

This electronic thesis or dissertation has been downloaded from the King's Research Portal at <https://kclpure.kcl.ac.uk/portal/>



The applicability of the concept of recovery for older people with mental health problems

Daley, Stephanie Karen

Awarding institution:
King's College London

The copyright of this thesis rests with the author and no quotation from it or information derived from it may be published without proper acknowledgement.

END USER LICENCE AGREEMENT



Unless another licence is stated on the immediately following page this work is licensed

under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

licence. <https://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to copy, distribute and transmit the work

Under the following conditions:

- Attribution: You must attribute the work in the manner specified by the author (but not in any way that suggests that they endorse you or your use of the work).
- Non Commercial: You may not use this work for commercial purposes.
- No Derivative Works - You may not alter, transform, or build upon this work.

Any of these conditions can be waived if you receive permission from the author. Your fair dealings and other rights are in no way affected by the above.

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

**THE APPLICABILITY OF THE CONCEPT OF
RECOVERY FOR OLDER PEOPLE WITH MENTAL
HEALTH PROBLEMS**

Stephanie Karen Daley

King's College London

Institute of Psychiatry

Health Service and Population Research Department

**Submitted to the University of London for the degree of
Doctor of Philosophy (PhD)**

December 2014

Abstract

Despite the emphasis on recovery in services for adults of working age, equivalent developments and research in older people's mental health services (OPMHS) have not taken place. In this thesis, the applicability of the concept of 'recovery' to older people with mental health problems is explored.

First, a qualitative study was undertaken with 28 service users and 10 carers, which produced a conceptual framework of recovery for older people with mental health problems. This highlighted similarities and differences in the experience of recovery for older people compared to their younger peers. This was used to identify the working practice implications and to develop an intervention for staff working within OPMHS and intended effects.

A feasibility study was undertaken to optimise the intervention and evaluation strategy, and to define the trial parameters for a future definitive trial. The intervention was delivered to 204 staff working in 15 clinical teams in South London, UK. The hypotheses were that the intervention would improve recovery and quality of life for service users.

A 'controlled before and after' (CBA) design was used with 103 service user participants at baseline, who were interviewed across three time points. Process evaluation comprised: qualitative interviews with staff and trainers (n=15), pre-post staff ratings of recovery knowledge and attitude (n=176), fidelity assessment and an audit of care plans of 328 service users.

The hypotheses were not confirmed. The process evaluation highlighted significant change in recovery knowledge, but not in other mediating variables. The OAR intervention was not delivered as intended. Fit between trainer and team, team culture, team readiness for change, organisational commitment, opinion leaders and profession were identified as factors in the acceptability of the intervention, and in the implementation of pro-recovery culture change.

Recovery measures suitable for use with older people are needed. Improved implementation strategies to tailor the intervention to team and professional group contexts are required.

Table of Contents

ABSTRACT	2
TABLE OF CONTENTS	3
LIST OF TABLES	10
LIST OF FIGURES	12
ACKNOWLEDGEMENTS	13
GLOSSARY OF TERMS	16
ABBREVIATIONS	17
CHAPTER 1 INTRODUCTION	18
1.1 CONTEXT	18
1.2 AIMS OF THE THESIS	20
1.2.1 <i>Research setting and context</i>	20
1.2.2 <i>Underpinning scientific framework</i>	21
1.2.3 <i>Stage one: Theory</i>	22
1.2.4 <i>Stage two: Modelling</i>	23
1.2.5 <i>Stage three: Exploratory trial</i>	23
1.3 STRUCTURE OF THESIS	24
1.4 STATEMENT OF PERSONAL CONTRIBUTION	25
CHAPTER 2 LITERATURE REVIEW	27
2.1 WHAT IS RECOVERY?	27
2.1.1 <i>Clinical recovery</i>	27
2.1.2 <i>Personal recovery</i>	28
2.1.3 <i>What is the impact of these differing views of recovery?</i>	30
2.2 COMPONENTS OF RECOVERY	32
2.3 WHAT DOES RECOVERY MEAN FOR MENTAL HEALTH SERVICES?	34
2.3.1 <i>Recovery-oriented practice</i>	35

2.4	RECOVERY FOR OTHER CLINICAL POPULATIONS.....	41
2.5	RECOVERY AND OLDER PEOPLE	42
2.5.1	<i>Policy supporting recovery and older people.....</i>	44
2.5.2	<i>Overlap between recovery and person-centred care.....</i>	46
2.5.3	<i>Recovery and people with dementia</i>	49
2.5.4	<i>Recovery and older people with functional mental health problems</i>	55
2.5.5	<i>Why has recovery not been taken forward within OPMHS?</i>	57
2.6	RATIONALE FOR RESEARCH.....	59
CHAPTER 3 DEVELOPMENT OF CONCEPTUAL FRAMEWORK.....		60
3.1	METHODOLOGICAL CONSIDERATIONS	60
3.1.1	<i>What is grounded theory?.....</i>	61
3.1.2	<i>Rationale for using grounded theory.....</i>	63
3.2	METHOD.....	64
3.2.1	<i>Sample and setting</i>	64
3.2.2	<i>Procedure</i>	64
3.2.3	<i>Process of analysis.....</i>	65
3.3	RIGOUR IN THE RESEARCH PROCESS	68
3.4	RESULTS.....	69
3.4.1	<i>Participant characteristics</i>	69
3.4.2	<i>Overall core category and key themes identified from the qualitative interviews</i>	70
3.5	DISCUSSION.....	85
3.5.1	<i>Are existing components of recovery meaningful to older people?</i>	86
3.5.2	<i>What are the dementia-specific aspects of recovery?.....</i>	91
3.6	STRENGTHS AND LIMITATIONS OF THE RESEARCH.....	95
CHAPTER 4 CLINICAL IMPLICATIONS OF THE CONCEPTUAL FRAMEWORK.....		97
4.1	METHODOLOGICAL CONSIDERATIONS	98
4.2	METHODS	99
4.2.1	<i>Sample and setting</i>	99

4.2.2	<i>Procedure</i>	99
4.2.3	<i>Analysis</i>	101
4.3	RESULTS	101
4.3.1	<i>Participant characteristics</i>	101
4.3.2	<i>Service User and Carer Focus Group Findings</i>	102
4.3.3	<i>Staff Focus Group Findings</i>	107
4.3.4	<i>Comparison between service user/carer and staff views</i>	117
4.4	DISCUSSION	119
CHAPTER 5 DEVELOPMENT OF THE OAR MODEL		122
5.1	DEVELOPMENT OF PRELIMINARY OAR INTERVENTION	122
5.2	CONTENT OF THE PRELIMINARY OAR INTERVENTION	124
5.2.1	<i>Active Ingredient 1: Recovery and Older People Training Module</i>	124
5.2.2	<i>Active Ingredient 2: Maintaining Identity Training Module</i>	125
5.2.3	<i>Active Ingredient 3: Enhancing Resilience Training Module</i>	126
5.2.4	<i>Active Ingredient 4: Action planning day and team level ownership</i>	126
5.3	INTENDED EFFECTS OF THE PRELIMINARY OAR INTERVENTION	128
5.4	PRELIMINARY EVALUATION STRATEGY	131
5.4.1	<i>Fidelity Assessment</i>	131
5.4.2	<i>Process Evaluation</i>	131
5.4.3	<i>Outcome Evaluation</i>	133
5.5	PILOT OF THE OAR INTERVENTION	134
5.5.1	<i>Aims</i>	135
5.5.2	<i>Method</i>	135
5.6	RESULTS	141
5.6.1	<i>Participants</i>	141
5.6.2	<i>Qualitative interviews</i>	141
5.6.3	<i>Training evaluation feedback</i>	144
5.6.4	<i>Staff measures</i>	145

