge the gap in this area. This paper aims to present the views of three major stakeholders – consumers, carers, and mental health nurses – in relation to barriers to mental health recovery. This paper is the second part of a two-paper series.

Method

This section provides a brief overview of the method used for the study. A more detailed explanation of the study method is presented in Part 1 of this paper and in Jacob, Munro, and Taylor (2015). Van Manen's qualitative hermeneutic phenomenological method was chosen as the methodology for the study. This research approach was carefully considered due to the nature of the study, as it enquired into a comprehensive understanding of what is understood by the term 'mental health recovery' and the factors influencing it (Jacob, Munro, & Taylor, 2015). This study received ethics approval from the relevant Human Research and Ethics Committee. Written informed consent was obtained and pseudonyms were used to anonymize the participants. Eight carers, nine consumers and nine nurses participated in the study. The data analysis and thematic development are described in Part One of the paper.

Results

Participants from each cohort identified many themes, some of which displayed close similarities. These themes are clustered under four overarching themes: control, that includes disrespect and paternalistic attitudes of staff; necessity, which addresses a lack of support and resources; iii) rejection, which includes stigma; and, struggle, that consists of issues related to drugs, alcohol and medication.

Theme of control

Consumers' views: disrespect & paternalistic attitudes

Many consumers explained how negative attitudes of staff hinder the process of mental health recovery. Liz described her experiences, in which she felt helpless and unable to carry out her daily or regular activities while admitted to an inpatient unit. Liz usually consumes a bottle of 'yakult' when she feels stressed and sick in the stomach. She wanted to repeat this practice when she was in an inpatient unit, but a staff member told her: "You have wasted enough time [of staff members, raising too many issues] and you are not having that

[bottle of yakult]". Liz felt that such attitudes serve to humiliate a person, especially when admitted as an inpatient, where consumers are placed in situations where they are required to ask for many things that are normally available to them, due to restrictions in place in an acute inpatient ward. This in turn requires staff cooperation. Additionally, some consumers felt that overprotective staff emerged as a problem. For example, Mike recalled: "I was on a Community Treatment Order (CTO) and pretty much had to go to the hospital when they [mental health staff] said". Mike felt the staff were too cautious about his mental health status and made decisions on his behalf.

Carers' views: power, negative attitudes

Carers also identified that exertion of power and negative attitudes of staff actually hinder the process of mental health recovery. David said "My wife was taken to the hospital under the Mental Health Act" and referred to the Act as an "authority" that mental health staff possessed. He reflected that this "authority" was exercised insensitively by the use of language such as: "We're [mental health staff] coming up and coming to grab her". David thought identifying what the consumer wanted, and behaving accordingly would have been a better approach. Emily also felt that talking and trying to understand what was going on with a consumer was more important than telling a consumer that "this is what's going to happen to you."

Cathy said comments by the mental health staff such as, "pull up your socks and get on with it" tended to aggravate and create anger. Similar comments were made by Mary; she agreed that mental health staff making comments such as, "snap out of it and get over it" would further wound a person rather than help to heal them.

Nurses' views: power, paternalistic attitudes, risk-aversion

Staff held similar views to consumers and carers in relation to paternalistic attitudes and the exertion of power over consumers. Simon was clear that "people [mental health staff] who don't believe in it [mental health recovery] are the biggest barrier." Simon

described one example where the protective attitudes of mental health staff and a person's guardians "prevented a consumer to make some decisions that had some risks", even though the "consumer had made major progress" in his recovery journey. He argued that such attitudes reveal the lack of trust and belief in consumers' recovery and will not empower consumers.

Paternalistic attitudes can also prevent a person's decision-making and confidence-building. Zac provided the following example: "[The client said] I want to get off my medications eventually. Instead of listening to the client, the doctor said you have a mental illness and you will be on this medications for the rest of your life." Zac felt that it is like "giving a life sentence" to someone and affixing a label that impedes the dreams and goals of a person.

Risk-aversion in mental health services in relation to consumers' decision-making capacity can significantly obstruct the recovery journey of consumers and can ruin the partnership of people who work with them. Russell raised his concerns in relation to mental health services being "risk avoidant." He stated: "There's always a consideration of risk, but there is also a kind of hopefulness that allows us to say; let's just try this, rather than be frightened of things at times."

Theme of necessity

Consumers' views: lack of support

Unhelpful relationships and unstable accommodation worsen the situation of an already vulnerable person. Ryan discussed the vulnerability of people with mental illness, especially when they are placed in shared accommodation where other people suffer from mental illness, and/or have problems associated with drugs and alcohol. He said: "living with more acute [acutely ill] people can rub off on you because they can bring you down."

Carers' views: lack of resources

Some carers identified the fact that a lack of resources hindered mental health recovery. Maureen recounted her son's early discharge due to lack of resources, and lack of follow-up post early discharge, including a failure to inform the family; she believed this put her son and the whole family at risk. She said: "He threw his microwave through the window . . . and was threatening his family with violence, but was discharged from the hospital around 4 o' clock in the morning". She said: "the greatest thing that is lacking is follow-up and . . . letting the carer at least know what's happening."

Nurses' views: lack of resources

Some nurses said that lack of resources, such as stable accommodation, friendships and family support, and social and recreational outlets compromise the mental health recovery of many consumers. Norman emphasised: "The thing that always springs to mind is the lack of accommodation and ministry of housing . . . it is very stressful and can be traumatic living in a rooming house". Aaron reiterated that the lack of staffing leads to early discharge to the care of a GP. He said: "We are having to rationalise care to a point that we are discharging acutely unwell people from our inpatient unit and then they are being followed up by understaffed clinicians . . . a lot of people are missing out on having the opportunity to recovery".

Theme of rejection

Consumers' views: stigma

Stigma was raised as a major barrier to mental health recovery. Ryan discussed the fact that "stigma doesn't help . . . I haven't experienced it much lately because I have been well, but when I was younger with the condition, people used to think [having] schizophrenia was a stigma . . . [therefore] we go off medication when we felt better, to normalise and not have the stigma of mental illness . . . stigma was a motivator [for] non-compliance because you want to be a normal person".

Carers' views: stigma in the community

Lucy disclosed that the community group which she attended did not welcome people with mental illness. She said: "We are 15 women in our craft group and one woman came into our group . . . the community centre said she had mental health problems and the group had great difficulty accepting her. I felt that was sad. I don't know how you change that . . . I understand mental health and I can feel that another family must be experiencing anguish, I think it doesn't cost me anything [to catch up] with consumers for a coffee . . . but not everyone understands, they don't understand".

Nurses' views: stigma & fear

Many nurses indicated that, compared to previous decades, stigma has lessened towards mental illness. However, the data from this study demonstrates that stigma still exists. Rosie stated: "Stigma is still around in this day and . . . is a very big thing. Probably less than it was when I first started this job". Melissa discussed the fact that, in order to combat stigma, more education is needed in the community so as "not to be frightened of psychosis, to be much more accepting and . . . to embrace people with mental illness".

Theme of struggle

The theme of struggle has two components – the side effects of drugs and alcohol, and non-adherence to medications. Many participants stated that the effects of these factors were a major hindrance to the recovery process. Furthermore, they highlighted an ongoing battle relating to the struggle with addiction to drugs and alcohol and the side effects of medication, all which lead to non-adherence to medication and, in turn, resulted in a decline in mental health.

Consumers' views: drugs and alcohol

Illicit drugs and alcohol commonly opened a pathway to creating friendships, though, for many, such relationships proved to be unhelpful. Mike reflected: "The only reason I got friends was because of the drugs". While some consumers struggled to abstain from illicit

drugs and alcohol, Michelle recognised: "It [illicit drug] slowed everything down and blinded me for a long time". The shame of having a mental illness was also a reason for drinking alcohol. John said: "I was accepting that I had a mental illness and maybe that's why I was sometimes drinking not in a normal way".

Carers' views

Carers also expressed the view that excessive use of alcohol hindered the process of mental health recovery. Even though some consumers were unaware of the detrimental effects of illicit drugs and alcohol on their body (described under *Consumers' views* above) these adverse effects were obvious to people around them. Maureen said: "[my] son's mental illness flared up when he used excessive alcohol".

Nurses' views

Nurses felt that illicit drugs and alcohol were factors that tended to slow down one's recovery. Rosie felt that the main problem was the "surplus availability of [illicit] drugs and alcohol and the media's influences in portraying alcohol as glamorous". She said: "it [illicit drugs & alcohol] can be very detrimental on people's mental health and can cause addictions and interact with medications, especially antidepressants."

Consumers' views: side effects of medications

Some consumers described how the side effects of medication lead them to become non-adherent with their prescribed medications. The non-adherence caused a relapse of symptoms. Ryan described his decision to reduce the dose of his medication when he "felt over-tired [sedated] . . . [and this] caused relapse". Ryan reflected that his actions were "irresponsible" as, in hindsight, he believed that this issue could have been discussed with his recovery clinician.

Carers' views: non-adherence to medications

Lucy recollected her son's rebellious attitude towards medications and the subsequent incidences when he became psychotic due to non-adherence. She indicated that "when unwell, he [son] was abusive and [I] had to halt the telephone dialogues with him many times". She stated that she could not bear the conversation anymore and sighed: "Yeah, that was [my] life for 40 years …"

Nurses' views: side effects & non-adherence

Nurses also asserted that side effect of medication lead to non-adherence; other side effects included weight gain and over sedation, affecting a consumer's body image. Aaron discussed the fact that one client he helped "is now resenting treatment of all forms because of the [side] effects of medications." Similarly, Rosie justified the views of younger women and men who are non-adherent to medications because they are conscious of their body image. She believed that "for these young people, the side effects outweigh the desired effects of medications. Unfortunately, medication has terrible side effects, especially [for] young ladies and men with weight gain . . . it does cause a lot of non-adherence with medications."

Minor themes

Power struggles & risk-aversion

Simon (Nurse) described many situations where consumers were prevented by staff or family members of making potentially risky decisions. He provided an example: "someone who was living extremely well despite an on-going mental illness was at the point they wanted to make a decision about his accommodation . . . people who had the power prevented that risky decision . . . if you have a welfare guardian . . . and a consultant saying I am not going to support that decision, [it] doesn't happen". In this situation, the consumer has achieved many of his recovery goals, even though the professionals who care for the person

remain paternalistic and overcautious about him making decisions for himself. Simon felt that even though the staff work with consumers and support their recovery goals, when it comes to the end stage "we're [mental health service or support person who have power] not prepared to go that far". Simon is referring to risk-aversion in mental health service. He believes that, when consumers are motivated and are achieving their recovery goals, which needs to be celebrated and embraced by others, including professionals and carers or family members. Simon asserts that, to promote recovery-orientation in mental health services, it is important to encourage positive risk-taking to allow the growth of the person in recovery (Tickle et al., 2014; Yuen, 2012).

Some participants referred to the Mental Health Act (MHA) as an authority to admit people with mental illness into an inpatient unit. MHA is meant to promote supported decision-making and encourages strong communication between health practitioners, consumers, their families and carers. MHA supports people with a mental illness to make and participate in treatment decisions and to have their views and preferences considered and respected (Department of Health, 2014). Mike (consumer) and David (Carer) described how the MHA was used inappropriately as an authority to admit clients into inpatient settings. They believed that for the majority of the time, this decision is made solely by the clinicians and not in conjunction with consumers or families.

Privacy and confidentiality

The maintenance of privacy and confidentiality in health care settings is aimed at protecting the consumer and providing them with a source of respect and dignity (Deshefy-Longhi, Jane, Olsen, & Grey, 2004). However, carers like Emily argue that issues of privacy and confidentiality can be a barrier at times. She described that: "we couldn't get anybody to listen to us and privacy and confidentiality come into a lot of this". Emily said that the family members are often the first to notice the "out-of-character behaviours" of a person with

mental illness and therefore, when family members contact the MHS with concerns, that should be taken seriously. She said that her daughter's mental health worsened as "nobody would listen to me so I blame the system for exacerbating her condition and I think that's the biggest barrier ever ... I understand the importance of privacy and confidentiality but let's get it right, it's got to be in the right place". Emily stated that many health professionals did not listen to her concerns as they believed that her daughter was able to make decisions; thus, they did not give priority to Emily's concerns and relied on their expertise to assess the mental health issues in the situation.

'Catch, grab and stab' style

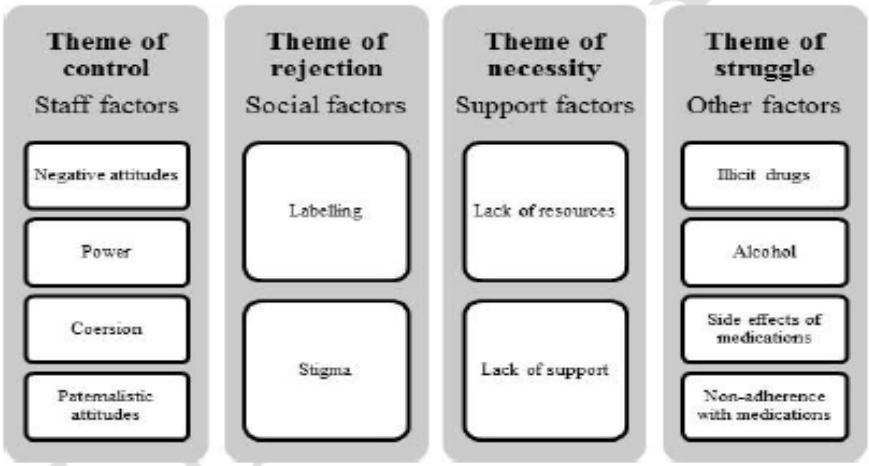
According to Aaron, (Nurse) there have been no major changes in many staff practices after the adoption of the recovery model of care in the AMHS. Aaron described the attitudes of older staff: "I think there is a lot of older staff working in the service who are very familiar with the old model of care and purely case management, 'catch and grab and stab' kind of approach with a lot of their patients. They [clinicians] see those [consumers] on a fortnightly basis, give them the depo [Antipsychotic injection] and leave". Aaron believed that both those older staff and their clients are used to that approach and the staff believe that mental health recovery is another word for what they are already doing. Zac (Nurse) also discussed similar themes, which included the view that older staff have negative attitudes towards recovery. He said: "I think some of the older clinicians who have been around since the day of the big institutions find that recovery is a little bit of a nonsense-type thing – that they still sort of see the patient and the nurses separate. They still focus on the medical model, they don't want to sit with the clients and work collaboratively, [and] they prefer to dictate 'you must do this and that'". Both these nurses' views indicate a clear need for education that can change the mindset of the older staff. Gale and Marshall-Lucette (2012) found that education may increase the confidence of service providers. Therefore, in order to

change the existing practices, an educational approach with practical applications to deal with complex issues should be considered (Hungerford, 2013b).