5.6.5	<i>Care Plan Audit</i>	146
5.6.6	<i>Service user measures</i>	148
5.7	DISCUSSION.....	149
5.7.1	<i>Aim 1 (Optimise the intervention)</i>	149
5.7.2	<i>Aim 2 (Data collection and analysis)</i>	149
5.7.3	<i>Aim 3 (Measure selection)</i>	154
5.7.4	<i>Aim 4 (Implementation)</i>	154
5.8	AMENDMENTS BASED ON PILOT	154
5.9	FINAL OAR MODEL AND INTENDED EFFECTS	158
5.10	EVALUATION STRATEGY	159
5.11	IMPLEMENTATION STRATEGY	160
CHAPTER 6 METHODS FOR THE OAR STUDY		164
6.1	AIMS, OBJECTIVES AND HYPOTHESES.....	164
6.2	RESEARCH DESIGN.....	165
6.3	SAMPLE AND SETTING	168
6.4	INTERVENTIONS.....	169
6.4.1	<i>Treatment as usual</i>	169
6.4.2	<i>The OAR intervention</i>	170
6.5	MEASURES	171
6.6	PROCEDURE.....	173
6.6.1	<i>Sub-study 1 (Staff outcomes)</i>	173
6.6.2	<i>Sub-study 2 (Comprehensive evaluation)</i>	175
6.7	ANALYSIS	182
6.7.1	<i>Objective 1 (Optimise the intervention)</i>	182
6.7.2	<i>Objective 3 (Establish trial parameters)</i>	185
CHAPTER 7 RESULTS FROM THE OAR STUDY		188
7.1	DESCRIPTIVES.....	188
7.1.1	<i>Staff participants in Sub-study 1 (Staff outcomes)</i>	188

7.1.2	<i>Outcome in Sub-study 1 (Staff outcomes)</i>	191
7.1.3	<i>Staff participants for Sub-study 2 (Comprehensive evaluation)</i>	193
7.1.4	<i>Service user participants in Sub-study 2 (Comprehensive evaluation)</i>	193
7.1.5	<i>Diagnostic spread of service users in Sub-study 2</i>	197
7.1.6	<i>Service user outcomes in Sub-study 2</i>	198
7.1.7	<i>Participation in Sub-study 2</i>	200
7.1.8	<i>Sub-study 2: Care plan audit</i>	201
7.2	OBJECTIVE 1 (OPTIMISE THE INTERVENTION)	203
7.2.1	<i>Results for Objective 1.1 (Acceptability)</i>	203
7.2.2	<i>Results for Objective 1.2 (Reach)</i>	212
7.2.3	<i>Results for Objective 1.3 (Fidelity)</i>	212
7.2.4	<i>Results for Objective 1.4 (Mediating variables)</i>	215
7.2.5	<i>Results for Objective 1.5 (Context)</i>	222
7.3	RESULTS FOR OBJECTIVE 2 (OPTIMISE THE EVALUATION)	232
7.3.1	<i>Results for Objective 2.1 (Measures)</i>	232
7.3.2	<i>Results for Objective 2.2 (Evaluation)</i>	235
7.4	RESULTS FOR OBJECTIVE 3 (ESTABLISH THE TRIAL PARAMETERS)	238
7.4.1	<i>Results for Objective 3.1 (Hypotheses)</i>	238
7.4.2	<i>Results for Objective 3.2 (Sample size calculation)</i>	243
7.4.3	<i>Results for Objective 3.3 (Recruitment)</i>	243
7.4.4	<i>Results for Objective 3.4 (Retention)</i>	244
	CHAPTER 8 DISCUSSION	246
8.1	THESES FINDINGS	246
8.1.1	<i>OAR Study: Research Objective 1 (Optimise the intervention)</i>	247
8.1.2	<i>OAR Study: Research Objective 2 (Optimise the evaluation)</i>	264
8.1.3	<i>OAR Study: Research Objective 3 (Establish trial parameters)</i>	270
8.2	STRENGTHS AND LIMITATIONS OF THE OAR STUDY	273
8.3	REFLEXIVITY	278

8.4	ETHICAL CONSIDERATIONS	280
	8.4.1 <i>Ethical considerations for service user and carer participants</i>	280
	8.4.2 <i>Ethical Considerations for staff</i>	282
8.5	SCIENTIFIC IMPLICATIONS	284
8.6	CLINICAL IMPLICATIONS	288
8.7	CONCLUSIONS	289
APPENDIX A.	ETHICS APPROVAL.....	290
APPENDIX B.	R & D APPROVAL	294
APPENDIX C.	SERVICE USER TOPIC GUIDE	296
APPENDIX D.	CARER TOPIC GUIDE	297
APPENDIX E.	INITIAL CODING FRAMEWORK.....	298
APPENDIX F.	FOCUSSED CODING FRAMEWORK.....	300
APPENDIX G.	SUMMARY OF THEORETICAL SAMPLING	301
APPENDIX H.	EXAMPLE OF THEORETICAL MEMOS	302
APPENDIX I.	PEER REVIEWED PUBLICATION.....	303
APPENDIX J.	STAFF TOPIC GUIDE	312
APPENDIX K.	TRAINING COMPONENT OF THE INTERVENTION	313
APPENDIX L.	LETTER OF INVITATION FOR SERVICE USER PARTICIPANTS	314
APPENDIX M.	SERVICE USER EXPERIENCE QUESTIONS.....	315
APPENDIX N.	TRAINER GUIDE	316
APPENDIX O.	ACCEPTABILITY CODING FRAMEWORK.....	317
APPENDIX P.	CONTEXT CODING FRAMEWORK.....	318
APPENDIX Q.	FIDELITY ASSESSMENT RAW DATA.....	319
APPENDIX R.	DIFFERENCES IN CHANGE SCORES BY TEAM	320
APPENDIX S.	DIFFERENCES IN CHANGE SCORES BY PROFESSION.....	322

APPENDIX T.	LINEAR REGRESSION FOR RAQ-7 AND RKI.....	324
APPENDIX U.	LINEAR REGRESSION BY STUDY ARM AND TEAM	327
APPENDIX V.	LINEAR REGRESSION FOR IMPACT OF DOSE.....	331
REFERENCES.....		333

List of Tables

Table	Description	Page
Table 2.1	Long term follow-up studies for people with psychosis	30
Table 2.2	Summary of recovery frameworks	33
Table 2.3	Summary of mapping review (recovery and older people)	44
Table 2.4	Overlap between person-centred care and recovery	49
Table 3.1	Summary of theoretical sampling	70
Table 3.2	Socio-demographic and clinical characteristics of service user participants (n=28)	71
Table 3.3	Socio-demographic of carer participants (n=10)	72
Table 3.4	Summary of five inter-related themes	73
Table 4.1	Clinical and socio-demographic characteristics of service user (n=4) and carer (n=2) participants	104
Table 4.2	Working practices from the service user and carer focus group	105
Table 4.3	Working practices from staff focus groups	110
Table 4.4	Similarities and differences between service user/carer and staff views	120
Table 5.1	Breakdown of pilot study staff participants (n=22)	143
Table 5.2	Pilot study staff participant training feedback (n=22)	146
Table 5.3	Pilot study RAQ-7 ratings (n=22)	147
Table 5.4	Pilot study RKI ratings (n=22)	148
Table 5.5	Pilot study care plan audit of topics (n=160)	149
Table 5.6	Pilot study care plan audit of responsibility for action (n=160)	150
Table 5.7	Comparison of RKI ratings between pilot baseline (n=22) and Irish study (n=129)	152
Table 5.8	Comparison of RAQ-7 ratings between pilot (n=22) and Collaborative recovery training (n=147)	154
Table 5.9	Amendments to the OAR intervention and evaluation strategy	159
Table 5.10	OD theories embedded within the implementation strategy	163
Table 6.1	Design for each research objective	170
Table 6.2	Summary of research activity by Sub-study	183
Table 6.3	Research question and methods for each process	185
Table 7.1	Team type, sub-study, staff and receipt of intervention by team (n=15)	191
Table 7.2	Receipt of training by profession	192
Table 7.3	RAQ-7 and RKI scores for Sub-study 1 (n=176)	194
Table 7.4	Characteristics of Sub-study 2 staff participants (n=12)	195
Table 7.5	Characteristics of Sub-study 2 service user participants (n=103)	198
Table 7.6	Service user outcomes	201
Table 7.7	Number of service users and care plan entries in Sub-study 2	203
Table 7.8	Overview of sub-themes influencing acceptability	205

Table 7.9	Receipt of team recovery training in Sub-study 1 (n=203)	214
Table 7.10	Fidelity assessment	215
Table 7.11	Pre-post training change in RAQ-7 and RKI (n=176)	218
Table 7.12	Care plan audit for arm 1 (immediate delivery)	220
Table 7.13	Care plan audit for arm 2 (delayed delivery)	221
Table 7.14	Summary of responses to questions on service user experience for Sub-study 2 (n=10)	223
Table 7.15	Linear regression for RAQ-7 sub-scale 1 (recovery is possible)	231
Table 7.16	Summary of the linear regression models for RAQ-7 and RKI	232
Table 7.17	Mean scores between professions at baseline	233
Table 7.18	Summary of issues with the IMR	235
Table 7.19	Receipt of intervention for eligible staff in Sub-study 2 (n=88)	239
Table 7.20	Review of evaluation strategy	240
Table 7.21	Change between time points for study arms	241
Table 7.22	Change in pooled outcomes between baseline and T2	243
Table 7.23	Difference in IMR change scores by diagnostic group	244
Table 7.24	Impact of training dose on DEMQOL (n=33)	245
Table 8.1	Scientific implications arising from knowledge gaps	287
Table 8.2	Scientific implications for optimising the OAR intervention	288
Table 8.3	Scientific implications for optimising the evaluation of the OAR intervention	289

List of Figures

Figure	Description	Page
Figure 1.1	MRC Framework as applied to the thesis	22
Figure 1.2	Thesis elements mapped onto the MRC Framework	24
Figure 2.1	The experience of dementia	47
Figure 3.1	Data analysis within grounded theory	64
Figure 3.2	Process of analysis	68
Figure 3.3	Recovery for users of OPMHS	93
Figure 3.4	Framework for recovery and dementia	97
Figure 5.1	Theory of planned behaviour	125
Figure 5.2	Preliminary OAR model	132
Figure 5.3	Final OAR model	160
Figure 5.4	Evaluation components related to the OAR Model	161
Figure 6.1	Convergence model (mixed-method design)	168
Figure 6.2	Evaluation and intervention sequencing for Sub-study 2	180
Figure 6.3	Summary of intervention and evaluation activity	182
Figure 6.4	Expected pattern of change	187
Figure 7.1	Flow diagram for service user participants in Sub-study 2	196
Figure 7.2	Attrition by diagnostic group	199
Figure 7.3	Completion rates by study arm	202
Figure 7.4	OAR model and evaluation strategy	238
Figure 8.1	Validation of the OAR model	250
Figure 8.2	Theory of planned behaviour as applied to mediating variables	251
Figure 8.3	Organisational defensive routines in the OAR study	263
Figure 8.4	OAR model and modified evaluation strategy	272

Acknowledgements

First and foremost, I would like to give equal thanks and appreciation to my two PhD supervisors, Professor Sube Banerjee and Professor Mike Slade, who have each undertaken the role of first and second supervisor over the duration of my PhD. Both supervisors took on their supervisory roles with me as an inexperienced researcher, and I have benefited greatly from their expertise and encouragement. I have also appreciated the extent of support received as well as the complementary nature of their respective styles.

There are also a number of other people who have provided academic advice and supervision to me, who I would like to thank. These include Joanna Murray for her guidance and extremely helpful supervision of the qualitative components of my thesis, Professor Michael Dewey for supporting the development of my statistical skills and knowledge, and Dr Francesca Pesola for her statistical advice in the last stage of my write-up.

I would like to thank the Guy's and St Thomas's and Maudsley charities for funding this programme of work, as well as my colleagues in the Mental Health of Older Adults and Dementia (MHOAD) Clinical Academic Group (CAG) at the South London and Maudsley NHS Foundation Trust. In particular, David Norman (Service Director) for supporting the exploration and implementation of recovery across CAG services and enabling me to undertake a PhD. Neil Robertson (Associate Director for Education and Training) and Nuala Conlan (Participation and Inclusion Lead) for their help, encouragement and support to me over the last few years. I am also grateful for the support and tolerance of my senior Occupational Therapy colleagues in the CAG. I have also valued the commitment and motivation of David Newton and Lynda McNab in delivering this programme of work with me. Finally, I am grateful to the service users and carers from the CAG who were willing to get involved in this programme of work. In particular, Yvonne Poulson, who died in 2013, for her contribution to the analysis of the qualitative interview transcripts. I have also appreciated the help and input of Syd Morris, Doreen Bryant, John Goodrum, Therese Gibbs and the other members of the SUCAG group.

I would like to thank Dr Barbara Grey, for sharing her experiences and learning from her own PhD, as well as her practical help in reviewing the coding of my qualitative interviews from the OAR study, and for reviewing my chapters with me towards the end of my write-up. I also appreciate the help given to me by Hilary Charlton, Sharon Daley

and Julie Williams in supporting the proof reading process of my final draft chapters prior to submission. Finally, thanks to Simon Pound at QA Limited for his willingness to answer my endless queries on the many of foibles of Word 2010.

My daughter, Issy has accepted the presence of my PhD in her life, since she was five years old with good grace and tolerance well beyond her years. Thank you my darling girl for being such a star, and for being so understanding and helpful. My husband Steve has also supported me through this journey with endless patience, goodwill, cups of tea, tolerance of its impact on our family life and by helping me to keep focused on the bigger picture.

Finally, I would like to thank my parents, Michael and Norah Daley, who both died while I was undertaking my PhD. I miss you both more than I can say. This thesis is dedicated to you both.

To Mum and Dad

You are always with me

Glossary of terms

Anosognosia	A deficit of self-awareness, a condition in which a person who experiences an illness seems unaware of the existence of the illness and its impact upon their life
Carers- informal	A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability or a mental health problem cannot cope without their support (Carers Trust 2014)
Clinical recovery	Amelioration of symptoms, reduced mental health service use, high level of functioning
Co-produced	Joint development of initiatives and materials by service users, carers and staff
First-person narratives	Written accounts by people who have experienced mental illness which described their experiences and the factors which help recovery
Life History	A written record of an individual's life history, giving details of significant life events, key biographical information, likes, dislikes and preferences for future care delivery
Lived experience	The experience of having or having had a mental health problem and the experience gained from living with, and managing the illness
Mental health services for adults of working age	Secondary mental health services which meet the needs of people under the age of 65 years, as well as those with persistent mental illness over the age of 65 years
Organisational Development	Literature on organisational change and service improvement
Personal recovery	Taking control of one's illness and ones' life, and living a full and meaningful life, regardless of on-going symptoms
OAR Intervention	An intervention for staff comprising team recovery training (3 days), action planning day and implementation support
Researchers	Principal investigator and research worker
Recovery supporters	People and services who work with people with lived experience to achieve personally defined recovery goals
Service managers	Managers who are responsible for the operational management and service delivery of a number of clinical teams, normally within a designated service or geographical boundary
Sub-study 1	Assessment of staff outcomes in 15 teams
Sub-study 2	Comprehensive assessment of service user and staff outcomes in 6 teams
Team (recovery) action plan	Plan for three areas of pro-recovery practice change, agreed by the team with objectives and timescales
WRAP	Wellness Recovery Action Plans

Abbreviations

CMHTs	Community Mental Health Teams
95%	95% Confidence Interval of Difference (Lower to Upper)
IMR	Illness Management and Recovery
Independent Researcher (BG)	Barbara Grey
Independent Qualitative Researcher/Supervisor (JM)	Joanna Murray
ICC	Intraclass correlation
OPMHS	Older People's Mental Health Services
Principal Investigator (SD)	Stephanie Daley
QoL	Quality of Life
RAQ-7	Recovery Attitude Questionnaire
Recovery training facilitator (LMc)	Lynda McNab
Research worker (DN)	David Newton
RKI	Recovery Knowledge Inventory
SMMSE	Standardised Mini-mental state examination
Service user researcher (YP)	Yvonne Poulson
SF-12 (MCS)	Short-Form 12 (mental health composite score)
SF-12 (PCS)	Short-Form 12 (physical health composite score)

Chapter 1 Introduction

1.1 Context

Mental disorder in later life

Mental disorder is common in later life. It has been estimated that 40% of older people (those over the age of 65) see their GP on a regular basis in relation to a mental health issue (Care Services Improvement Partnership 2005). There are an estimated 2.4 million older people in the UK with depression (Age Concern 2007), with lower rates of detection and treatment compared to adults of working age with depressive disorders (Chew-Graham et al. 2004).