Discussion

Studies that explore factors influencing mental health recovery among key stakeholders other than consumers are scarce (Kidd et al., 2015a, Kidd et al., 2015b, Noiseux and Ricard, 2008, Noiseux et al., 2010). This study provides a three- dimensional description of consumers', carers' and nurses' views on barriers to mental health recovery. Many themes discussed by participants in this study highlighted consensus in relation to the barriers to recovery. The various perspectives suggest that there are four overarching themes that lead to barriers to mental health recovery (Figure 1).

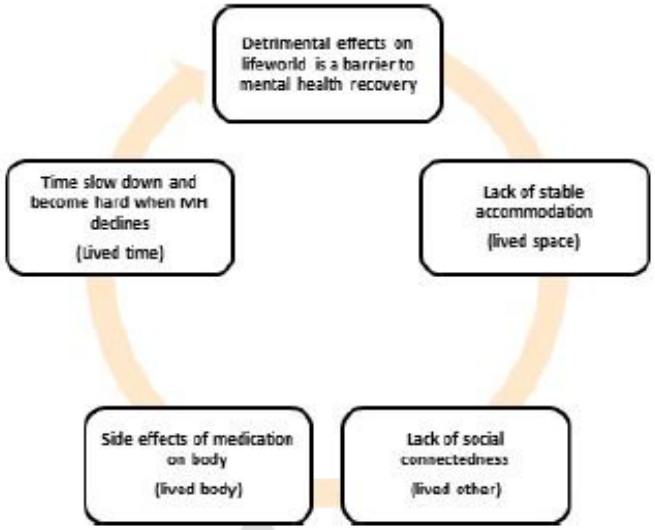
Figure 1: Impediments to mental health recovery



Many themes from this study demonstrated a close relationship with van Manen's (1997b) lifeworld of a person. For example, mental health recovery is impeded when there is lack of stable accommodation (lived space) where a person can live comfortably. Similarly, factors such as side effects from medications affect the body image (lived body) of people with mental illness, persuading the person to be non-adherent with medications. This non-adherence eventually results in a snowballing effect, causing a relapse of mental illness.

Moreover, a lack of relationships and social connectedness (lived other) was identified as another major barrier to mental health recovery. Participants' described the subjective experience of time as 'traumatic' and 'hard' time' (lived time), especially when their loved ones were unwell (Figure 2).

Figure 2: Impediments to recovery and lifeworld of a person



Participants among these three cohorts echoed how negative staff factors damage the progress to mental health recovery. This includes both mental health staff and other supportive allies, such as guardians. Happell (2008b), Jensen and Wadkins (2007) and Mancini et al. (2005) also elicited similar themes that coercive, negative and paternalistic attitudes of staff act as hindrances to mental health recovery. Mental health staff play a major role in empowering consumers (Crane-Ross et al., 2006). However, staff who demonstrate authoritative or indifferent views, and who have difficulty in handing over power to consumers act as barriers to the promotion of recovery (Happell, 2008b, Mancini et al., 2005). For example, Simon (nurse) detailed how some people exert their power over

consumers by telling them what to do, rather than allowing consumers to make their own decisions, therefore preventing or significantly limiting their decision-making capacity. Similar themes were voiced by consumers involved in the study by Mancini et al. (2005), where consumers found their capacity to return to work and make decisions were underestimated by those involved in their care; this, in turn, hampered the process of mental health recovery.

Consumers experience stigma when mental health practitioners undermine the ability of consumers and were paternalistic (Schauer et al., 2007). In contrast, Cleary et al. (2013) found that the application of humanistic principles by staff, such as listening, positive reinforcement, discussion of options and future-oriented approaches, can promote mental health recovery. Many other studies (Siu et al., 2012, Lakeman, 2010, Happell, 2008a, Piat and Lal, 2012) also support the findings of Cleary et al. (2013). Findings by Kidd et al. (2015a) also recommend that mental health services need to address their paternalistic approaches; thus, protective care could be balanced by approaches that encourage self-determination and opportunities for empowerment.

Social factors are pivotal for the recovery process. Such factors include support by the general community, and resources such as staffing, accommodation and community drop-in houses to build social connectedness. Piat et al. (2010) identified the recovery process as a more environmental or social approach to mental health. While this is important, many participants in this study highlighted the issues of lack of resources, such as good staffing and support in the general community. Similar views were found by Happell (2008b) and Jensen and Wadkins (2007) that staff shortages and early discharge were major barriers to mental health recovery. The lack of resources include stable accommodation (Browne and Hemsley, 2010, Browne et al., 2008, Vernon, 2009), and support in society, and the opportunity for social connectedness (Mancini, 2007, Mancini et al., 2005, Pernice-

Duca, 2010). Cleary et al. (2013) identified in their study that, upon discharge, clients move from a highly supported environment to a situation of no support, which negatively impacts on the recovery process. Furthermore, a place in society is important in order for one to identify oneself with the rest of the society (Goffman, 1973) and this reduces social stigma.

Stigma and labelling isolate consumers and their families in the community. More recently, in comparison with previous decades, informative health literature and anti-stigma initiatives have emerged (Arboleda-Florez and Sartorius, 2008, Corrigan, 2011, Corrigan, 2012, Corrigan et al., 2013, Ehrlich-Ben Or et al., 2013, Wallace, 2012). However, participants in the present study suggest that stigma still exists as a major hindrance to mental health recovery. Lefley (1989) delineates the way in which stigma affects both consumers and their families. Similar to the present study, participants from the study by Piat and Lal (2012) reported that stigma and social exclusion were major challenges that they experienced. Piat and Lal (2012) indicate that many individuals across social services have negative attitudes and stigma that hinder the recovery process for people with mental illness. Hatzenbuehler et al. (2013) also argue that stigma is a fundamental cause of population health inequalities. Public labelling and stigmatisation of mental illness can lead consumers to develop and feel stigma and can lead to non-adherence with treatments (Fung et al., 2008, Fung et al., 2007, Bureau et al., 2012).

Other factors, such as the effects of drugs and alcohol and side effects of medications were also highlighted by participants in this study. Illicit drugs and excessive alcohol contribute to a decline in the mental health of people and society (Hart and Ksir, 2013). Use of illicit drugs and alcohol can also increase the need for hospitalisation (Menezes et al., 1996) and is associated with an increase in violence (Soyka, 2000); more specifically, the use of cannabis can cause the onset of schizophrenia (Arendt, Rosenberg, Foldager, Perto, &

Munk-Jørgensen, 2005; Arseneault, Cannon, Witton, & Murray, 2004; Barnes, Mutsatsa, Hutton, Watt, & Joyce, 2006).

Another barrier discussed by participants was the side effects of medications, which then lead to non-adherence with prescribed medications. Similar themes were discussed by Mancini et al. (2005) and Happell (2008b), demonstrating that side effects of medication motivate consumers to be non-adherent with their medications. However, carers involved in this study were more focused on the effects of non-adherence and the decline in mental state. Due to these differing views, the use of medication in the treatment of mental illness is a topic of debate. While the positive effects of medication were discussed by participants (Kartalova-O'Doherty and Doherty, 2011), the negative effects of medication are also concerning for consumers (Brad F et al., 2010, Harrow and Jobe, 2013, Kartalova-O'Doherty and Doherty, 2011).

While consumer and carer participation is a core principle of recovery-oriented practices, risk-aversion in mental health services is a major barrier and is a cause of mistrust being built between consumers and clinicians, including those involved in the decision-making process. Tickle et al. (2014) identified that clinicians are not prepared to consider the broader possibility of taking positive risks due to the risk-aversion focus of services. They suggest that professionals should be encouraged to broaden their conceptualisations of risk and share responsibility among team members, service users, and carers. Tickle et al. (2014) asserted that service users and carers should be included in the decision making process to reduce anxiety about risk and to increase opportunities for taking positive risk, which can promote recovery. The recent changes in the state of Victoria, to the Mental Health Act (VMHA) is an example that bring these above suggestions into actions. For example, the VMHA (Department of Health, 2014) promote Advance Directives and Nominated Persons to enhance consumer and carer participation when making decisions. Also the appointment

of the Mental Health Tribunal (MHT) as the supreme authority to decide the Mental Health Treatment Orders are some strategies that help to prevent the barriers of risk-aversion.

Therefore, to address the barriers to recovery, mental health services should engage in multidimensional facets of service delivery, which include developing a workforce free from paternalistic attitudes, and empowering and encouraging consumers to enhance the likelihood of their participation in the latter. Also recognition of the marginalisation of perspectives on the lived experience is necessary (Radden, 2012), especially in terms of treatment options; services should offer various alternative resources to address mental illness. The issues of lack of resources and support in the community need to be tackled by providing adequate housing options and ensuring follow-up, especially when consumers are discharged from acute services. In addition, a concerted effort is necessary to continue to eradicate stigma in order to build an accepting community that learns to be resilient and supportive in order to accommodate individuals with mental health problems.

Strengths and Limitations

This study identified, through the hermeneutic phenomenological lens of three different cohorts, many factors impeding mental health recovery. Exploring barriers to mental health recovery provides many opportunities for key stakeholders. For consumers, this allows an understanding of the difficulties which impede their journey of recovery. Insight into barriers to mental health recovery provides carers with a better understanding of how to support their loved ones. For mental health services, having an understanding of the impeding factors that influence everyday service delivery will provide opportunities to review and change practices. At a government level, increased awareness of the barriers to mental health recovery can instigate collaborative efforts to influence policy and, thus, further break down these barriers. However, as mentioned in Part 1 of this paper and in line with phenomenological epistemological assumptions, the study outcomes cannot be

generalised (van Manen, 2014). Although other professionals were excluded to make this study feasible, it is also a limitation of the study.

Conclusion

Many western mental health systems are aiming to provide recovery-oriented services to consumers. Therefore, exploring barriers to mental health recovery is a topic of interest in current mental health settings. This study investigated the views of three major groups of stakeholders in relation to the barriers to mental health recovery. It identified a number of influential themes in mental health recovery, such as control, necessity, rejection and struggle (Figure 1). The study highlights that, even though various efforts have been made to address the many hindrances to the re-integration of consumers into the society, the gaps that prevent consumers and families from being empowered in and connected to society, still exist. The study recommends that, to enhance recovery-oriented practices in mental health services, identified barriers needs to be targeted at both an organisational and government level.

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The above article discussed major themes identified by the participants. The following paragraphs further explore and expand some of these themes and discuss some other themes that were not discussed in the article, as follows:

Poor communication, insensitivity and involuntary admission

Poor communication and lack of information was another barrier identified by many participants, especially when consumers were facing the acute phase of their illness. Steve (consumer) said: "the psychiatrist wouldn't explain the illness or how to cope with it. Some psychologists will say 'how does that make you feel?' It's questions like that make you think, maybe they don't know what else to say". Kristy (Carer) affirmed Steve's views by stating that good communication regarding follow-up appointments post-discharge is crucial. She said: "Communication, particularly about things like appointments . . . they sound trivial but I think it's important".

Clinicians using technical terms without explaining what they mean was identified as another issue. Liz asked: "How can I make sense of the term 'involuntary'?" In addition, Liz described the trauma associated with her admission into the inpatient unit. She was working as a full-time physiotherapist and she had few days off. She was feeling stressed and was planning to go for a holiday. Instead she was taken to the hospital. She described what happened:

> The [psychiatrist] came out [and] gave me 60 seconds . . . he lied to me in the 60 seconds and then everyone followed suit. Within 2 minutes, there were 2 cops and 2 ambulance officers at my door saying 'give me your keys, you can't reverse your car'. He said I was psychotic, manic, disorganized and lacked insight . . . I was traumatised.

Liz said that she knew she was stressed and knew how she could manage her stress. However, she was not given the choice of self-management of her stress. She described her discussion with the police:

> I said, "Can I have my pills, I need stuff for stress, can I sit for a minute?" They said "No" and I said, "Can I have a cigarette or water?" and the only thing a medical team will give you is cigarette. I had a choice, ambulance or divvy van. I said, 'What is the difference?" They said, "It will be a lot more dignified in the ambulance and you can tell someone your problems".

David (Liz's husband and carer) also described the involuntary admission as quite traumatic for both Liz and the entire family. He felt that admission into the hospital was not necessary at that stage, as he knew the holiday planned for her would have been more beneficial. He described those events as follows:

> I got a call from the psychiatrist at that time … I didn't know who he was and he is trying to tell me that my wife is in trouble . . . I said to him I understand she is elevated at the moment, but she is in no danger, she is not suicidal, I know more than anybody else. I really resented somebody could call me out of the blue and tell me what's going on with my wife . . . the whole thing was forced on her and not in the best way . . . it was very messy, it really was.

Both Liz and David were describing their encounter with the Crisis Assessment Team. They realised that Liz was stressed and they both hoped that the holiday would relax her. They both deemed that the intervention of the mental health service was inappropriate at that stage. It is not clear whether the clinicians involved in this situation explored other options to manage Liz in the community, nor whether she

was acting in a manner that put herself and others at risk. It is also unclear as to the experience and expertise of the clinicians who made the decision to take Liz into a hospital for admission. However, for Liz and her entire family, the whole admission episode was traumatic and frightening, such expressions reflected the views of participants involved in the study by Wyder, Bland, Blythe, Matarasso, and Crompton (2015) that involuntary treatment was a daunting and frightening experience and the hospital admission provided no benefit for their recovery.

Both Liz and David described the period when Liz was an inpatient; they felt that communication had broken down to a point where they were provided with inconsistent information that frustrated both parties. David said:

> It was time and time again where one person said one thing and 5 minutes later it's another thing . . . I didn't see people screaming at her, but I saw people telling her with a lot of malice and really unkind . . . I say the whole experience to me [was traumatic], just I wouldn't wish it on my worst enemy.

Lack of structure

Peter (consumer) stated one of the biggest barriers he faced was lack of structure in mental health wards, such as lack of various activities that promote mental health recovery. He argued that the word 'choice' has been used fruitlessly in mental health settings in terms of consumer participation in ward routines. Peter explains that staff allow consumers to stay in bed for longer periods in the morning and to boycott group activities on the basis of their 'choice'. He described his frustration:

> What do families think when they come and visit their client [loved one] and they are lying in bed 3 in the afternoon…it's all done on this false idea of choice . . . I believe in choice but it must be within boundaries.

Peter thinks that consumers should work hard for their recovery. He said:

> If I am working with someone I will give them a contract . . . their job is to recover, my job is to facilitate recovery. If I am working 9 to 5 they are working 9 to 5. He went on to say: I want a person working on the recovery from 9 to 5 Monday to Saturday six days a week.

Peters' argument is powerful and inspirational, however, the researcher believes that, in the acute stages of mental illness, people might need respite; therefore their inpatient recovery goals could be reflected accordingly which balances rest and group activities.