Dementia is a term used to describe a progressive neurodegenerative syndrome caused by a number of conditions, for which there is currently no cure. Common difficulties include memory loss, problems with planning, problem-solving, and language, orientation to time and place, as well as psychological and behavioural problems (Alzheimer's Society 2013). In 2005, the number of people with dementia living in the UK was estimated to be 700,000 and this figure is expected to grow to 940,000 by 2021 and to 1.7 million by 2051 (Knapp et al. 2007). The national dementia strategy for England: *Living Well with Dementia*, was developed in response to the rising numbers with dementia, and the need to improve services to people with dementia and their carers (Department of Health 2009). Older people are also more likely to have co-existing mental and physical health problems than their younger peers (Joint Commissioning Panel for Mental Health 2013).

Specialist care for older people with mental disorder is provided in part by Older People's Mental Health Services (OPMHS), which are services which have been designed specifically to respond to the secondary needs of older people with dementia and mental illness (Gavan 2011). OPMHS can fall between mental health services for adults of working age and general older people's services in terms of investment, new developments and priority setting (Appleby and Philp 2005, Anderson et al. 2009). Concerns also exist about the equity of mental health service provision to older people, with the suggestion that older people have less access to equivalent services and developments compared to adults of working age (Joint Commissioning Panel for Mental Health 2013, National Development Team for Inclusion 2011). Recent equality legislation has heightened debate about whether the current model of OPMHS providing services for people with both organic and functional mental health problems

will continue, or whether older people's services will become dementia-only services (Anderson 2011). However, the need for OPMHS to modernise, and adopt working practices which are commonly used within mental health services for adults of working age is a priority (National Development Team for Inclusion 2011).

Recovery

One area of development which has significantly impacted upon mental health services for adults of working age is the concept of recovery. Recovery is the subjective process of gaining control over one's life, actively managing one's illness and being able to live a satisfying life (Davidson et al. 2009). Over the last decade there has been a strong international service user and policy agenda to refocus mental health services for adults of working age, in order that they actively support the recovery of service users. Considerable recovery-related service redesign and research has taken place within the UK, Australia, New Zealand, USA, and Canada.

Recovery and Older People

A number of specific policy drivers also make clear the need to implement recovery-oriented practice within OPMHS (Department of Health 2011, Care Services Improvement Partnership 2005, Care Services Improvement Partnership 2007, Social Care Institute for Excellence 2006, National Institute for Mental Health Excellence 2005). A recent editorial in the *British Journal of Psychiatry* suggested that old age psychiatrists had the opportunity to redefine themselves, through a focus on recovery and successful ageing (Jeste and Palmer 2013). A number of expert opinion pieces have explored the relevance of recovery for users of OPMHS (Woods 2007, Hill et al. 2010, Cheffey et al. 2013).

However, there is a lack of practice guidance, implementation experience and empirical evidence about what recovery means and what services should do in relation to recovery for older people in OPMHS. This is the focus of this thesis.

1.2 Aims of the thesis

The research reported in this thesis is concerned with the experience of recovery in older people using OPMHS. The aims of the research were:

- i. Aim 1 (Conceptual framework): to develop a conceptual framework for recovery for older people with mental health problems
- ii. Aim 2 (Working practice implications): to identify the working practice implications for staff arising from this conceptual framework
- iii. Aim 3 (Recovery intervention): to develop a manualised team based recovery intervention based on this conceptual framework
- iv. Aim 4 (Evaluation): to evaluate the recovery intervention

1.2.1 Research setting and context

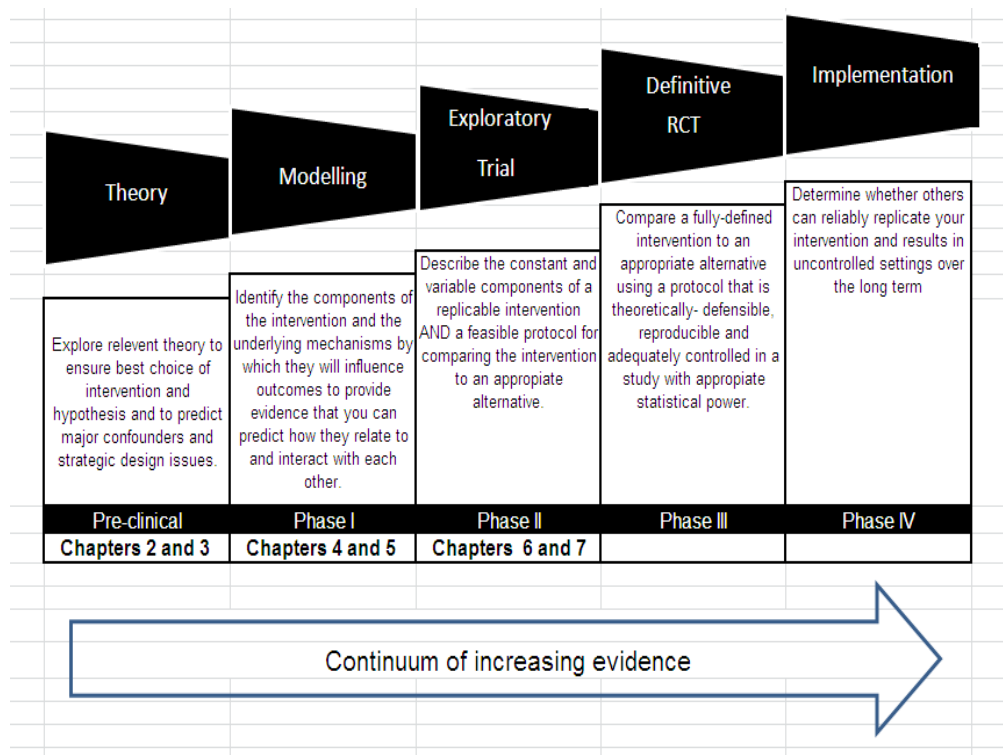
All of the research took place in an OPMHS which was part of an NHS Foundation Trust in South London. Funding of £520,000 was obtained by the principal investigator from two charitable organisations to support the implementation of recovery-oriented practice across all of the clinical services within the OPMHS. The principal investigator was the overall project lead for this wider programme of work which ran over a three year period. The outputs for the wider programme of work, which were set by the service director and clinical director in the OPMHS and the funders, included a framework for recovery and older people, delivery of recovery training to all clinical teams, evaluation of the recovery training and a development of a sustainable approach to service user and carer involvement within the local OPMHS. The principal investigator managed the budget for delivery of the programme of work, and was responsible for the delivery of all the agreed outputs within the three year period. A steering group was convened at the beginning of the programme of work, which included the service director, senior professionals and managers from the local OPMHS.

1.2.2 Underpinning scientific framework

The research was underpinned by the original Medical Research Council (MRC) Framework for the development and the evaluation of complex interventions to improve health (Campbell et al. 2000), and the updated guidance (Craig et al. 2008). The original MRC Framework (2000) made clear a set of sequential stages to support the evaluation of the complex interventions. Complex interventions are defined as interventions which comprise a number of independent and interdependent components, and which involve a range of complexity. For example, a number of specific behaviours required for the delivery and/or receipt of an intervention, or identification of a range of organisational levels or groups which are to be targeted by an intervention, and as such require measurement of a number of different outcomes (Campbell et al. 2000). The MRC framework includes five stages, with specific objectives for each stage, although it is recognised that more or less research activity may be required at any one stage dependent upon the current state of the evidence in the specific area. The subsequent revised guidance (2008) identifies a number of questions which researchers should consider in order to identify the most appropriate research method, as well as guidance on non-experimental methods. The MRC framework can be viewed as approach to defining research activity and development, and is distinguished from a clinical model of practice, which in contrast provides a more prescriptive approach to the steps required in the delivery of an professional intervention as well as providing an underlying theoretical perspective (Kielhofner 2008). Criticisms of the MRC framework include concerns that it remains overly focused on randomised controlled trials (Craig and Petticrew 2013), that its' definition of complexity is too simplistic (Anderson 2008) and that it does not adequately address contextual factors or the evaluation of policy (Mackenzie et al. 2010). Further it is suggested that the sequential approach may be overly simplistic and not suitable for broader health services research where the process of developing and evaluation of new interventions may be more iterative and emergent.