Discussion

Mental health recovery occupies a significant focus in the Australian Mental Health System. However, there are many barriers existing in current service delivery that prevent enhancement of recovery-orientated practices. Issues of power struggles, lack of respect, insensitivity, lack of hope and poor communication are some of the ongoing barriers in mental health settings. The National Mental Health Commission (2014) (NMHC) identified that:

> … there is evidence that far too many people suffer worse mental and physical ill-health because of the treatment they receive, or are condemned to ongoing cycles of avoidable treatment and medications, including avoidable involuntary seclusion and restraint. These challenges are compounded by a mental health workforce under pressure, with services experiencing shortages, high rates of turnover and challenges in

> recruiting appropriately skilled and experienced staff. Too frequently, the voices of people with lived experience, their families and support people are ignored, misheard and undervalued" (2014, p. 14).

The findings from this study concur with the findings of the NMHC (National Mental Health Commission, 2014), which summarise the areas that need attention in order to develop and sustain a healthy recovery-oriented mental health system for all stakeholders; such areas include: staff shortages; the unnecessary use of restrictive interventions; and, the lack of consumer and carer participation. The concept of recovery requires considerable openness from service providers, consumers, and carers. Current developments in policies and legislation are good evidence that Australia is striving to improve mental health service delivery, but these policies must be applied and reflected in clinical practice. For example, the recently revised mental health legislations resonates with principles relating to recovery that enhance consumer and carer participation (Department of Health, 2014; The Parliament of Western Australia, 2014). Changes such as 'Advance Directive' and 'Nominated Person' enable autonomy and decision- making capacity, and enhance communication between consumers, carers and service providers.

Summary

In this chapter, participants' views about the major barriers to mental health recovery are explored. These include the themes of: control, rejection, necessity, struggle, power struggles, risk-aversion, poor communication, insensitive practices, inpatient admission, privacy and confidentiality, lack of structure. The findings from this study concur with the findings of the NMHC that summarise the current challenges in the Australian MHS that hinder the path of recovery-oriented reform. The notion of recovery upholds humanistic values such as hope and optimism that can

overturn this chaos into order and harmony. The next chapter focuses on participants' views on the essential elements of a recovery-oriented mental health service.

Chapter 8

Recovery-oriented mental health reform

Introduction

This chapter presents the final section of findings, comprising an exploration of participants' views about what constitutes a recovery-oriented mental health service. This chapter consists of a paper submitted for publication which offers insights from consumers, carers and nurses in relation to recovery-orientated reform in MHS. The findings highlight three overarching themes that are necessary for a recovery-oriented service; firstly, promotion of belongingness by enhancing more resources within the community, developing more peer support programs and increasing therapeutic interactions; secondly, promotion of consumer autonomy by providing choices for alternative therapies and decision-making processes; thirdly, promotion of community awareness by educating key stakeholders about mental health recovery and combatting stigma. This paper argues that, if government carefully considers the above three factors and responds accordingly in conjunction with positive attitudes among staff, the recovery-oriented approach may happen in reality and not be merely confined to policy documents.

Shaping a recovery-oriented mental health service: Insights from consumers, carers and mental health nurses

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Under Review
Contemporary Nurse 2015

Monash University

Declaration for Thesis Chapter Eight

Declaration by candidate

In the case of the paper entitled: *Shaping a recovery-oriented mental health service: Insights from consumers, carers and mental health nurses*, which appears in Chapter Eight, the nature and extent of my contribution to the work was the following:

Nature of contribution	**Extent of contribution (%)**
Concept development, research, original ideas, writing up	70%

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Dr. Ian Munro	Draft review and editing	
Assoc. Prof. Debra Griffiths	Draft review and editing	

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate's and co-authors' contributions to this work.

Candidate's Signature	[redacted]	**Date: 02/11/2015**
Main Supervisor's Signature	[redacted]	**Date: 02/11/2015**

Shaping a recovery-oriented mental health service: Insights from consumers, carers and mental health nurses

Introduction

Application of recovery-oriented practice as everyday business is a core agenda for many mental health services (MHS). Recovery-oriented practice is defined as "an approach to mental health care that encompasses principles of self-determination and individualised care. A recovery approach emphasises hope, social inclusion, goal-setting, and self-management" (Department of Health, 2011b, p.4). The literature pertaining to the implementation of recovery-oriented practices in mental health service delivery, including policy documents and legislation, is growing (Anthony, 2000; Davidson, 2007; Department of Health, 2009, 2011a, 2011b, 2014; Department of Health and Ageing, 2008, 2013a, 2013b; Le Boutillier et al., 2011; Mental Health Association of New York City, 2013; National Institute for Mental Health in England, 2005; New Zealand Minister of Health, 2005). Recovery-oriented practice involves recognition of several facets, including: the consumer's lived experience; hope-oriented practices; social inclusion; consumer empowerment; and, consumer and carer involvement in treatment development and decision- making (Mental Health Association of New York City, 2013; National Institute for Mental Health in England, 2005; New Zealand Minister of Health, 2005).

While government mental health policies promote recovery-oriented practices in service delivery, knowledge about the practical application of recovery-oriented care principles is necessary among key stakeholders, such as consumers, carers and service providers, who are in the "front-line" to implement recovery-oriented practices in everyday service delivery. Therefore examining the views of these front-liners on recovery-oriented practices is crucial. The literature demonstrating research that explores the views of key stakeholders on recovery-oriented care in mental health care is limited (Gale & Marshall-

Lucette, 2012; Hungerford, 2013a; Kidd, Kenny, & McKinstry, 2015; Le Boutillier et al., 2011; McKenna et al., 2014) . Therefore, this study aimed to explore the views of three key stakeholders' – consumers, carers and mental health nurses – in relation to factors that promote a recovery-oriented approach in mental health settings.

Method

Van Manen's hermeneutic phenomenological method was used in this qualitative study. Phenomenological research is an "explication of phenomena as they present themselves to consciousness" (van Manen, 1997, p. 9) and enables a researcher to "systematically uncover . . . the internal meaning structures of lived experience" (1997, p. 10). The authors were guided by van Manen's life-world existential themes such as lived body (corporeality), lived time (temporality), lived space (spatiality), and lived other (relationality) (van Manen, 1997, pp. 101-102). Twenty-six participants were recruited to the study, which included nine consumers, eight carers and nine mental health nurses. All participants were from the community settings of an Area Mental Health Service in Victoria, Australia. Consumers who were receiving voluntary treatment, with an Axis 1 diagnosis and living in community settings, were included in the study. Consumers in acute inpatient units, and those on Community Treatment Orders (CTO) and/or acute care follow-up in the community were excluded from the study. Carers such as support workers or family members who were actively involved in the care and treatment of consumers were recruited into the study. Mental health nurses recruited to the study were those with postgraduate qualifications in mental health and at least two years' experience, and registered or enrolled nurses who had been working in mental health for more than five years. All the interested nurses recruited to the study were community mental health nurses.

Ethics considerations

Ethics approval was sought from the Area Mental Health Services Human Research and Ethics Committee and the university's Human Research Ethics Committee. Participants were given verbal and written information before obtaining consent. In order to ensure the confidentiality of participants, pseudonyms were used.

Data collection and analysis

Green and Thorogood (2009) suggest that, in order to build the trust of participants, personal sharing and a friendly approach would be helpful. Otherwise, a fast-paced or rushed interview can generate an impression of 'data raid' as Schneider, Whitehead, and Elliott (2007) described. Therefore the participants were initially orientated to the environment by the researcher and had an initial informal chat to develop rapport and a relaxed environment. Informed consent was obtained after providing verbal and written information about the study and participants' rights, such as the right to withdraw from the study at any stage without any care or work-related compromise until coding of the data. van Manen (2014, p. 316) described the specific purpose of hermeneutic phenomenological interviews as " . . . exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon and . . . to develop a conversational relation with the interviewee about the meaning of an experience". The researcher sought to gain a rich and unique description of the meaning attributed to mental health recovery by participants' as they individually perceived it. The initial informal discussion helped the researcher to build a conversational relation with the participants and, when participants were settled, in-depth interviews were conducted using a semi-structured core questionnaire, which was slightly amended according to the cohort. An in-depth description of the data collection and analysis is described in (Jacob, Munro, & Taylor, 2015).

Data analysis

In-depth data analysis was guided by approaches proposed by van Manen (1997) in order to uncover themes (Jacob et al., 2015). The themes were identified, highlighted and clustered. A line-by-line analysis of the clustered data was carried out using the life-world existentials introduced by van Manen (1997). This process helped the researcher to conduct a structured analysis of the data (van Manen, 1997). The emergent themes from each cohort were clustered under subthemes and themes (Table 1). Similarly, the differences in the views were identified and integrated into the derived understanding of factors influencing mental health recovery.

Table 1: Theme development

Texts	Sub themes	Themes	Lifeworld existential
"I would like to see drop-in houses where people can drop-in and have a coffee or chat…where you can socialise and just catch up and have common ground and a common place…" (Ryan- Consumer) "…the carers of people with mental illness don't get the right help. I went into respite for a while… but there's always a part of you that makes you wonder what's going on back there." (Cathy- Carer) "…getting people to use their usual supports in the community, as well as, added support of the health professionals is much less restrictive … and I think people recover quickly in a community and don't feel as embarrassed as someone admitted into an in-patient setting." (Rosie- Nurse)	Community resources	Promotion of belongingness	Lived space
"I have read a book about the Power of Now and if you can only think about the present it takes away the pain of the past. That's quite a good technique to use" (Jodie- Consumer) "…The treatment [non-invasive] like TMS[1] and Open Dialogue[2] should be available for voice hearers . . .(Jack-Carer) "… I think good recovery focused support will reduce the amount of dependence we have on medication…."(Simon-Nurse)	Choice for alternative therapies	Promotion of autonomy	Lived body

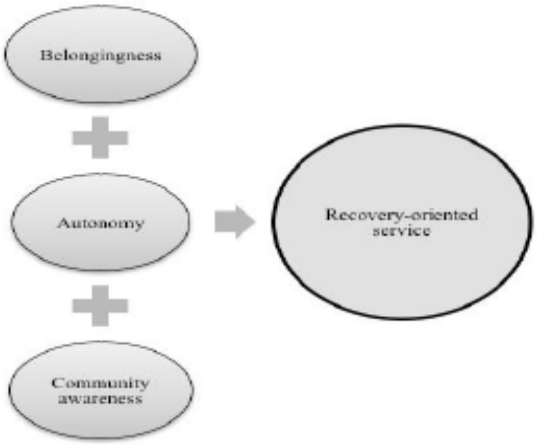
Themes

Participants identified various elements of a recovery-oriented mental health service, which formed several similar themes. These involve: the desire for increased resources; more peer support; increased therapeutic interactions; a choice for alternative therapies; decision-making; more education about recovery principles and recovery-oriented practices; and, combatting MH stigma. These concepts were clustered under three overarching themes comprising: promotion of belongingness, encompassing community resources, peer support

[1] Trans Magnetic Stimulation Therapy
[2] Narrative Therapy

and therapeutic interactions; promotion of autonomy, encompassing decision-making, choices for alternative therapies and independence; and promotion of community awareness, encompassing education of key stakeholders and combatting stigma (Figure 1).

Figure 1. A recovery-oriented mental health service



Promotion of belongingness

The need for belongingness in mental health is seldom explored. Hagerty, Lynch-Sauer, Patusky, Bouwsema, and Collier (1992, p. 173) defined "*sense of belonging* (author's italics) as the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment'. Participants involved in this study stated that a recovery-oriented mental health service promotes community resources, peer support and therapeutic interaction. Part of belongingness in a community involves having resources such as community houses and respite centers where consumers can feel connected to a community. Belongingness involves the ability to have meaningful relationships with people who have similar experiences; it can also be fostered in mental health care through the application of core principles of nursing, such as empathetic listening

and therapeutic interactions, rather than focusing on medication adherence and undertaking paperwork.

Community resources

Consumers' views

Some consumers felt greater access was needed in the community through drop-in houses to enable them to catch up and socialise. Being connected to a community may allow the consumers to feel they have a common ground to ensure equality with the rest of the community (Goffman, 1973). Ryan's statement in Table 1 above provides a powerful example of this.

Carers' views

Table 1 provides a carers' view about respite services for carers in current mental health services. According to Cathy, sometimes carers need extra help and a break from caring from a mentally unwell relative.

Nurses' views

Nurses also viewed resources (Table 1), including community houses, stable accommodation, and funding, as important aspects in building a recovery-oriented mental health service. Some nurses thought that, for some consumers, long-term facilities were appropriate. Aaron stated: "On paper, we are a recovery-oriented system. In reality there is a long way to go . . . we do need long term facilities back again . . . the quality of life for some patients is at such a low level and they would benefit from being in institutions (sic) where they can live for a long period of time . . . some patients who live in some Supported Residential Services and boarding houses where the quality of life is next to zero". Whereas Melissa said: "…recovery is a healing process. I would look much more at creating smaller

houses and community settings in local environments where people could come and spend 2 or 3 days in acute distress . . . and then send (sic) back out again".

Many nurses raised the need for increased funding for mental health services in order to promote recovery-oriented practices. Norman argued that similar to youth services, adult services also need greater funding resources to promote continuity of care. He said: "youth team had lots of resources, Occupational Therapists and Psychologists and when they got to a certain age they were transferred to adult services . . . that just had a case manager and none of those supports they had . . . I think that is problematic".

Peer support

Consumers' views

Peer support was seen as central to a recovery-oriented mental health service and described as a resource outside the usual support network. Ryan was referring to services such as Personal Helpers and Mentors Program (PHaMS), NEAMI National and Persons in Recovery (PIR) where peer support workers assist the individual needs of the person with mental illness (Aftercare, 2012; Neami National, 2014). Ryan believed: "They [peers] are addressing certain conditions that we have . . . [and] sometimes key workers [and family members] can only go so far, so peer groups provide services and support outside the umbrella".

Carers' views

Carers favoured the integration of mental health care in community settings. They preferred less restrictive environments such as Community Care Units (CCU), and resources such as Personal Helpers and Mentor (PHaMs) programs, and respite services. Kristy felt the work of PHaMs with her son was 'wonderful'. She stated that:

> those sorts of programs [PHaMs, NEAMI National, PIR] are not well funded . . . there is a real need for more community assistance so that people can start moving along . . . given the large number of people there are in the community with mental illness they could be putting more work into those kinds of support services.

Nurses' views

Melissa asserted the need for understanding the role of peer support. She said: "peers can be helpful in process . . . things like Hearing Voices Group and other groups based on self-help and moving forward . . . however there is always some danger in self-help as in any other group that they become stagnant . . . and people don't make changes."