For the purposes of this thesis, the MRC framework has been used to define and organise the approach towards the whole programme of research and to support the development of the research aims for each stage of the research activity. The methodological considerations are discussed in each relevant data chapter. The research was carried out in three stages, spanning the MRC Framework's theory, modelling and exploratory trial phases. The MRC Framework as applied to the thesis is shown in Figure 1.1

Figure 1.1 MRC Framework as applied to the thesis



1.2.3 Stage one: Theory

A review of the recovery literature identified the components of personal recovery, which are the active elements which directly enable the individual with experience of mental illness to move forward in their own recovery journey. This was followed by a mapping review on recovery and older people. Both were used to develop topic guides for qualitative interviews with service users and their carers. The purpose of the qualitative interviews was to identify the individual components of recovery which are applicable to older people. The interview transcripts were analysed using grounded theory techniques, in particular, constant comparison to develop possible hypotheses which were validated through repeated interviews. Data were simultaneously collated and analysed, and further theoretical sampling took place to test out the emerging themes.

A conceptual framework for understanding the experience of recovery for older people with mental health problems and a linked framework for people with dementia were developed.

1.2.4 Stage two: Modelling

The conceptual frameworks were presented to service users, carers and staff in focus groups to establish the working practice implications. The conceptual frameworks and focus group findings were used to develop the OAR model, comprising a team based recovery intervention (OAR) and intended effects. The purpose of the OAR intervention was to change the working practice of staff in order that they facilitate the recovery of service users.

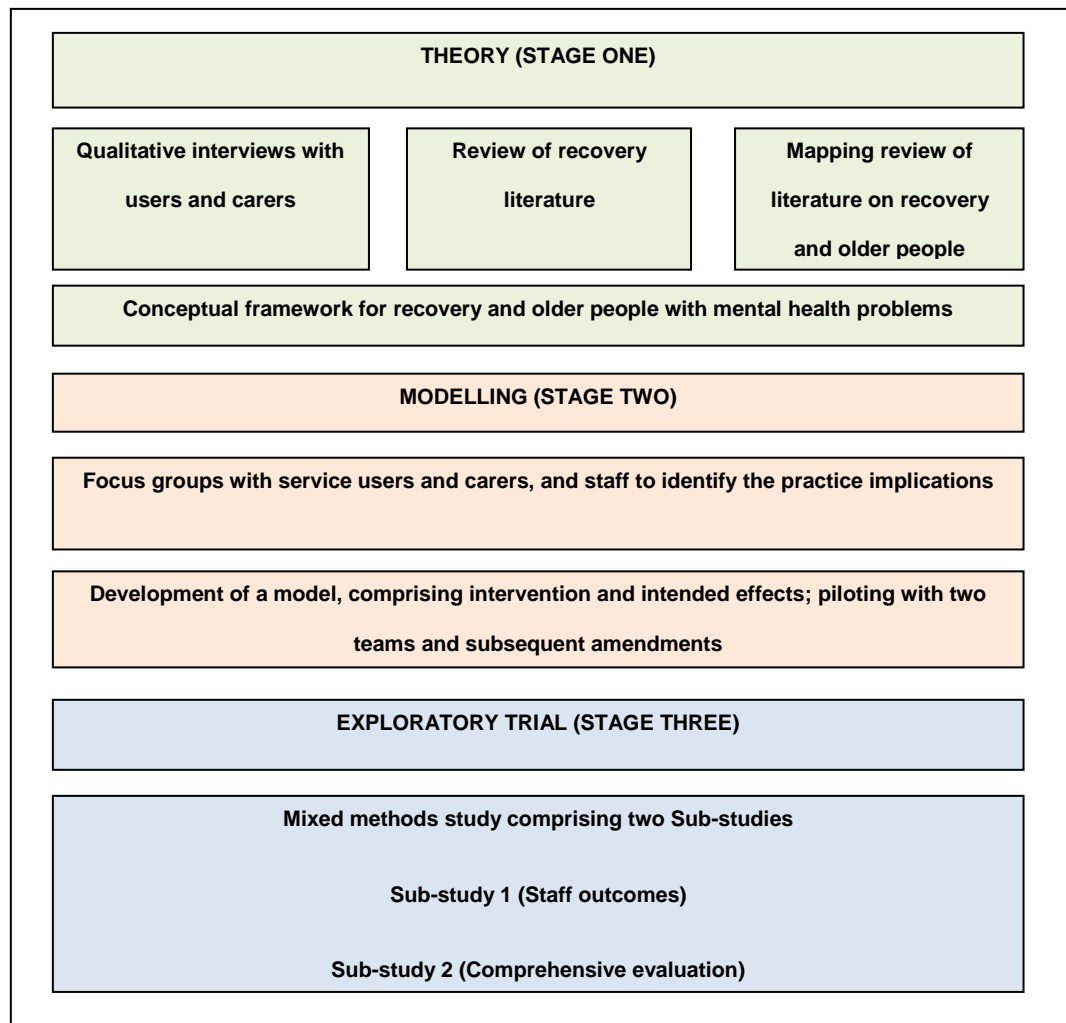
The OAR intervention and suggested candidate evaluation measures were piloted in two community mental health teams. This involved delivery of the OAR intervention, completion of pre-post quantitative measures by staff, evaluation feedback and qualitative interviews with staff regarding acceptability and implementation of the intervention. It also included piloting of quantitative recovery measures with service users, and completion of a care plan audit. This allowed for the redesign of the intervention and for review of the measures. A process evaluation framework and supporting implementation strategy were also developed for the final phase of the research. Review of the pilot findings and subsequent amendment generated a final OAR model suitable for use with clinical teams within OPMHS.

1.2.5 Stage three: Exploratory trial

The OAR intervention was delivered to a further 13 teams, and formally evaluated within the OAR feasibility study. In line with the MRC Framework, the OAR study had three research objectives: 1) to optimise the intervention 2) to optimise the evaluation and 3) to establish trial parameters. It comprised two Sub-studies. In Sub-study 1 (Staff outcomes) outcomes for staff were assessed. Sub-study 2 (Comprehensive evaluation) was nested in Sub-study 1, and involved a more detailed mixed methods evaluation of process and outcome for service users and staff in six teams. Specifically a 'controlled before and after' (CBA) design was employed to measure the impact of delivering the OAR intervention to staff upon service users. This involved delivery of the OAR intervention on a phased basis to a total of five CMHTs and one memory service. Comparisons of data were made between those teams who had the intervention and those who had not. All clinical teams within the study received the OAR intervention by the end of the research.

The research activity as applied to the MRC Framework is shown in Figure 1.2

Figure 1.2 Thesis elements mapped onto the MRC Framework



1.3 Structure of thesis

This thesis reports research in the context of a programme of work to develop recovery-oriented practice in an OPMHS in South London, UK.

Chapter 1 provides an introduction to the context in relation to OPMHS and recovery, and makes clear the aims of the research and structure of the thesis.

Research aim 1 (Conceptual framework) is addressed in Chapters 2 and 3. Chapter 2 reports a review of the literature on recovery, recovery-oriented practice, and a mapping review on recovery and older people. This provides the rationale for the research undertaken in this thesis, and underpins the development of topics guides.

Chapter 3 presents a qualitative study undertaken with service users and carers in order to develop a conceptual framework of recovery for older people.

Aim 2 (Working practice implications) is addressed by Chapter 4. Chapter 4 presents the findings from three focus groups which identified the clinical implications arising from the framework of recovery and older people.

Aim 3 (Recovery intervention) is addressed by Chapter 5. Chapter 5 describes the development of the OAR model, comprising intervention and intended effects, evaluation and implementation strategies. It also presents the results of a pilot with two clinical teams and subsequent refinements to the intervention and evaluation.