Therapeutic interactions

Consumers' views

Some consumers valued therapeutic interactions over medications and other task-oriented activities. The therapeutic interactions involved some core principles, such as listening and communication. For example Mark said: "I was going to say to people to listen, but it's difficult for them [service providers] to listen . . . they've to fill out paperwork . . . [there needs to be] less medication and more talking, more listening and acknowledging the pain", whereas Peter suggested that allowing consumers to write their own notes may

promote more interaction and less focus on paperwork. He questioned: "I think consumers could write their own notes. Why do staff need to be sitting in offices writing notes, why not be with the client to write the notes and sharing that time?"

Carers' views

Emily described the heightened stress carers undergo when their loved ones are admitted into hospital. She explained the inability of carers to take anything on board during the initial stage of admission due to the intense stress. The busy nature of service providers' work hindered the therapeutic time available for consumers and carers. She said: "listening to carers . . . and more interaction . . . carers want to sit and talk to people . . . sometimes you feel there is no one else you can talk to . . . nurses were pretty good, but . . . you couldn't get onto them because they are so busy on the ward."

Nurse's views

Nurses highlighted the need for empowerment of consumers to enable them to take responsibility for their own journey. Zac said: "Make them [consumers] aware, it is their journey . . . they need to take responsibility for their own behaviours and what they do in their lives."

Promotion of autonomy

Harnett and Greaney (2008, p. 3) describe autonomy as "an individual's capacity to engage in rational decision making and disregard or choose options while remaining free from coercive elements". Participants in each cohort involved in this study expressed the view that a recovery-oriented mental health system should ideally be promoting the autonomy of consumers. This involves promoting independence and decision-making, and providing choices for treatments such as alternative therapies.

Choice for alternative therapies

Consumers' views

The effects of alternative therapies on mental health well-being is well explored by Shannon (2002). Consumers considered various treatments such as alternative therapies and other stress reduction strategies as important. Steve suggested that "massage therapists [should be] included in the hospital. When I am stressed my body is like a cement brick, I am that tense and if there was somebody massaging the knots out of it would benefit the mental illness aspect of it. I have physical and mental illness in one, one kind of support the other."

Carers' views

Carers like Jack were in favour of implementing non-invasive therapies such as Trans Magnetic Stimulation (TMS) and Open Dialogue in Australia. Jack was very critical of doctors; he believed that drug companies are still providing benefits to doctors for prescribing medications, regardless of the systems in place to monitor and regulate this (Australian Medical Association, 2014). Jack asserted: "One of the reasons for not having these [non-invasive treatments like TMS and Open Dialogue] are they [MHS] think it's too expensive, but really in the long term it will be cheaper. Imagine being able to live without mental illness . . . they will soon get the money tenfold back if it was more available".

Nurses' views

Melissa thought medication had detrimental effects on one's brain's chemistry. She said: "Research is now showing the brain changes [in schizophrenia] are due to childhood trauma or usually the result of the antipsychotics given." Melissa's views concur with those of Harrow and Jobe (2013), who argued that antipsychotics make the consumers more biologically vulnerable to psychosis and there is risk of developing drug resistance.

Decision-making

Consumers' views

According to Liz, when one is unable to make decisions due to the effects of mental illness, it was deemed appropriate to hand over the power to someone close to them. Liz's views merged with the principles of the Advance Statement according to the Victorian Mental Health Act (Department of Health, 2014). For example, Liz stated: "In the past I had said my husband is the one who can tell me if I am going off the rails and I can't see it myself, he will be the first one I will listen to."

Carers' views

One carer, Emily, was frustrated when she described her experience of referring her daughter to MHS when her daughter was unwell and was unable to make decisions. She felt that the MHS did not listen to her due to privacy and confidentiality issues. She asserted: "We couldn't get anybody to listen to us [due to privacy and confidentiality] . . . I don't think . . . people would say things just to get a person locked up."

Nurses' views

Russell advocated for clients regarding their capacity to make decisions. He said: "I think you have to be more mindful about decision making and if the person themselves can give informed consent, we need not to be flippant about making decisions on their behalf, we need to take it very seriously."

Promotion of community awareness

Deinstitutionalization and community-based care for consumers were deemed to be more humane than previous highly institutionalised care (Parker, 2013). However, social constructs of mental illness and a heightened level of social stigma diminish the integration of consumers into the community. The participants from two cohorts (carers and nurses) identified that recovery-oriented mental health services increase community awareness through participation in health promotion activities such as education and combatting stigma.

Education

Carers' views

Carers believed that education regarding mental illness and recovery was important. For example, Kristy claimed: "I think there needs to be . . . more information and sharing with [carers]." Emily also had strong views about the need for education for carers. She stated: "If there was an education session for carers . . . even if it was only a day, I think that would help." She thought that education about mental illness generates awareness among teenagers and younger children, and that this might in turn assist in the long-term reduction of stigma.

Nurses' views

Nurses also perceived education was an important aspect to move towards a recovery-oriented system. For example, Kim described: "Training . . . getting it out there that this is the model and having people doing the recovery training . . . and funding for education."

Combatting stigma

Carers' views

Lucy's description of the community's attitude towards people with mental health problems depicts the stigma existing in society towards mental illness (Goffman, 1973), that affects both people with mental health issues and those who stand up for them. She said: "I would tell them, [people in community group] but I am outnumbered . . . they don't understand . . . they are not tolerant."

Nurses' views

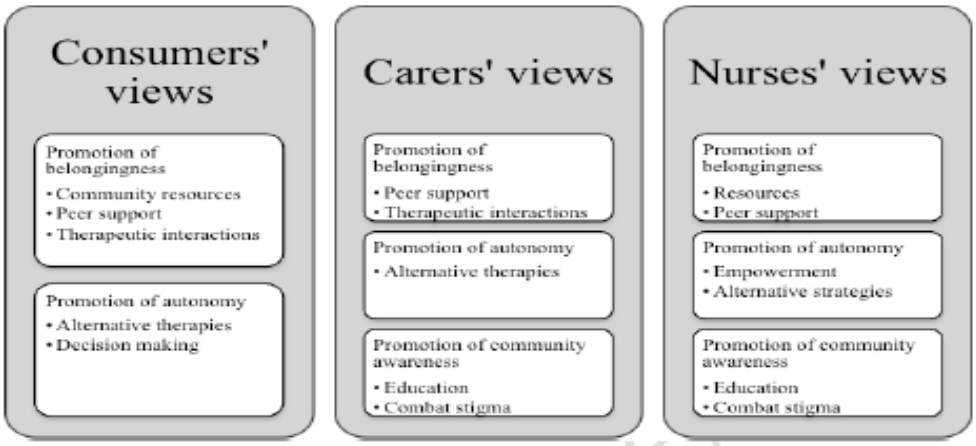
Some nurses' argued that generating positive awareness about mental health through media campaigns such as Sane's StigmaWatch (Sane Australia, 2014) and Scotland's program, (Government of Scotland, 2014) are beneficial. Melissa pointed out: "We have to work much more with communities to understand mental distress, not to be frightened of psychosis, to be much more accepting and that's a lot of work."

Discussion

Participants from these three cohorts had differences and similarities in their views (Figure 2). The consumers' views were largely focused on the promotion of belongingness and autonomy. Carers and nurses had similarities in their views to those of consumers, but emphasised the need for promoting community awareness. Many findings in this study concurred with the findings arrived at by McKenna et al. (2014), such as promoting

autonomy, self-determination, collaborative partnerships, meaningful engagement, community participation and citizenship.

Figure 2: Differences and similarities in the views

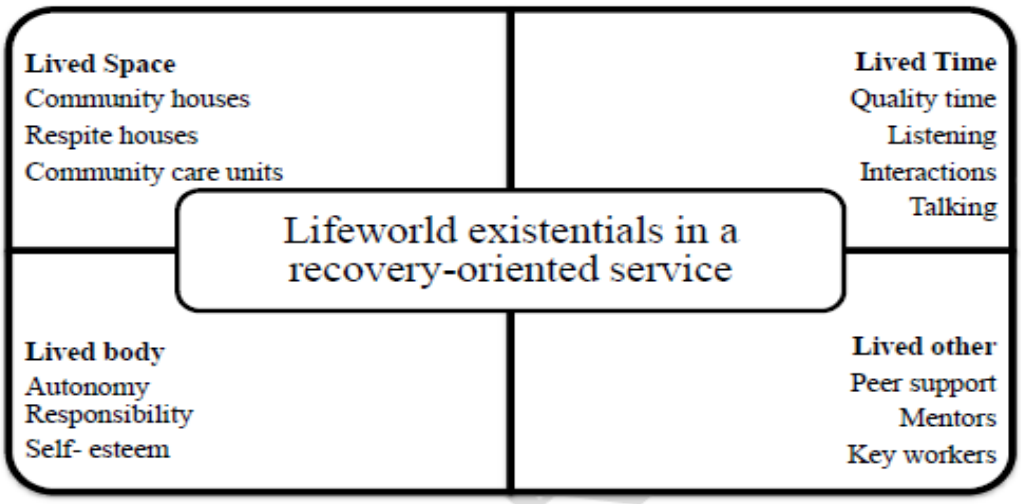


Lived world forms a recovery-oriented mental health service

The three cohorts in this study identified many factors that form a recovery-oriented service. Van Manen's (1997) 'life world existentials theme' was woven throughout these views. The incorporation and promotion by van Manen (1997) of lifeworld – that is, lived body, lived space, lived time and lived other – are found to be essential components in a recovery-oriented service (Figure 3). For example, participants described the importance of having community resources (lived space) such as drop-in houses and respite houses, and person-centeredness (lived body), where the person felt a sense of self as respected and that s/he was able to choose how he/she wanted to manage their illness. Being able to spend therapeutic time (lived time) with key workers was also seen as important. To have support from various allies such as family, peers, friends and key workers (lived self-other) was also seen as constituting part of recovery-orientation. Incorporating these factors into service

provision may enable mental health services to be more recovery-oriented and treat the person as a whole, rather than addressing only the sickness present.

Figure 3: The lifeworld in a recovery-oriented mental health service



Despite the 'recovery-oriented approach' existing as a well-used term in many mental health settings, there are limited studies that highlight the views of key stakeholders to this approach (Gale & Marshall-Lucette, 2012; Hungerford, 2013a; Kidd et al., 2015; Le Boutillier et al., 2011; McKenna et al., 2014). Generally, participants in the present study had positive views towards recovery-oriented reform, compared to those demonstrated by Piat and Lal (2012) study, where participants discussed both positive and sceptical views towards the recovery-oriented reform.

The cohorts in this study identified the importance of belongingness in the community through the allocation of increased resources, such as community houses, respite services, community-based treatments, group programs and funding to make all these possible. Similar views were expressed by decision- makers involved in Piat, Sabetti, and Bloom (2010) study, which found that community-based services were most open to recovery-oriented approaches

and can be more easily implemented in the community. Facilitating community- based treatment options, where consumers could comfortably receive treatments and drop-in houses where they can socialise, may also enhance their feeling of acceptance and equality within the community (Goffman, 1973). Besides this, peer support is critical in helping people to overcome barriers to recovery and social isolation. Therefore, incorporating services such as NEAMI National, PHaMs and PIR in public and private mental health care is an investment in establishing a recovery-oriented MHS.

Participants in this study believed that, in order to shape a recovery-oriented mental health service, the focus of current mental health service needs to shift from the traditional medically-dominated system of providing services, to facilitating a multifaceted service for consumers. Atterbury (2014) argues that recovery is a necessary approach that should be available to all and should not be an exceptional intervention for a few. The participants had similar views that a recovery-oriented service promotes therapeutic interactions more readily than medication management and paperwork. Peter (consumer) felt that service providers were spending 70% of their time completing paperwork. It is possible that service providers could fall into routines tasks such as visual observations and conducting mental status examinations and risk assessments rather than spending time on empathetic listening and enhancing recover-oriented interactions.

Participants asserted recovery-oriented mental health services promote autonomy of consumers. In a recovery-oriented system, the person with mental health difficulties is encouraged to be perceived as an expert by their lived experience (Slade et al., 2012). Enabling this autonomy for consumers to write their own notes and be central to their treatment will strengthen a user-driven mental health system, as referred to by Ning (2010). Additionally, the ability to have choices for alternative therapies, empowerment and decision-making also promote autonomy. Various alternative therapies had proven benefits, such as art

therapies (Van Lith, Fenner, & Schofield, 2011; Van Lith, Schofield, & Fenner, 2013), music therapy (Solli, 2013) Trans Magnetic Stimulation (TMS) (Slotema, Blom, Hoek, & Sommer, 2010) and Open Dialogue (Seikkula et al., 2006). A review conducted by Slotema et al. (2010) concluded that repetitive TMS should be considered as a clinical treatment method for depression, auditory hallucinations and possibly for negative symptoms of schizophrenia. The effectiveness of TMS (Slotema et al., 2010) and Open Dialogue (Seikkula et al., 2006) has been proven; however, these were not readily available in the local MHS as a treatment choices.

The ability to access non-invasive therapies might give consumers a sense of normality, as they are not relying on medications to enhance their mental health. Making their own decisions and taking responsibility for their own actions promotes citizenship (Le Boutillier et al., 2011) and enhances shared decision-making. Matthias (2012) found that, even though a high level of person-centeredness was present in a recovery-oriented service, shared decision- making was not prevalent. This raises concerns that, if a recovery-oriented approach is not applied diligently, the recovery-oriented reform may be mere rhetoric.

One aspect of health promotion is the incorporation of education. Education of key stakeholders can address lack of knowledge about mental health recovery and address differential power relationships between service providers and service users (Kidd et al., 2015). The carers and nursing cohorts in this study saw the importance of education in order to move towards a recovery-oriented service. The lack of understanding of the current concept of mental health recovery by carers was examined by Jacob et al. (2015) and Hungerford (2013a). These studies identified that carers' understanding of the current concept of mental health recovery was insufficient. Hence, generating awareness among carers through support and family education (Davidson, 2007; Lloyd, Deane, Tse, & Waghorn, 2009) will help to address this gap. Education of recovery principles may also

assist in improving the confidence of service providers to provide recovery-oriented services (Gale & Marshall-Lucette, 2012) and increase consumer optimism among service providers (Tsai, 2010). Hungerford (2013b) uncovered that, even when service providers were given education about recovery principles they felt 'ill-equipped' to manage complex issues. Additionally, Gale and Marshall-Lucette (2012) found there was a gap existing in relation to incorporating recovery education in nursing education curriculums. Thus, providing education about recovery principles and approaches, with practical applications to address complex issues within multidisciplinary teams, should be considered (Tse, 2013).

Stigma is a stumbling block and a challenge in the promotion of recovery-oriented practice (Piat & Lal, 2012). Stigma prevents the person from being accepted and valued within society (Corrigan et al., 2005; West, Hewstone, & Holmes, 2010). Carers and nurses in this study had strong views about combating stigma as part of a recovery-orientation. They suggested that generating community awareness through education and linking mental health care through primary care settings are some interventions that may address stigma. Some nurses believed that receiving care in the community, as opposed to in in-patient settings, can boost self-esteem of consumers, increase social connectedness and may reduce their internalised stigma (Corrigan, Kosyluk, & Rüsch, 2013; Sibitz, Provaznikova, Lipp, Lakeman, & Amering, 2013).

Limitations

While this study provides valuable insights from the perspectives of participants, van Manen (2014) argues that generalisation of findings is not possible with phenomenological studies, as phenomenological studies always seek for new insights. Therefore, in line with qualitative epistemological assumptions, the themes derived cannot be generalised. The other limitation included the exclusion of other professionals to make this study feasible. Therefore, in order to generate further evidence, comparative studies involving various major stakeholders across Australia would be beneficial.

Conclusion

Promoting a recovery-oriented services across mental health service delivery is generally accepted as a modern approach to service delivery; however, there is a paucity of literature that examines the views of key stakeholders such as consumers, carers and service providers. While local policy documents (Department of Health, 2011a; Department of Health and Ageing, 2010) uphold a recovery-oriented approach, according to participants in this study, there are a number of changes required for the current service to reflect a truly recovery-oriented service. These changes involved promotion of belongingness by enhancing more resources within the community, developing more peer support programs and increasing therapeutic interactions. Promotion of autonomy can be achieved by allowing consumers to choose alternative therapies, thereby taking charge of their decision-making process. Promotion of community awareness can be facilitated by educating key stakeholders in relation to mental health recovery and combatting stigma.

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The above article explored some key elements of a recovery-oriented system such as resources, peer support, alternative therapies, decision-making, therapeutic interactions, empowerment, education and combatting stigma. The following paragraphs build upon these themes and explore various other minor themes discussed by the participants, such as legislative changes and decreasing the dependency of consumers within the mental health system.

Changes in legislation

Peter (consumer) thinks that, in order to create a recovery-oriented mental health system in Australia, there should be some major changes in legislation such as a National Mental Health Act, rather than each State producing its own legislation, and tighter guardianship laws. He said: "Get rid of all the State Mental Health Acts and have one to cover Australia." Currently, some States, such as Victoria, New South Wales, South Australia and the Australian Capital Territory, allow reciprocal arrangements for mental health treatment (Fitzroy Legal Service Inc, 2013). However, Peter thinks that a National Law should be the ideal to standardise mental health care across the entire country. Aaron (Nurse) states that the AMHS is a "recovery-oriented service on paper", but not in practice. Aaron is indicating that the attitude of staff in the AMHS is yet to be shifted towards the recovery-oriented culture; this might not only be the case of one AMHS, but may also be the situation at the national level. For example, the recent report of the 2014 National Mental Health Commission (NMHC) criticises the current state of the Australian MHS as follows:

> The need for mental health reform has had long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Instead of a "mental health system"—which implies a planned, unitary whole—we have a collection of often

> uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice (National Mental Health Commission, 2014, p. 38).

The commission's report is an eye-opener and an assertion that, currently, recovery-orientation in Australia is mere rhetoric and there is a long way to go in terms of the application of recovery principles in service delivery. In order to achieve this, the NMHC recommends that the Commonwealth confirm its primary roles in mental health as being in national leadership, where a national approach is efficient and effective, and in enabling regional integration around the needs of people, their families and communities. In order to apply recovery principles, major investment in the development and education of the key stakeholders, promotion of health, re-integration of consumers into society and a nationally coordinated system that delivers standardised best practices across States and Territories are needed. A system that promotes greater consumer and carer participation in policy development, recruitment and education of mental health clinicians, as well as greater autonomy for consumers, are some of the high ambitions of a recovery-oriented mental health system. In order to achieve this, a planned and unitary mental health system must be developed in Australia.

Guardianship was another point discussed by Peter, who stated: "I would only expect people with severe learning disability or adults well into dementia to ever be under guardianship, I wouldn't expect young men or women to be under guardianship". Peter is arguing that placing young consumers into situations where a guardian has been appointed will disable and prevent them from taking responsibilities. However, there might be times where some people with severe mental illness need guardians to act in their best interest. In Victoria, the policy of

guardianship was introduced during the deinstitutionalisation in the late 1980s (Dearn, 2009). Guardianship may be considered when a person with a disability cannot make reasonable judgements about their own personal and lifestyle affairs, and there are concerns about the decisions they are making, or others are making for them. The guardian may be appointed if there are different views which cannot be resolved about what is in the best interests of the person with the disability, and a decision needs to be made (Office of the Public Advocate, 2015) (OPA). The data indicates that, since 1988, there has been an increase in the number of guardianship cases managed by the OPA. The total number of new guardianship orders made by the Victorian Civil and Administrative Tribunal (VCAT) per year increased from 442 orders in 1987/88 to 970 orders in 2007/08 (Dearn, 2009). The researcher did not explore the reason for this substantial increase in guardianship orders over the last two decades, as it is not the focus of this study; however, Peter's comments might be relevant to consider in light of this increase in numbers to understand whether it is a reflection of the paternalistic approach of the mental health system.

'Create victors not victims'

Many participants identified that, the longer consumers are in the mental health system, the more they learn to be dependent. Peter (consumer) was sure about this, as he stated: "The longer a person is in our system, the longer they're going to stay in the future, because they become accustomed to being a victim. We need to create victors if we want to achieve recovery". To attain this, Peter argues that handing responsibility back to consumers is imperative along with working collaboratively with them to develop achievable recovery goals. Similar themes are expressed by Simon (nurse): "For a nurse, I feel the recovery model is very liberating, because we are saying we are handing over the responsibility, because we shouldn't

have had it in the first place . . . this should be the ownership of the person creating their own destiny, taking that journey." Simon states that clinicians with paternalistic attitudes are "taking away the essential independence [of consumers]." In order to create victors, promoting autonomy is a cornerstone, and this has been discussed in the article included in this chapter.

Summary

This chapter draws upon the insights of participants' in relation to a recovery-oriented MHS. Participants identified that many improvements are necessary for a recovery-oriented MHS such as: peer support; alternative therapies; resources such as community based services; person-centered care; quality time spent with consumers; education regarding mental health recovery; and, a stigma free society. Many of these elements are identified in some of the government reports (Department of Health and Ageing, 2013c; Edeson, 2012; National Consumer and Carer forum of Australia, 2005; National Mental Health Consumer & Carer Forum, 2011). The State legislative changes and the National MH policy framework in Australia (Department of Health, 2014; Department of Health and Ageing, 2013a, 2013b; The Parliament of Western Australia, 2014) are some of the significant initiatives from the government levels aimed at fulfilling the identified needs. While there has been significant progress in mental health reform, the National Mental Health Commission (2014, p. 38) concludes that "Australia still has a long way to go in designing and delivering a quality, high-performing mental health and suicide prevention system". Hence, careful reallocation of funding to community-based services and promotion of easy access to self-help options to help consumers, carers and communities to support themselves (National Mental Health Commission, 2014) are also strategies that might assure Australia is firmly on the path towards recovery-oriented reform.

Chapter 9

Conclusions and recommendations

Introduction

This chapter represents the end of a journey. In this journey, the researcher explored the experience of mental health recovery for consumers, carers and mental health nurses via the lens of van Manen's hermeneutic phenomenology. This research helped the researcher to gain an in-depth understanding in relation to the concept of mental health recovery from a three-dimensional perspective. In this chapter, the researcher concludes with the essential insights identified by the participants, including the recommendations drawn from those insights.

Summary of this research

This research study highlighted many insights and challenges that exist in current mental health care service delivery. The unique stories of individual participants were inspiring and sometimes emotionally moving. Twenty-six participants (nine consumers, eight carers and nine mental health nurses) contributed to this research. Individuals described how they personally experience the phenomenon of mental health recovery, how other factors influence the phenomenon of mental health recovery, and shared their insights in relation to a recovery-oriented mental health system. The research also highlighted the differences in the experiences of mental health recovery and factors influencing mental health recovery. These differences and similarities in the individual views explained some of the dilemmas that exist in mental health care.

There are many challenges affecting the current mental health system nationally and internationally, and these were highlighted in Chapters 7 and 8. These include: individual and community stigmatising attitudes towards people with mental

health issues; negative connotations that consumers and carers receive from society; and, lack of awareness about mental health recovery, which highlights the need for community health education programs for consumers, cares, and other stakeholders. Many participants highlighted the necessity for increasing community awareness about mental health issues and greater support for people with mental health issues and families. Many participants suggested the need for increased peer support, more community resources and better access to alternative therapies in order to improve the current service delivery. The majority of the participants from the three cohorts highlighted how negative and paternalistic attitudes of mental health clinicians hindered the process of mental health recovery.

Recommendations

Some recommendations based on the findings of this research are made and are highlighted herein.

Implications for education

1. Education for service providers: From this research, the researcher understood that there was a positive attitude towards mental health recovery among nurses who were educated in relation to the concept of mental health recovery. This indicates that adequate education of the workforce will benefit the successful transformation to a recovery-oriented mental health system. In New Zealand, the policy statements outline the recovery approach and the required competencies of the mental health workforce (Lloyd et al., 2004). The Standards of Practice by the Australian College of Mental Health Nurses (2010) (ACMHN) provides competency standards for nursing members, though not all mental health nurses are members of the ACMHN, and these

standards are also not inclusive of other professionals. Many online resources exist; for example, the ‘Recovery Library’ resources developed by the Centre for Psychiatric Nursing (2015) is a great initiative and allows more flexibility for the workforce to gain access to evidence-based literature. While this momentum persists, the Australian mental health system should require specific education in the area of mental health recovery, demonstrating knowledge as a required competency for practice for the mental health workforce.

2. Recovery education in a multidisciplinary curriculum: Developing a workforce grounded in recovery-oriented principles and practices is essential to sustain the recovery-oriented care model in mental health service delivery. Therefore, revisiting the undergraduate and post graduate curriculum of various disciplines such as medicine, nursing and other health sciences to incorporate recovery-oriented educations should be a focus. While this approach is suitable for new staff, development for existing staff should also be considered and can be achieved by setting recovery education as a mandatory requirement in mental health services.
3. Mental Health Recovery Education Program (MHREP) for Consumers and Carers: Consumers and carers need more information about mental health recovery and the various approaches to promote their recovery from mental health issues. Information in relation to available resources, changes in mental health legislation and policies, how to access other services to compliment the life they wish to lead, for example, living an independent life or gaining work and so on, would enable their independence and self-directed learning. An initiative such as Mind Recovery College by MIND Australia (2015) should

be available for consumers across Australia. Also MHREP initiated by Mental Health Services for those who access both Acute and Community services will be beneficial. As discussed in Chapter 5, carers have a very different understanding in relation to the concept of mental health recovery. Some carers think that mental health recovery is impossible. In order to combat these barriers, flexible education programs that facilitate online and face-to-face education sessions, must be developed and delivered for mental health carers and families. For example, education provided through non-government organisations such as MIND Australia (2015), and Mental Illness Fellowship (2011) are beneficial for many carers and family members. However, government initiatives to provide on-going education services for carers and family members who access public mental health services are also necessary.

Implications for clinical practice

4. Peer support for staff: Peer support is beneficial for consumers, carers and service providers. Participants from the three cohorts acknowledged the need for support for frontline service providers, consumers and carers in order to be proficient in recovery practices. Peer support for staff to enhance recovery-oriented practices is not established in the Australian MHS. The use of peer support groups represents an alternative approach to facilitating the development of staff skills that is not dependent upon the continued involvement of external specialists. In this approach, staff members are encouraged to meet regularly in small groups, to support each other in their day-to-day work and in the use of new skills for the management of residents with challenging behaviours (Davison et al., 2007, p. 869). Adopting the

recovery approach can be challenging for many staff due to various reasons, such as being accustomed to the medical model of care for longer periods and the existence of complex mental health issues. Hence, support of staff who struggle to embrace the recovery approach by those who hold the values of recovery principles will build a central support program to develop staff into competent role models of the recovery approach.

5. Consumer Workforce Development: There is evidence in relation to the benefits of peer support for consumers (Bouchard, Montreuil, & Gros, 2010; Lawn, Smith, & Hunter, 2008; Ostrow & Adams, 2012; Wallcraft, 2012). Findings from this study suggests that peer support provides 'supports outside the usual umbrella' (Ryan). Developing a workforce who are experts by experience will enable mental health services to provide efficient and cost-effective service delivery to consumers.
6. Partnership and sharing: Collaboration and a listening environment are appreciated by many consumers and carers to aid the recovery process (Cleary, Freeman, & Walter, 2006; Hitchen et al., 2011; Ridley, Hunter, & Rosengard, 2010). Many consumers and carers in this study identified that clinicians spend the majority of time on paperwork rather than with their clients. Involving consumers in activities such as the handover process (Australian Commission on Safety and Quality in Health Care, 2014), visual observations (Department of Health, 2013) and writing their own mental health and risk assessments could address this concern to some extent. Service providers in a recovery-orientation are considered as partners in recovery (Gehart, 2012). Therefore, mental health service providers need to step back

from the hierarchical approach to adopt more of a partnership relationship (Mancini, Hardiman, & Lawson, 2005).

7. Recovery-oriented model of care: Setting the recovery approach as the organisational philosophy and strong leadership are two crucial elements in the successful implementation of a recovery-oriented mental health service. Therefore, developing a model of care that underpins the recovery principles to guide practices will be beneficial for mental health services.
8. Increasing community resources: Many participants commented on the lack of resources available to support consumers and carers. Resources such as community houses and drop-in centres where consumers could find 'common ground' would help consumers to reintegrate into society. These facilities may counteract the internalised stigma experienced by consumers, and possibly go some way to reducing community stigma. Recovery Houses are short-term, home-like services in the community that support people in acute distress, and are already established in the UK and New Zealand. The Prevention and Recovery Care Service (PARCS) in Australia provides a similar service to these Recovery Houses and are used as a step-down service for Acute Mental Health or a step-up from the community. In order to promote reintegration, more facilities such as Recovery Houses or PARCS should be considered over Acute Inpatient Care (Edeson, 2012).
9. Funding: Funding guaranteed and secured in such a manner that is available only for MHS is crucial to provide better resources. Therefore, in order to provide recovery-oriented mental health care, which underpins consumer and carer participation, sustainable funding needs to be allotted to mental health systems.

Dissemination of findings

From research to practice

In order to move from recommendations to actions, some strategies were developed, which are detailed below.