Aim 4 (Evaluation) is met by Chapters 6 and 7. Chapter 6 presents the research objectives, hypotheses, design and methods used for the feasibility study of the OAR intervention. Chapter 7 presents the findings from the study for three objectives 1) optimise the intervention, 2) optimise the evaluation and 3) define the trial parameters for a future definitive trial.

Finally, Chapter 8 makes clear the overall contribution to knowledge made by the thesis. The findings are discussed, as are its overall strengths and limitations. The future scientific and clinical implications are presented.

1.4 Statement of Personal Contribution

As the principal investigator for this study, my overarching contributions were:

- obtaining the necessary funding for this research (and the wider programme of work)
- recruiting, managing and supervising the personnel (a research worker, a recovery training facilitator and an administrator)
- obtaining organisational support from the local OPMHS
- designing the study with input from research supervisors
- acting as the principal investigator and project lead
- obtaining NHS ethics and local R & D approval

I wrote all of the text within this thesis.

In Chapter 2, I reviewed the literature on recovery, recovery-oriented practice and recovery and older people.

In Chapter 3, I developed the service user and carer topic guides and conducted 16 of the 39 qualitative interviews. I conducted the analysis of 31 interview transcripts, in conjunction with two colleagues and a service user researcher.

In Chapter 4, I co-facilitated the focus groups with two colleagues. I conducted all of the analysis of the focus group data, which was reviewed with a senior qualitative researcher.

In Chapter 5, I developed the working practice implications, and the draft OAR model, comprising intervention and its intended effects. I conducted and analysed three staff qualitative interviews as part of the pilot. I established and chaired the Training Advisory Group, and worked jointly with a colleague in piloting outcome measures with 25 service users. I reviewed the data from the pilot study, and developed the final OAR intervention, evaluation and implementation strategies.

In Chapter 6, I recruited service user participants (n=67) in Arm 2 (delayed delivery) of Sub-study 2 and administered measures over three time points for this cohort. I undertook all of the data cleaning of staff and service user measures and the statistical analysis of all quantitative data. I conducted 14 of 15 staff and trainer qualitative interviews, and carried out the analysis of all of the interview transcripts, working with an independent researcher to agree the coding framework used.

Chapter 2 presents the literature on recovery, and makes clear the rationale for the research undertaken in this thesis.

Chapter 2 Literature Review

The purpose of this chapter is to define the meaning of 'recovery' as used in this thesis, and to explore its applicability for older people. This will be achieved by describing the evolution of the contemporary concept of recovery, identifying some key components and outlining existing frameworks for understanding recovery. The impact of recovery on working practices and service delivery is explored, as well as the potential benefits for different groups of service users. Finally, the literature on recovery and older people will be reviewed and the rationale for the research described in this thesis developed.

2.1 What is recovery?

In exploring the meaning of recovery for people with mental health problems, it is recognised that there are a variety of different interpretations of the term in use. The breadth of differing definitions has led to confusion and misunderstanding. Furthermore, use of the term 'recovery' has expanded in use and meaning, and has been given stronger prominence over the last three decades by people with lived experience (those who have or have had mental illness) (Andresen et al. 2003). There has been a polarisation between two broad views of recovery, those which support a biomedical or clinical definition of recovery compared to those supporting a strengths-focused, personal growth, service user-led definition (Henderson 2011). Whilst it is acknowledged that multi-dimensional models exist (Whitley and Drake 2010) and that binary distinctions may be overly simplistic, to support exploration of these two views, the differences between clinical recovery compared to personal recovery will be presented (Slade 2009).

2.1.1 Clinical recovery

For many mental health professionals, researchers and general public, the term recovery is typically understood in relation to clinical recovery. This involves amelioration of symptoms, reduced level of service use, lack of hospitalisation and improved functioning (Lloyd et al. 2008). Emphasis is often placed on full recovery from illness (Lieberman and Kopelowicz 2005), with a high threshold of objective measurement by professionals of this achievement over time (Davidson et al. 2008). An example of an operational definition of recovery from schizophrenia is: symptom remission for two consecutive years, vocational or educational engagement for at least a year, independent living and independence in activities of daily living, and at least one peer relationship (Lieberman et al. 2002). Clinical recovery has historically underpinned traditional mental health service

provision, with a focus upon treatments and interventions to address these clinical outcomes, with emphasis upon working practice, care pathways, evidence-based treatments and professional roles. More recently, there has been an increasing trend towards a more technological or neuro-scientific outlook underpinning this approach (Bracken et al. 2012). However, whilst there has been some variation over time within the manifestation of this approach, common to all is the conceptualisation of recovery as a return to a 'normal' and 'stable' state, as assessed by 'expert' others (professionals or researchers) using pre-defined and invariant criteria.

2.1.2 Personal recovery

Personal recovery can be described as the subjective process of taking back control of one's life and one's illness, taking personal responsibility for one's own recovery and having optimism for the future (Roberts and Wolfson 2004). One definition of recovery (Anthony 1993) is:

'A deeply personal, unique process of changing one's attitudes, values and feelings, goals and skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of a new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (p 21)

This has been used within a number of national mental health policies such those in Ireland (Mental Health Commission 2005) and Australia (Australian Health Ministers 2012b).

Within this conceptualisation, the process of personal recovery is led and instigated by the person with a mental illness, and the process may involve a range of supporters, which may, or may not, include mental health services. An amelioration of symptoms is not required for personal recovery to take place. Other terms used to describe the same phenomenon, include being 'in recovery' (Davidson et al. 2008), 'life' recovery (Collier 2010), 'social recovery' (Care Services Improvement Partnership et al. 2007), 'psychological recovery' (Andresen et al. 2003), and 'existential recovery' (Whitley and Drake 2010).

Personal recovery has evolved as a contemporary concept from two sources; first-person narratives and second from evidence from longitudinal studies (Slade et al.

2008). First-person narratives have come from people who have experienced mental illness (those with lived experience) who have written about their experiences and the factors which have supported their recovery (Coleman and Smith 2002, Deegan 1996, Geller 2000, Lette 1989). These have challenged the requirement of a complete absence of symptoms as evidence of recovery, and have instead placed emphasis on personal growth, self-management, well-being and achievement of life goals. Furthermore, these narratives have made explicit the service user discontent with traditional mental health service provision. Many narratives stress that the process of recovery is both instigated and led by the person with lived experience as opposed to the professional, and have highlighted factors such as hope, self-management, peer support and personal responsibility as key components within the process. These narratives have been complemented by qualitative studies which have sought to understand the process of recovery from a first-person as opposed to a professional perspective (Davidson et al. 2005, Ralph 2000, Ridgway 2001),

First-person narratives and qualitative research have both sought to redefine and expand the existing definition of recovery, and have been supported by evidence from long-term follow up studies. These follow-up studies have shown that clinical recovery from psychosis is much higher than previously considered. The Vermont Longitudinal Research project was a 32 year study looking at long-term outcomes for 269 service users discharged from institutions without planned mental health aftercare in Vermont. The researchers found that 68% of participants did not demonstrate symptoms of schizophrenia and were functioning at a level which most would consider normal (81% were able to look after themselves). 68% described themselves as having close relationships, and 54% were in touch with mental health services. Overall, 25% were fully recovered and 41% showed significant improvement (Harding et al. 1987). These longitudinal studies have been summarised (Slade 2009) as shown in Table 2.1.

Table 2.1 Long-term follow up studies for people with psychosis

Researchers	Location	Participant numbers	Research team	Significantly or completely recovered (%)
(Huber et al. 1975)	Bonn	502	22 years	57%
(Ciompi 1984)	Lausanne	289	37 years	53%
(Bleuler 1978)	Zurich	208	23 years	53 – 68%
(Tsuang et al. 1979)	Iowa	186	35 years	46%
(Ogawa et al. 1987)	Japan	140	23 years	57%
(Desisto et al. 1995)	Maine	269	35 years	49%
(Harrison et al. 2001)	18 site	776	25 years	56%

These studies have been used to highlight that for many people with psychosis recovery does take place, although it may take some time. Whilst there is variation in the methodologies used, these findings have been used as a call for a more optimistic outlook for people with psychotic disorders (Harding and Zahniser 1994, Davidson et al. 2008, Slade 2009). In particular, they have been used to challenge the therapeutic pessimism about service user outcomes which can exist within traditional mental health services (Allott et al. 2002). One reason given for this pessimism is the ‘clinician’s illusion’ (Cohen and Cohen 1984), a phenomenon of overly negative prognostic beliefs arising from a) professionals predominantly having more contact with individual service users in crisis rather than when more recovered and b) professionals seeing people who are at the more severe end of the severity spectrum. This pattern of clinical encounter provides professionals with skewed evidence, easily leading to the belief that people with mental health problems will always encounter difficulties and crises.

These first-person narratives and qualitative studies, and evidence from longitudinal studies have together broadened the definition of recovery, and as such, have encouraged working practices and delivery of mental health services that go beyond symptom reduction (Shepherd et al. 2008).

2.1.3 What is the impact of these differing views of recovery?

Clinical recovery can be characterised as an existing framework, based on clinical phenomena and associated outcomes, and personal recovery as an emergent

framework, which has developed as a challenge to the prevailing paradigm which underpins traditional mental health care. The compatibility of clinical recovery and personal recovery is contested.

A joint position paper on recovery suggests that clinical and personal recovery are complementary and that both are required (Care Services Improvement Partnership et al. 2007). In other words, effective evidence-based treatments and wider supports which build resilience and personal growth beyond the limitations of illness. Multi-dimensional frameworks such as the framework proposed by Whitley and Drake lead to a broadening of the concept of recovery. Such frameworks encompass clinical, existential, functional, physical and social dimensions of recovery (Whitley and Drake 2010). These frameworks encourage consideration of more focussed interventions for each dimension. Further they recognise the symbiotic relationship between dimensions as well as the contribution which can be made from a range of recovery supporters including: family, professionals, friends and the wider community.

In contrast, concern has been expressed about the impact which clinical recovery, and an overly strong emphasis on symptom reduction can have for service users, in focussing on deficits and the dismissal of personally meaningful goals (Repper and Perkins 2003):

'The challenge facing people with mental health problems is to retain, or rebuild, a meaningful and valued life.... Recovery is not about 'getting rid' of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering social roles and relationships that give life meaning.' (p. ix)

This underpins the view that the constructs hold entirely different meanings and outcomes, and that a combined approach towards is not possible (Collier 2010).

An alternative view is that components of personal recovery are important mediators towards the outcome of full clinical recovery from illness, but with personal recovery not being equivalent to full clinical recovery (Lieberman and Kopelowicz 2005).

The discourse on recovery is emergent and continues to grow, and opinion about what constitutes recovery remains divided. In this thesis the focus is upon personal recovery. The generic term recovery will be used to categorise and describe phenomena which fit within this definition. In exploring recovery further, its components and impact on

working practices will be explored.

2.2 Components of Recovery

Recovery should be viewed as a construct with a number of independent and inter-dependent active components, which enable recovery to take place (Bellack 2006). Whilst the unique and subjective nature of personal recovery can make definition problematic, first-person narrative accounts and qualitative research identify a number of active components which appear to be commonly experienced. One framework that has been proposed based on a review of published narratives, qualitative research and service user definitions (Andresen et al. 2003) comprises four components:

- a) Hope: the belief that things which get better
- b) Identity: a sense of self as distinct to one's illness
- c) Meaning: deriving meaning and understanding from the experience of illness
- d) Personal responsibility: taking of responsibility to manage one's illness

Further review of the recovery literature has identified components which appear to be commonly experienced (Leamy et al. 2011, Bonney and Stickley 2008). A number of these frameworks for understanding recovery processes, consisting of both key components and stages of recovery are summarised in Table 2.2.

Table 2.2 Summary of recovery frameworks

Researchers	Summary of key components and stages
(Andresen et al. 2003)	Five stage model of psychological recovery comprising: Moratorium, Awareness, Preparation, Rebuilding and Growth
(Bonney and Stickley 2008)	Review of British literature on recovery: six themes emerged: identity, service provision, social domain, power and control, hope (and optimism) and risk and responsibility
(Davidson et al. 2005)	Being <i>'in'</i> recovery. Key themes includes 1) how the individual deals with his or her difficulties 2) the role of material resources 3) the various roles of formal and informal health systems 4) the roles, and absence, of significant others and 5) the roles of social and cultural factors
(Henderson 2011)	Overcoming loss as a central task in the process of recovery within biomedical, psychological and/or social dimensions. Three phases: Recuperation, Moving forward and 'Getting back'. Facilitated by protective factors, as well as external mechanisms.
(Jacobson and Greenley 2001)	Model of internal and external conditions to support recovery. Internal conditions include: hope, healing, empowerment, connections. External conditions focus on human rights, recovery-oriented and culture of healing
(Leamy et al. 2011)	Systematic review of recovery literature. The CHIME framework comprising five recovery processes; Connectedness, Hope, Identity, Meaning and Empowerment.
(Song and Shih 2009)	Unity model of recovery. Key cornerstones include: resilience, (gaining) control of symptoms, family support, having meaningful roles and reciprocal relationships, as well as a sense of self and internal locus of control, and social networks
(Tew 2013)	Viewing the person in their social context and assessing capital. Building of efficacy and capability in five distinct forms of capital (Economic, Social, Identity, Personal and Mental) which combined can offer recovery capital

There is variation in the range of recovery components identified and research methodologies used (Henderson 2011). However, overlap between some of these frameworks is evident. A broad distinction is the extent to which recovery is seen as an individual experience, compared to a process whereby relationships with others (supporters) or wider societal structures are crucial. Within frameworks which see recovery as primarily an individual experience whereby hope, agency and meaning are key components (Leamy et al. 2011, Andresen et al. 2003, Henderson 2011). In frameworks which place emphasis on relationships, significant attention on the role of, and relationships with others (families/peers/services) in the process of recovery is stressed (Song and Shih 2009, Jacobson and Greenley 2001). In frameworks which consider wider structures, emphasis is placed upon the negative impact of wider societal inequalities and recovery is conceptualised as a social/political issue (Hopper 2007, Tew 2013). Common to all of these frameworks is the range of potential outcomes which may arise from the process of recovery, which extend significantly beyond symptom reduction. As such, recovery has the potential to challenge and redefine the goals and consequently the practices of traditional mental health service provision.

2.3 What does recovery mean for mental health services?

Mental health services have a key role in either facilitating or limiting the opportunities for recovery to take place. A position paper by the Centre for Mental Health proposes that mental health services should be able to do more than simply reduce symptoms and that services should be able to help people to manage, overcome and live well beyond their illnesses (Shepherd et al. 2008). This is supported by current UK policy on mental health (Department of Health 2011), which has an objective that more people with mental health problems will recover and:

'Will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.' (p.21)

Similar policy endorsement has been received internationally, in the USA (New Freedom Commission on Mental Health 2005), Australia (Australian Health Ministers 2012b), New Zealand (Mental Health Commission 2012), Canada (Mental Health Commission of Canada 2012) and Ireland (Mental Health Commission 2005). A key

expectation of these policies is a move towards recovery-oriented practice - working practices which facilitate recovery. For example, the national framework for recovery-oriented mental health services in Australia (Australian Health Ministers 2012a), provides 17 domains of recovery-oriented practice, and specifies the capabilities required by staff and mental health services within each domain.

Within the UK, recovery-oriented practice is endorsed by the UK professional bodies for the main professional groups. This includes nursing (Department of Health 2006), occupational therapy (College of Occupational Therapists 2006), psychiatry (Royal College of Psychiatrists 2008) and psychology (British Psychological Society. Division of Clinical Psychology et al. 2000). In supporting practice change, a position statement by consultant psychiatrists working within two London NHS Trusts, makes clear that recovery-oriented practice should be provided to all service user groups (South London and Maudsley NHS Foundation Trust and South West London and St George's NHS Trust 2010). Further it provides clarity for what this means for psychiatrists, for example, placing value on service user knowledge gained from personal experience, as well as emphasis on the priorities of service users.