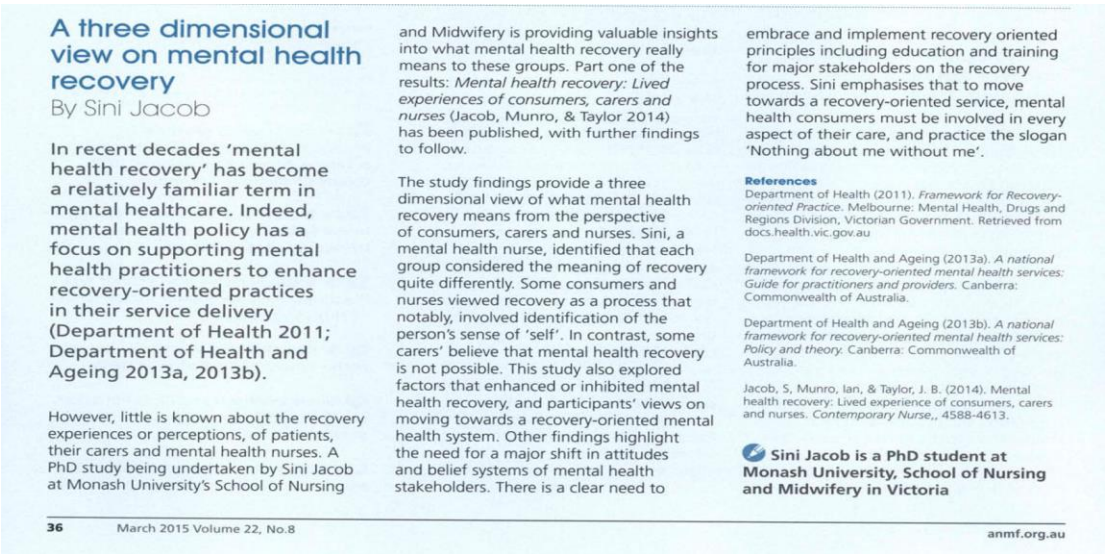
Influence in local practice

As a clinical manager in a public mental health facility, the researcher is actively engaged, through the use of information and material gleaned from her research, in the education of mental health clinicians in relation to recovery. Also, engagement in promoting the recovery approach is carried out through quality improvement activities, such as developing, in the in-patient unit, a recovery-oriented model of care and a project to involve consumers in the nursing handover with respect to their privacy and confidentiality, the aim here is to promote consumer participation in service delivery. Outcomes from this research have been presented to the executive and senior mental health nurses and other clinicians in the AMHS and a Report of the research has been submitted to the Senior Management.

Influence in national practice

In order to raise awareness and disseminate the findings nationally, articles were published from the research in the *Australian Nursing and Midwifery Journal* (below). This research has also been presented at state level at the *Victorian Collaborative Conferevbcnce, (2012*). The presentation included the importance of understanding, on the part of mental health professionals, of the meaning of mental health recovery.

Focus Article: A three dimensional view on mental health recovery (2015): Published in the *Australian Nursing and Midwifery Journal*



A three dimensional view on mental health recovery

By Sini Jacob

In recent decades 'mental health recovery' has become a relatively familiar term in mental healthcare. Indeed, mental health policy has a focus on supporting mental health practitioners to enhance recovery-oriented practices in their service delivery (Department of Health 2011; Department of Health and Ageing 2013a, 2013b).

However, little is known about the recovery experiences or perceptions, of patients, their carers and mental health nurses. A PhD study being undertaken by Sini Jacob at Monash University's School of Nursing and Midwifery is providing valuable insights into what mental health recovery really means to these groups. Part one of the results: *Mental health recovery: Lived experiences of consumers, carers and nurses* (Jacob, Munro, & Taylor 2014) has been published, with further findings to follow.

The study findings provide a three dimensional view of what mental health recovery means from the perspective of consumers, carers and nurses. Sini, a mental health nurse, identified that each group considered the meaning of recovery quite differently. Some consumers and nurses viewed recovery as a process that notably, involved identification of the person's sense of 'self'. In contrast, some carers' believe that mental health recovery is not possible. This study also explored factors that enhanced or inhibited mental health recovery, and participants' views on moving towards a recovery-oriented mental health system. Other findings highlight the need for a major shift in attitudes and belief systems of mental health stakeholders. There is a clear need to embrace and implement recovery oriented principles including education and training for major stakeholders on the recovery process. Sini emphasises that to move towards a recovery-oriented service, mental health consumers must be involved in every aspect of their care, and practice the slogan 'Nothing about me without me'.

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Influence in international practice

Five publications were produced from this study. One paper is published in the journal, *Contemporary Nurse*, and another article is published in the *Collegian*. Two articles are under review by the *International Journal of Mental Health Nursing and* another article is under review by *Contemporary Nurse.* The findings and recommendations of this research have also been presented to scholarly and clinical audiences of mental health and academic peers including; *International Mental Health Nursing Conference* (Gold Coast 2011, Perth 2013, Melbourne 2014, and Brisbane 2015) and *Research School Conference* (Clayton 2012, Berwick 2013, and Berwick 2014). In 2013, the researcher won the Research Award for the Best Research Presentation at the *International Mental Health Nursing Conference* in Perth.

Limitations of this study

Generalisation: Van Manen (2014b) emphasises that phenomenological studies should never be generalised. Hence, in line with qualitative epistemological assumptions, the sample only represents a local area and does not represent the generalised views of the Australian population.

Sampling: The participants in this study were recruited from community settings and the experience of mental health recovery might be perceived differently in acute in-patient units.

Exclusion criteria: This research only included nurses from the multidisciplinary team. Other professionals also have important roles in mental health care. However, the decision to exclude other professionals was based on the need to meet certain criteria such, as the homogeneity of the sample, and the feasibility of the project within a given timeframe.

Further investigations

Mental health recovery is a prominent topic of interest, though the concept has not been explored well in the Australian context. In order to explore the concept further and to build evidence, comparative studies involving various stakeholders would be useful. Three questions are raised in the researcher's mind for further studies:

- Firstly, how do other professionals view the experience of mental health recovery?
- Secondly, how is an admission into an acute mental health inpatient unit perceived by consumers; this perspective may assist an understanding of whether inpatient admissions benefit or disadvantage consumers in terms of their recovery.

- Thirdly, to what extent is peer support for staff and clients implemented within the Australian mental health system? (1) Peer support for staff is related to learning sets or discussion groups to develop their knowledge and understanding and (2) is peer support for consumers through sharing recovery journeys. Exploring the extent of peer support will indicate how far Australia has moved forward in terms of recovery-oriented practice.

Summary

The chapter has provided a short summary of the research, a number of recommendations based on the participants' and the researcher's own insights, and suggestion as to how these recommendations can be put into practice at the local, national, and international level. This chapter also outlined what has been achieved thus far, as well as moves taken to disseminate these findings and the recommendations from this study. Furthermore, the researcher has stated the limitations for this research and posed three further questions that could be explored to further enhance knowledge in this area. This research has contributed to the knowledge currently in existence in relation to the experience of mental health recovery. The researcher trusts that this research will shed light on the process of improvement of mental health care for those subject to mental health issues.

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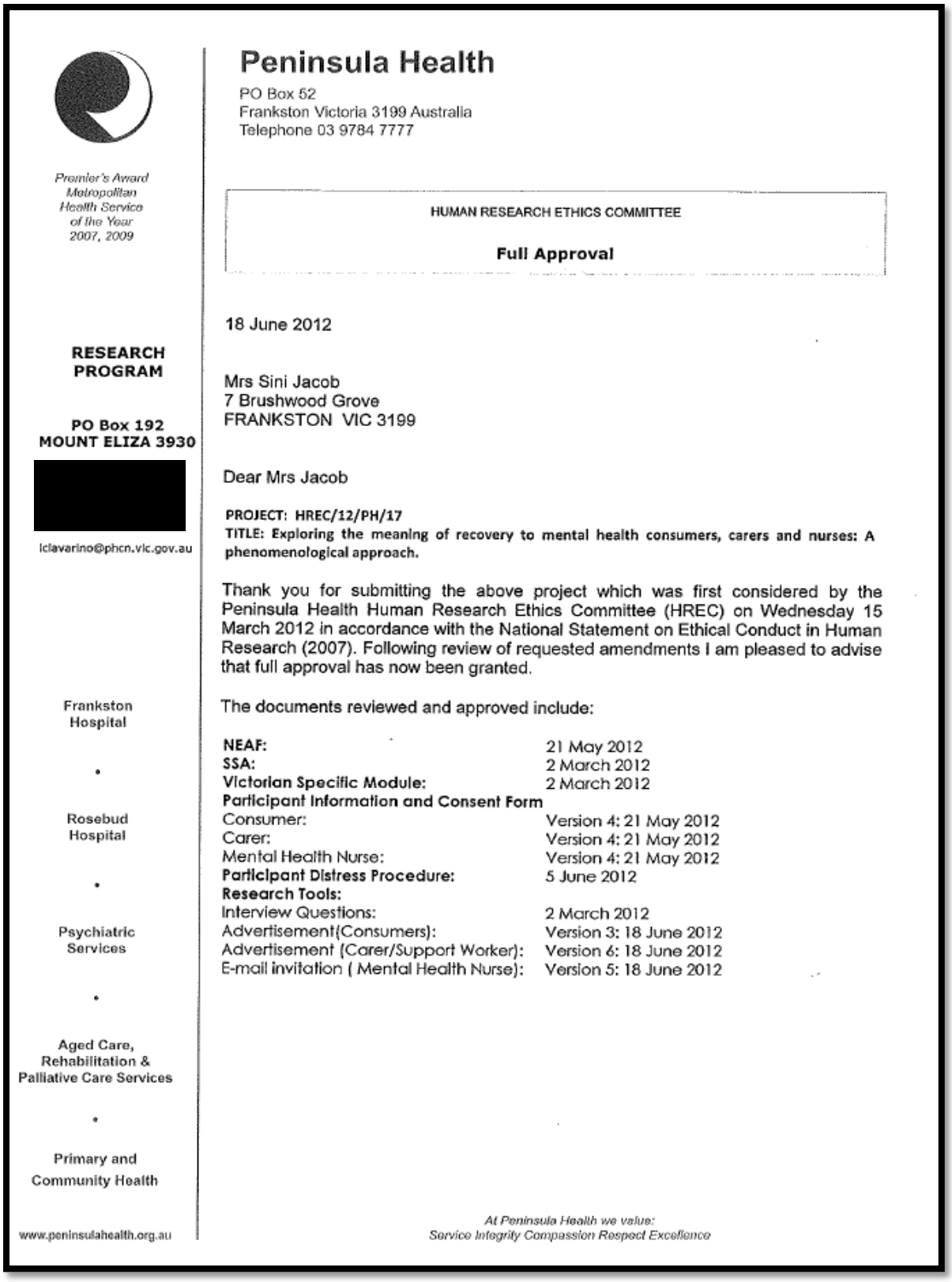
Appendices

Appendix A:

Ethics approval



Premier's Award
Metropolitan
Health Service
of the Year
2007, 2009

RESEARCH PROGRAM

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lclavarino@phcn.vic.gov.au

Frankston Hospital

•

Rosebud Hospital

•

Psychiatric Services

•

Aged Care, Rehabilitation & Palliative Care Services

•

Primary and Community Health

www.peninsulahealth.org.au

Peninsula Health

PO Box 52
Frankston Victoria 3199 Australia
Telephone 03 9784 7777

HUMAN RESEARCH ETHICS COMMITTEE

Full Approval

18 June 2012

Mrs Sini Jacob
7 Brushwood Grove
FRANKSTON VIC 3199

Dear Mrs Jacob

PROJECT: HREC/12/PH/17
TITLE: Exploring the meaning of recovery to mental health consumers, carers and nurses: A phenomenological approach.

Thank you for submitting the above project which was first considered by the Peninsula Health Human Research Ethics Committee (HREC) on Wednesday 15 March 2012 in accordance with the National Statement on Ethical Conduct in Human Research (2007). Following review of requested amendments I am pleased to advise that full approval has now been granted.

The documents reviewed and approved include:

NEAF:	21 May 2012
SSA:	2 March 2012
Victorian Specific Module:	2 March 2012
Participant Information and Consent Form	
Consumer:	Version 4: 21 May 2012
Carer:	Version 4: 21 May 2012
Mental Health Nurse:	Version 4: 21 May 2012
Participant Distress Procedure:	5 June 2012
Research Tools:	
Interview Questions:	2 March 2012
Advertisement(Consumers):	Version 3: 18 June 2012
Advertisement (Carer/Support Worker):	Version 6: 18 June 2012
E-mail invitation (Mental Health Nurse):	Version 5: 18 June 2012

At Peninsula Health we value:
Service Integrity Compassion Respect Excellence

Please note the following requirements of the Peninsula Health HREC:

1. The principal investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
- any serious or unexpected adverse events
- unforeseen events that might affect continued acceptability of the project.

2. Proposed changes to the research protocol, conduct of the research, or research completion date will be provided to the HREC for review in the specified format.

3. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

4. The principal investigator will provide an annual report to the HREC and at completion of the study a final report, in the specified format.

Should you have any queries about the HREC's consideration of your project please contact Ms Lee-Anne Clavarino, Manager, Research Program. Details of review processes and guidelines are available on the Peninsula Health website http://www.peninsulahealth.org.au/humanresearchandethicscommittee or http://www.phcn.vic.gov.au/departments/research/HREC/.

Please quote the Peninsula Health Project Number in all correspondence.

The Committee wishes you every success in your research

[redacted]

Dr David Rankin
Executive Director - Medical Services,
Quality and Clinical Governance

Executive Sponsor
Research

Appendix B

Participants information and consent forms

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

FOR MENTAL HEALTH CONSUMERS

Full Project Title: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological approach.**

Site: **Peninsula Health & Monash University**

Principal Researcher: Sini Jacob

Supervisors: Dr. Ian Munro

Prof. Beverley Taylor

HREC Ref. No: HREC/12/PH/17

1. Introduction

You are invited to take part in this research project because you are a person with mental illness and you have shown expression of interest to participate in the study through your GP or Clinicians. The research project aims to explore the concept of mental health recovery and recovery-oriented practices to consumers, carers and nurses to identify similarities and differences in the views of the participants and draw recommendations based on the results.

This Participant Information and Consent Form inform you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to and it will not affect your care.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- understand what you have read;
- consent to take part in the research project;
- consent to be involved in the procedures described;

You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research project?

The aim of the study is to explore the concept of mental health recovery and recovery-oriented practices to consumers, carers and nurses to identify similarities and differences in the views of the participants and draw recommendations based on the results.

The background: The notion of recovery and recovery-oriented practices in mental health are grounded on consumer-centeredness and strength-based services. The Australian mental health service policies are encouraging recovery-oriented practices in the mental health service delivery. However, the notion of recovery is still being debated given the lack of evidence base. This study involves mental health consumers, carers or support workers and nurses to explore their concept about recovery-oriented practices to identify similarities and differences in the views and draw recommendations based on the results.

The anticipated number of participants are 8- 15 from each group (consumers, carers & nurses). The participants will be recruited from the Peninsula Health Mental Health Services catchment area. The results of this research will be used by the researcher to obtain a Doctor of Philosophy degree and also may assist in improving care.

3. What does participation in this research project involve?

Your participation will involve an in-depth interview for about 60- 90 minutes with the researcher at the Frankston Hospital. At the beginning you will be provided explanation about the project and will be asked to sign the consent form. You will again have the opportunity to have any questions answered and to decline the offer of participation without any impact on your care.

You will be given a microphone to use and a tape recorder will be centrally located to record the discussion. The tape recorder will be turned on at the beginning of the interview. You will be able to take a break or to terminate the interview if you do not wish to continue. The recorder will be turned off at your request at any time if you do not wish to record certain parts of the interview.

The preferred time for appointment is Monday-Friday between 0800hrs -1800 hrs. However appointments can be made outside of these times according to your convenience. Once the interview is completed the tape will be transcribed and the text will be sent back to you to confirm the information is correct and valid. You will be given three weeks to respond if there are amendments to be made in the texts. If the researcher does not get any response from you in three weeks' time, it will be assumed that there are no changes to be made. You will be given $ 20 of gift voucher to reimburse the travel costs.

4. What are the possible benefits?

I cannot guarantee or promise that you will receive any benefits from this research, however, it is expected that the outcomes of the research may aid to improve the service delivery and provide strong data as to what are the similarities and differences in the perspective of people with mental illness, carers of people with mental illness and nurses in terms of mental health recovery-oriented practices.

5. What are the possible risks?

There are potential risks of inconvenience or discomfort. If you become upset or distressed as a result of your participation in the research, you will be able to terminate, postpone or take break during the interview.

If you require more assistance you can also call **Peninsula Health Mental Health Triage on 1300 792 977 or contact your GP or Psychologist** according to your preference. The researcher will be able to provide assistance with these matters.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

If you do consent to participate, you can withdraw at any time but you must be aware that the information collected during the interview will be de-identified and any information given prior to your withdrawal will be used by the researcher.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researcher or the Mental Health Service.

7. How will I be informed of the final results of this research project?

If you would like to be informed of the aggregate research finding, please contact Sini Jacob on [redacted] The findings will be accessible between 01/02/2016- 31/01/2017. The findings will be submitted to the university as a thesis and to the organisation as a report.

8. What will happen to information about me?

Any information obtained for the purpose of this research project will be de-identified and coded soon after the collection of data. The de-identified data will only be accessible to the researcher and the supervisors. Data collected will be stored in accordance with Monash University regulations. The data from this study will be stored for 5 years.

All information collected during the study will be handled in the highest confidence. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. Your confidentiality will at all times be respected.

9. Can I access research information kept about me?

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. Please contact the researcher named at the end of this document if you would like to access your information.

In addition, in accordance with the university regulatory guidelines, the information collected in this research project will be kept for 5 years.

You must be aware that the information collected at the interviews will be de-identified. All transcripts will not identify any specific participant so access to information about you after this point will not be possible.

10. Is this research project approved?

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Peninsula Health and Monash University.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council

of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Consent Form

Full Title of the project: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological Approach**

Site: **Peninsula Health**

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project, as described.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) .....

Signature..... Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) .....

Signature..... Date

Note: All parties signing the consent section must date their own signature.

12.Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information or appointments:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact the principal researcher on 0423908901 or any of the following people:

Name: Dr. Ian Munro: Phone: 99044515

Prof. Beverley Taylor: Phone: 990 26130

Role: Supervisors

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Name: Convenor
Position: Peninsula Health Research and Ethics Committee, **Telephone:** 9788 1473.

You will need to tell the convenor the name of one of the researchers given in section 12 above.

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

FOR CARERS OF A PERSON WITH A MENTAL ILLNESS

Full Project Title: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological approach.**

Site: **Peninsula Health & Monash University**

Principal Researcher: Sini Jacob

Supervisors: Dr. Ian Munro

Prof. Beverley Taylor

HREC Ref. No: HREC/12/PH/17

1. Introduction

You are invited to take part in this research project because you are a carer of a person with a mental illness and you responded to the advertisement seeking participants. The research project aims to explore the concept of mental health recovery and recovery-oriented practices to consumers, carers and nurses to identify similarities and differences in the views of the participants and draw recommendations based on the results.

This Participant Information and Consent Form inform you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to and it will not affect you in any way.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- understand what you have read;
- consent to take part in the research project;
- consent to be involved in the procedures described;

You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research project?

The aim of the study is to explore the concept of mental health recovery and recovery-oriented practices to consumers, carers and nurses to identify similarities and differences in the views of the participants and draw recommendations based on the results.

The background: The notion of recovery and recovery-oriented practices in mental health are grounded on consumer-centeredness and strength-based services. The Australian mental health service policies are encouraging recovery-oriented practices in the mental

health service delivery. However, the notion of recovery is still being debated given the lack of evidence base. This study involves mental health consumers, carers or support workers and nurses to explore their concept about recovery-oriented practices to identify similarities and differences in the views and draw recommendations based on the results.

The anticipated number of participants are 8- 15 from each group (consumers, carers & nurses). The participants will be recruited from the Peninsula Health Mental Health Service catchment area. The results of this research will be used by the researcher to obtain a Doctor of Philosophy degree and also may assist in improving care.

3. What does participation in this research project involve?

Your participation will involve an in-depth interview for about 60- 90 minutes with the researcher at the Frankston Hospital. At the beginning you will be provided explanation about the project and will be asked to sign the consent form. You will again have the opportunity to have any questions answered and to decline the offer of participation without any impact on you.

You will be given a microphone to use and a tape recorder will be centrally located to record the discussion. The tape recorder will be turned on at the beginning of the interview. You will be able to take a break or to terminate the interview if you do not wish to continue. The recorder will be turned off at your request at any time if you do not wish to record certain parts of the interview.

The preferred time for appointment is Monday-Friday between 0800hrs -1800 hrs. However appointments can be made outside of these times according to your convenience. Once the interview is completed the tape will be transcribed and the text will be sent back to you to confirm the information is correct and valid. You will be given three weeks to respond if there are amendments to be made in the texts. If the researcher does not get any response from you in three weeks' time, it will be assumed that there are no changes to be made. You will not be paid for your participation in this research.

4. What are the possible benefits?

I cannot guarantee or promise that you will receive any benefits from this research, however, it is expected that the outcomes of the research may aid to improve the service delivery and provide strong data as to what are the similarities and differences in the perspective of people with mental illness, carers of people with mental illness and nurses in terms of mental health recovery-oriented practices.

5. What are the possible risks?

There are potential risks of inconvenience or discomfort. If you become upset or distressed as a result of your participation in the research, you will be able to terminate, postpone or take break during the interview.

If you require more assistance you can also call **Peninsula Health Mental Health Triage on 1300 792 977 or contact your GP or Psychologist** according to your preference. The researcher will be able to provide assistance with these matters.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

If you do consent to participate, you can withdraw at any time but you must be aware that the information collected during the interview will be de-identified and any information given prior to your withdrawal will be used by the researcher.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researcher or the Mental Health Service.

7. How will I be informed of the final results of this research project?

If you would like to be informed of the aggregate research finding, please contact Sini Jacob on [redacted] The findings will be accessible between 01/02/2016- 31/01/2017. The findings will be submitted to the university as a thesis and to the organisation as a report.

8. What will happen to information about me?

Any information obtained for the purpose of this research project will be de-identified and coded soon after the collection of data. The de-identified data will only be accessible to the researcher and the supervisors. Data collected will be stored in accordance with Monash University regulations. The data from this study will be stored for 5 years.

All information collected during the study will be handled in the highest confidence. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. Your confidentiality will at all times be respected.

9. Can I access research information kept about me?

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. Please contact the researcher named at the end of this document if you would like to access your information.

In addition, in accordance with the university regulatory guidelines, the information collected in this research project will be kept for 5 years.

You must be aware that the information collected at the interviews will be de-identified. All transcripts will not identify any specific participant so access to information about you after this point will not be possible.

10. Is this research project approved?

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Peninsula Health and Monash University.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Consent Form

Full Title of the project: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological Approach**

Site: **Peninsula Health**

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project, as described.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) .....

Signature..... Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) .....

Signature..... Date

Note: All parties signing the consent section must date their own signature.

12.Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information or appointments:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact the principal researcher on 0423908901 or any of the following people:

Name: Dr. Ian Munro:	Phone: 99044515
Prof. Beverley Taylor:	Phone: 990 26130
Role: Supervisors	

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Name: Convenor
Position: Peninsula Health Research and Ethics Committee, **Telephone:** 9788 1473.

You will need to tell the convenor the name of one of the researchers given in section 12 above.

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

FOR MENTAL HEALTH NURSES

Full Project Title: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological approach.**

Site: **Peninsula Health & Monash University**

Principal Researcher: Sini Jacob

Supervisors: Dr. Ian Munro

Prof. Beverley Taylor

HREC Ref. No: HREC/12/PH/17

1. Introduction

You are invited to take part in this research project because you are a mental health nurse and have responded to the e-mail seeking participants. The research project aims to explore the concept of mental health recovery and recovery-oriented practices to consumers, carers and nurses to identify similarities and differences in the views of the participants and draw recommendations based on the results.

This Participant Information and Consent Form inform you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to and it will not affect your care.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- understand what you have read;
- consent to take part in the research project;
- consent to be involved in the procedures described;

You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research project?

The aim of the study is to explore the concept of mental health recovery and recovery-oriented practices to consumers, carers and nurses to identify similarities and differences in the views of the participants and draw recommendations based on the results.

The background: The notion of recovery and recovery-oriented practices in mental health are grounded on consumer-centeredness and strength-based services. The Australian mental health service policies are encouraging recovery-oriented practices in the mental

health service delivery. However, the notion of recovery is still being debated given the lack of evidence base. This study involves mental health consumers, carers or support workers and nurses to explore their concept about recovery-oriented practices to identify similarities and differences in the views and draw recommendations based on the results.

The anticipated number of participants are 8- 15 from each group (consumers, carers & nurses). The participants will be recruited from the Peninsula Health Mental Health Services catchment area. The results of this research will be used by the researcher to obtain a Doctor of Philosophy degree and also may assist in improving care.

3. What does participation in this research project involve?

Your participation will involve an in-depth interview for about 60- 90 minutes with the researcher at the Frankston Hospital. At the beginning you will be provided explanation about the project and will be asked to sign the consent form. You will again have the opportunity to have any questions answered and to decline the offer of participation without any impact on you.

You will be given a microphone to use and a tape recorder will be centrally located to record the discussion. The tape recorder will be turned on at the beginning of the interview. You will be able to take a break or to terminate the interview if you do not wish to continue. The recorder will be turned off at your request at any time if you do not wish to record certain parts of the interview.

The preferred time for appointment is Monday-Friday between 0800hrs-1800hrs. However appointments can be made outside of these times according to your convenience. Once the interview is completed the tape will be transcribed and the text will be sent back to you to confirm the information is correct and valid. You will be given three weeks to respond if there are amendments to be made in the texts. If the researcher does not get any response from you in three weeks' time, it will be assumed that there are no changes to be made. You will not be paid for your participation in this research.

4. What are the possible benefits?

I cannot guarantee or promise that you will receive any benefits from this research, however, it is expected that the outcomes of the research may aid to improve the service delivery and provide strong qualitative data as to what are the similarities and differences in the perspectives of people with mental illness, carers of people with mental illness and nurses in terms of mental health recovery-oriented practices.

5. What are the possible risks?

There are potential risks of inconvenience or discomfort. If you become upset or distressed as a result of your participation in the research, you will be able to terminate, postpone or take break during the interview.

If you require more assistance such as debriefing you will be able to select a senior staff of your choice from a list of staff who agreed to support the study. If you require further assistance, you will also be able to access Employee Assistance Program. The researcher will be able to provide assistance with these matters.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

If you do consent to participate, you can withdraw at any time but you must be aware that the information collected during the interview will be de-identified and any information given prior to your withdrawal will be used by the researcher.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researcher or the Mental Health Service.

7. How will I be informed of the final results of this research project?

If you would like to be informed of the aggregate research finding, please contact Sini Jacob on [redacted] The findings will be accessible between 01/02/2016- 31/01/2017. The findings will be submitted to the university as a thesis and to the organisation as a report.

8. What will happen to information about me?

Any information obtained for the purpose of this research project will be de-identified and coded soon after the collection of data. The de-identified data will only be accessible to the researcher and the supervisors. Data collected will be stored in accordance with Monash University regulations. The data from this study will be stored for 5 years.

All information collected during the study will be handled in the highest confidence. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. Your confidentiality will at all times be respected.

9. Can I access research information kept about me?

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. Please contact the researcher named at the end of this document if you would like to access your information.

In addition, in accordance with the university regulatory guidelines, the information collected in this research project will be kept for 5 years.

You must be aware that the information collected at the interviews will be de-identified. All transcripts will not identify any specific participant so access to information about you after this point will not be possible.

10. Is this research project approved?

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Peninsula Health and Monash University.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council

of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Consent Form

Full Title of the project: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological Approach**

Site: **Peninsula Health**

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project, as described.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) .....

Signature..... Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) .....

Signature..... Date

Note: All parties signing the consent section must date their own signature.

12.Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information or appointments:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact the principal researcher on [redacted]. or any of the following people:

Name: Dr. Ian Munro: [redacted]

Prof. Beverley Taylor: [redacted]

Role: Supervisors

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Name: Convenor
Position: Peninsula Health Research and Ethics Committee, [redacted]

You will need to tell the convenor the name of one of the researchers given in section 12 above.

Appendix C

Process to manage distress

Process to manage distress associated with interview by the Researcher

FOR MENTAL HEALTH CONSUMERS

Full Project Title: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological approach.**

Site: **Peninsula Health & Monash University**

Principal Researcher: Sini Jacob

Supervisors: Dr. Ian Munro

Prof. Beverley Taylor

HREC Ref. No: HREC/12/PH/17

Risks associated with the research and management:

There are potential risks of inconvenience or discomfort associated with the research. If the consumers become upset or distressed as a result of the participation in the research, the interview will be terminated or postponed.

However, if consumer require more assistance he/she will also be able to call **Peninsula Health Mental Health Triage on 1300 792 977 or contact GP or Psychologist** according to his/her preference. The researcher will be able to provide assistance with these matters.

The above plan has been discussed with me and has been granted permission to address risks associated with the research.

1. Name: Teresa Kudinoff

   Signature:..... Date:
   Position: Acting Chief Nursing Officer
   Peninsula Health Mental Health Services.

2. Name: Adrian Griffin

   Signature:..... Date:
   Position: Manager
   Peninsula Health Consultation Liaison Inpatient Psychiatry Service

Process to manage distress associated with interview by the Researcher

FOR MENTAL HEALTH CARERS

Full Project Title: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological approach.**

Site: **Peninsula Health & Monash University**

Principal Researcher: Sini Jacob

Supervisors: Dr. Ian Munro

Prof. Beverley Taylor

HREC Ref. No: HREC/12/PH/17

Risks associated with the research and management:

There are potential risks of inconvenience or discomfort associated with the research. If the carers become upset or distressed as a result of the participation in the research, the interview will be terminated or postponed.

However, if carers require more assistance he/she will also be able to call **Peninsula Health Mental Health Triage on 1300 792 977 or contact GP or Psychologist** according to his/her preference. The researcher will be able to provide assistance with these matters.

The above plan has been discussed with me and granted permission to address risks associated with the research.

1. Name: Teresa Kudinoff

   Signature:..... Date:
   Position: Acting Chief Nursing Officer
   Peninsula Health Mental Health Services.

2. Name: Adrian Griffin

   Signature:..... Date:
   Position: Manager
   Peninsula Health Consultation Liaison Inpatient Psychiatry Service

Process to manage distress associated with interview by the Researcher

FOR MENTAL HEALTH NURSES

Full Project Title: **Exploring the meaning of recovery to mental health consumers, carers and nurses: A Phenomenological approach.**

Site: **Peninsula Health & Monash University**

Principal Researcher: Sini Jacob

Supervisors: Dr. Ian Munro

Prof. Beverley Taylor

HREC Ref. No: HREC/12/PH/17

Risks associated with the research and management:

There are potential risks of inconvenience or discomfort associated with the research. If the nurses become upset or distressed as a result of the participation in the research, the interview will be terminated or postponed.

However, if nurses require more assistance such as debriefing you will be able to select a senior staff of your choice from a list of staff who agreed to support the study. If you require further assistance, you will also be able to access Employee Assistance Program. The researcher will be able to provide assistance with these matters.

The above plan has been discussed with me and has been granted permission to address risks associated with the research.

1. Name: Teresa Kudinoff

   Signature:..... Date:
   Position: Acting Chief Nursing Officer
   Peninsula Health Mental Health Services.

2. Name: Adrian Griffin

   Signature:..... Date:
   Position: Manager
   Peninsula Health Consultation Liaison Inpatient Psychiatry Service

Appendix D

A Report to the organisation

The Meaning of Mental Health Recovery for Consumers, Carers and Nurses: A Phenomenological Exploration

A Thesis Report to the Organisation

Submitted by:

Sini Jacob

Supervisors:

Dr. Ian Munro
Assoc. Prof. Debra Griffiths

School of Nursing and Midwifery
Monash University, Peninsula Campus
Date: 02/11/2015

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Introduction

The concept of mental health recovery (MHR) has advanced considerably in the postmodern era in western countries with more focus on consumers' lived experience. The current concept of MHR conveys that recovery from mental illness is possible. The recent developments in mental health care around the world, portray an optimistic view towards recovering from mental illness (Anthony, 1993; Department of Health and Ageing, 2008; National Institute for Mental Health in England, 2005; New Zealand Minister of Health, 2005). Interestingly, compared to previous decades, the terms mental health recovery and recovery-oriented practices are more frequently used in many mental health care systems. This report provides a brief summary of the thesis and the recommendations drawn from the study. The whole study has been presented to the Peninsula Health Mental Health Services' Senior Nurses meeting on 14/10/2015.

Statement of the Problem

The concept of MHR has been challenged and scrutinised by those who had focus on a cure-oriented medical model of care, given its lack of evidence base (Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Lester & Gask, 2006). Peyser (2001) and Frese et al. (2001) warn that enthusiasm towards the recovery model should not interfere with the benefits of medical treatment for consumers who require treatment. Further, the concept of MHR has been criticized for its inability to be applied cross-culturally across the lifespan (Lal, 2010) and for setting unrealistic expectations about recovering from mental illness (Masland, 2006). From the researcher's clinical observations, mental health staff particularly those who are not trained in recovery paradigm have not accepted the concept of recovery. The literature review identified two major gaps:

1. Lack of wide examination about the concept of MHR in the Australian context.

2. Little remains known about the diverse views of MHR among carers and/or family members, service providers and policy makers.

Aim of the Study

The overall aim of this study was to explore the meaning of MHR as it is perceived to consumers, carers or family members and mental health nurses in a community setting in Australia.

Research Questions

The research questions underlying the aim of the study are:

1. What are the views of participants on the meaning of mental health recovery?
2. What are the differences and/or similarities in their perspective?
3. What are the enablers to mental health recovery?
4. What are the barriers to mental health recovery?
5. How do participants view a recovery-oriented mental health system?

Research objectives

- To explore the participants' views on the meaning of mental health recovery and identify differences and/or similarities in their views.
- To identify enablers and/ or barriers to mental health recovery.
- To explore the participants' insights on recovery-oriented mental health system.
- To make recommendations based on the participants' views.

Method

In light of the literature review, the hermeneutic phenomenological method by van Manen (1997) was chosen to conduct the study. Phenomenology is described as the study of essences, which aims at gaining a deeper understanding of the nature or meaning of the phenomena (van Manen, 1997). This methodology was carefully considered due to the nature

of the study, because it provided a framework to explore and understand how participants viewed recovery from mental illness in various dimensions (van Manen, 1997). The study received ethics approval from the Area Mental Health Services Human Research and Ethics Committee (Ref: HREC/12/PH/17) and from the Monash University Human Research Ethics Committee (Ref: CF12/2022 – 2012001088). Written informed consent was obtained from all interviewees who participated in the study. Nine consumers, eight carers and nine nurses were recruited to the study. The participants were informed that he/she has the right to withdraw from the study at any stage without any compromise until coding of the data. A semi-structured interview schedule was developed and in-depth interviews were conducted using this core questionnaire, which was slightly amended according to the cohort. The in-depth data analysis was guided by approaches proposed by van Manen (1997) to uncover themes. Van Manen (2014) highlighted the importance of writing and re-writing to distil and illuminate the phenomenon of investigation. The researcher used the thematic draft writing activity (van Manen, 2014) that generated themes and subthemes from the data to illuminate the essence of the phenomenon. Findings from these four aspects of research such as the meaning of recovery, enablers to MHR, barriers to MHR and recovery-oriented mental health system are written as publications and are submitted for review (Jacob, Munro, & Griffiths, 2015a, 2015b, 2015c; Jacob, Munro, & Taylor, 2015).

Findings

Four aspects of mental health recovery were explored in this study:

1. The meaning of mental health recovery;
2. The enablers to mental health recovery;
3. The barriers to mental health recovery;
4. Recommendations about a recovery-oriented mental health system.

Finding One: The meaning of mental health recovery:

Jacob, S., Munro, I., & Taylor, J.B. (2014). Mental health recovery: lived experience of consumers, carers and nurses. *Contemporary Nurse*, (Published).

Participants' meaning of mental health recovery was discussed in this paper. The paper details similar and dissimilar views of mental health recovery. The similar views were categorised under two processes involving self, an internal process and an external process. These two processes involved reclaiming various aspects of self, living life, cure or absence of symptoms and contribution to community. The dissimilar views involved returning to pre-illness state and recovery was impossible. The major difference in the themes indicated many carers believed that mental health recovery was impossible (Figure 1). Addtionally, the paper discusses the importance of the 'sense of self' of the person with mental illness, the ability to understand 'who am I' and therefore reclaim various aspects of self such as self-understanding, self-control, self-belief and self-acceptance as the essence of mental health recovery.

Figure 1:Overarching theme of Mental Health Recovery

Finding Two: The enablers to mental health recovery

Jacob, S., Munro, I., & Griffiths, D. (2015). Mental health recovery: Views of consumers, carers and nurses: Part 1: What aids recovery? *International Journal of Mental Health Nursing* (Under Review).

This paper delivered findings in relation to helpful factors to mental health recovery from a three dimensional view from the participants. The major themes evolved from the data included a theme of optimism, theme of safety, theme of belongingness and theme of choices. These four themes were consistently evident from the data among the three cohorts. Consumers' personal attributes such as hope, acceptance, belief, a positive change in language by mental health professionals were categorised under theme of optimism. Theme of safety implied to social elements such as accommodation, safe environment and meaningful activity such as having a job. Data that described the inter-personal dynamics were clustered under theme of belongingness. The themes such as safety and belongingness are basic needs of humans explained by Maslow in the hierarchy of needs (Rowan, 1998). Exploring and assessing various alternative therapies to ones' mental health, provides the consumers with a multitude of strategies, rather than relying only on medications. These elements were classified under the theme of choice and were identified as treatment.

Finding Three: Barriers to mental health recovery

Jacob, S., Munro, I., & Griffiths, D. (2015). Mental health recovery: Perspectives of consumers, carers and nurses: Part 2: Impediments to recovery. *International Journal of Mental Health Nursing* (Under review).

This paper presented impeding factors to mental health recovery from the views of consumers, carers and nurses. Four major themes were identified as barriers to mental health recovery such as the theme of control, theme of rejection, theme of necessity and theme of struggle. Elements comprising the theme of control included staff factors such as negative

attitudes, use of power or coercion and paternalistic attitudes. The theme of rejection included social factors such as labelling and stigma. Lack of resources and a lack of support were classified under the theme of necessity. Other issues included illicit drugs, over use of alcohol, side effects of medications and non-adherence to medications were clustered under theme of struggle.

Finding Four: Views about a recovery-oriented mental health system (MHS)

Jacob, S., Munro, I., & Griffiths, D. (2015). Shaping a recovery-oriented mental health service: Insights of consumers, carers and mental health nurses. ***Contemporary Nurse*** **(Under Review).**

This paper offers the insights of consumers, carers and nurses in relation to promoting a recovery-oriented MHS. This includes similar and dissimilar views. The findings suggested three overarching themes that are necessary for a recovery-oriented service. Firstly, promotion of belongingness by enhancing more resources in the community, developing more peer support programs and increasing therapeutic interactions. Secondly, promotion of autonomy by having choices for alternative therapies and decision-making process. Thirdly, promotion of community awareness by educating key stakeholders about mental health recovery and combating stigma. This study argues if government carefully considers these factors and respond accordingly, a recovery-oriented approach may happen in reality and not merely be confined to policy documents.

Recommendations

From this research, the researcher has drawn some recommendations in line with the National Standards for Mental Health Services that includes implications for recruitment, education and clinical practice.

Implications for recruitment and education

National Standards for Mental Health Service (Std. 8.6, p. 18): "The recruitment and selection process of the MHS ensures that staff have the skills and capability to perform the duties required of them"

1. Inclusion of Lived Experience in the Recruitment of Workforce: Recruiting the right staff who hold positive attitude towards mental health recovery is essential for the successful implementation of recovery orientation. Incorporating people with lived experience when recruiting staff may help in the recruitment process to identify employees who hold values of recovery-orientation.

National Standards for Mental Health Service (Std. 8.7, p. 18): "Staff are appropriately trained, developed and supported to safely perform the duties required of them"

2. Education for Mental Health Workforce: Developing a workforce grounded in recovery-oriented principles and practices is essential to sustain the recovery-oriented care model in mental health service delivery. Currently PHMHS focus on recovery training for nurses and allied health staff and incorporate people with lived experience in the delivery of education. The research data indicated a positive attitude about mental health recovery among nurses who were educated in relation to the concept of mental health recovery. Therefore this study recommends that adequate education to workforce including medicine, nursing, allied health and support services would be beneficial for the successful transformation to a recovery-oriented mental health system.

National Standards for Mental Health Service (Std. 10.1.6, p. 21): "The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives".

3. Mental Health Recovery Education Program (MHREP) for Consumers and Carers: Mental health Recovery Education Program is beneficial for people with lived experience who are employed by the mental health services (MHS) and for those who receive services from the MHS. In order to promote recovery-orientation consumers and carers need more information about various approaches to promote mental health recovery. Information in relation to available resources, changes in mental health legislation and policies, how to access other services to compliment the life they wish

to lead, for example, living an independent life or gaining work and so on would enable their independence and self-directed learning. Therefore as a public mental health facility it would be beneficial for people who access PHMHS to receive MHREP both in Community and Acute settings and also for those who are employed to receive adequate education to undertake their duties.

Implications for clinical practice

National Standards for Mental Health Service (Std. 3.3, p. 11): "The MHS provides training and support for consumers, carers and staff, which maximise consumer and carer(s) representation and participation in the MHS".

1. Experts by Experience Workforce Development (Peer support): There are evidence in relation to the benefits of peer support for service users (Bouchard, Montreuil, & Gros, 2010; Lawn, Smith, & Hunter, 2008; Ostrow & Adams, 2012; Wallcraft, 2012). Findings from this study suggests that peer support provides 'supports outside the usual umbrella' (Ryan). Developing a workforce who are experts by experience with adequate education and support will enable mental health services to provide efficient and cost effective services to those who access MHS.

National Standards for Mental Health Service (Std. 6.7, p. 14): "Consumers are partners in the management of all aspects of their treatment, care and recovery planning".

2. Partnership and sharing: Collaboration and a listening environment are appreciated by many consumers and carers to aid recovery process (Cleary, Freeman, & Walter, 2006; Hitchen et al., 2011; Ridley, Hunter, & Rosengard, 2010). Many consumers and carers in this study identified clinicians spend the majority of time on paperwork rather than with their clients. Involving consumers in activities such as the handover process (Australian Commission on Safety and Quality in Health Care, 2014), nursing visual observations (Department of Health, 2013) and writing their own mental health and risk assessments could address this concerns to some extent. Service providers in

a recovery-orientation are considered as partners in recovery (Gehart, 2012). Developing recovery-oriented model of care in the MHS.

Conclusion

This research explored the meaning of recovery, factors affecting recovery and insights of participants in relation to recovery-orientated reform. The authors used van Manen's hermeneutic phenomenological approach in this research. The findings of this study recommends inclusion of lived experience in the recruitments and education of multi-disciplinary team, development of Mental Health Recovery Education Program for Consumers and Carers in Acute and Community settings, development of Peer Workforce, inclusion of consumers in the day to day services to promote participation such as involvement in nursing handover, writing notes and risk assessments and engagement in nursing visual observations. The researchers encourage the Board of Management to consider these recommendations when strive for implementing recovery-orientation in the service delivery. The researchers wish to thank the Board of Management, staff, consumers and carers for supporting and for participating in this study.

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