2.3.1 Recovery-oriented practice

There is a developing evidence base about working practices which support recovery outcomes (Slade et al. 2014). Working practices which underpin four recovery-oriented values have been identified: Person-orientation, service user involvement, autonomy and choice, and hope (Farkas 2007). In a qualitative analysis of 30 international recovery-oriented practice guidance documents, working practices were categorised into four areas of the most commonly recommended practice implications (Le Boutillier et al. 2011):

- 1) Promoting citizenship
- 2) Supporting personally defined recovery
- 3) Changing the nature of the working relationship between service users and professionals
- 4) Organisational commitment in the implementation of recovery-oriented practice

Promoting Citizenship

The first area of working practice which supports recovery are those which promote citizenship. Working practices which promote citizenship include a range of activities

which may be delivered by statutory and non-statutory services. Practices have been categorised (Le Boutillier et al. 2011) as including:

- the promotion of service user rights
- service user involvement
- challenging the stigma and discrimination faced by people with mental health problems
- promoting social inclusion
- facilitating engagement in meaningful occupation and meaningful social roles

Recovery-oriented mental health practice is underpinned by a strong commitment to meaningful service user involvement (Allott et al. 2002). Involvement can lie on a continuum, from involving service users in the development and evaluation of services, to actively increasing the number of people with a lived experience of mental illness employed within the organisation, to employing peer support workers. Securing meaningful engagement involves pro-actively engaging with service users, overcoming financial barriers to involvement, using advocacy services, and supporting and developing the skills of service users in this area, in order to build sustainable involvement (Beresford 2013). Working practices which recognise the contribution of, and facilitate involvement of peer support, namely support from others who have lived experience has been strongly advocated (Mead et al. 2001, Lette 1989, Repper and Carter 2011), and evidence in this area is developing (Davidson and Guy 2012).

The involvement of professionals in actively promoting and delivering mental health awareness to community groups, as a means to challenge stigmatising attitudes has been encouraged (Australian Health Ministers 2012a). Engaging with community leaders and faith groups is also encouraged as a means of promoting service user rights and enhancing inclusion (Beresford 2013). Working practices which further promote social inclusion, include ensuring that achieving a meaningful community life is part of care planning, and use of mainstream community resources is the norm (Davidson et al. 2009). For adults of working age, this may also include interventions such as Individual Placement and Support (IPS) which focus on the obtainment of socially valued roles through tailored support to gain open employment (Rinaldi et al. 2008). Overall, the key practice elements involve actively challenging stigma and discrimination, promoting service user involvement and social inclusion and supporting engagement in meaningful occupation and obtaining socially valued roles.

Supporting personally-defined recovery

The second area of working practice which supports recovery are those which enhance the personally-defined recovery of service users. Supporting personally-defined recovery involves maintaining focus on the individual service user, their preferences and goals and promoting autonomy and choice (Le Boutillier et al. 2011). Areas of practice which have been identified include understanding the values of the service users and using their strengths, collaborative goal setting, activity supporting autonomy and where necessary positive risk-taking, building resilience and self-management.

Understanding the values of the service user involves understanding their life history and their story (Barker and Buchanan-Barker 2010). The need to undertake assessments which amplify strengths, talents and interests, rather than weaknesses and deficits, is stressed in building an understanding of the service user (Bird et al. 2011). An approach which specifically incorporates this is the strengths model, in which failure to identify strengths and abilities is seen as an inability of the professional to elicit the information, rather than a weakness in the service user (Rapp and Goscha 2006). Fidelity to the strengths model has demonstrated improved service user outcomes (Fukui et al. 2012). The knowledge gained through a strengths assessment, and in-depth knowledge of the service user, can be used to identify service user goals and aspirations (Collier 2010) and plan towards goal attainment. Factors identified in successful goal setting include: collaborative working, ensuring that the goals fit with the underlying values of the service user and are owned by the service user, as well as the grading of goals into achievable steps (Crowe et al. 2012).

Promoting choice and autonomy can support personally-defined recovery. Choice and autonomy involve providing meaningful opportunities for informed decision making about illness management and future goals and aspiration in order that personal responsibility (for managing one's illness) remains with the person with lived experience. For example, in providing a diagnosis or giving information, this should be provided in a way which enables service users to make decisions about their care preferences, and so enhances their autonomy (Topor et al. 2006). Supporting choice and autonomy also involves a shift from practice which is risk avoidant towards positive risk taking. Positive-taking involves identifying both the benefits as well as the risks of action and behaviour which may meet service user aspirations and goals. This involves

professionals more clearly identifying areas where risk exists as well as where it does not (Davidson et al. 2006). It also involves actively sharing concerns about risk with service users, and where possible agreeing a planned response collaboratively in relation to the identified risk. Within this approach, there is a need for professionals to consider where there are opportunities for positive risk taking to take place so that opportunities for self-determination and learning are present (Boardman and Roberts 2014) . As Deegan (1996) points out, many people without mental health problems frequently take risks and make mistakes, sometimes against advice of others, and through this process, people are able to learn and grow. She makes clear that people with mental health problems should be afforded the right and dignity of being able to make their own decisions and be allowed to fail (Deegan 1996). Such an approach to risk taking differs from a more traditional approach to risk management in services oriented towards clinical recovery in which practice can become overly defensive, and maintain the status of service users as passive and incapable of managing their illnesses, and in turn places all of the responsibility onto professionals who become the containers and monitors of risk (Boardman and Roberts 2014).

Finally, interventions which build resilience and strengthen self-management support the achievement of personally defined recovery (Allott et al. 2002, Deegan 1996). Interventions such as the Illness Management and Recovery (IMR) programme, which introduces service users to the concept of recovery, and the identification of recovery goals, along with a number of educational illness managements modules (Mueser et al. 2006). The intervention which has 40 sessions can be delivered individually or in groups. Three RCTs have demonstrated the effectiveness of the IMR programme in improved illness management outcomes, when delivered in a group format (Färdig et al. 2011, Levitt et al. 2009, Hasson-Ohayon et al. 2007).

Additionally, tools such as Wellness Recovery Action Plans (WRAP) have been used to support self-management and a focus on wellness (Copeland 2005). The WRAP is a service user developed/owned plan comprising:

- a) daily maintenance plan to keep well
- b) potential triggers and coping strategies
- c) early warning signs and action
- d) Signs of relapse and action
- e) Crisis plan
- f) Post crisis plan

A recent RCT promoting self-management with 519 service users with serious mental illness using WRAP planning demonstrated significant improvement in symptoms, hopefulness and quality of life (Cook et al. 2012).

Overall, the key practice elements include understanding service user values and goals, joint goal setting, and supporting self-determination and resilience by promoting self-management and positive risk-taking.

Changing the nature of working relationships

The third area of working practice which support recovery is the way in which professionals work with service users and the nature of the working relationships. There are two key domains which influence the nature of working relationship between professionals and service users in promoting recovery; partnership and inspiring hope (Le Boutillier et al. 2011).

Partnership relationships differ from traditional clinician-patient relationships. The expertise through qualification and professional experience remains necessary, but a higher value is also put on the expertise of 'lived experience' i.e. the individual's self-knowledge about their personal values, life history and developing narrative. In a partnership relationship, both these forms of expertise are activated. In developing true partnership working, there is a need for professionals to consider how their skill and expertise (by qualification) complements and assists the expertise (by experience) of service users. It has been suggested that professionals should shift their approach to the provision of support to one which is 'on tap' rather than 'on top' (Shepherd et al. 2008). A redefinition of the role of professionals as coaches/mentors rather than being singularly responsible for getting people better or for people's failures has been suggested (Rogers et al. 2007). Using a coaching framework to support this process can be beneficial (Bird et al. 2011). Further, professionals recognising the personal resourcefulness of the person with mental illness was rated as one of the most important practices in a study of service user views on staff competencies (Lakeman 2010).

The significance of hope as an important component within the individual process of recovery was discussed in section 2.2. If a professional is hopeless about the future for a particular service user, this is likely to decrease both the optimism of the individual

service user, and the likelihood of working towards an improved future. Encouragement of hope by professionals is important, as is the need for professionals to recognise that they have a choice as to whether they impart hope or hopelessness to users, and that both are infectious (Bassett and Repper 2005). The concept of the 'clinician's illusion' (Cohen and Cohen 1984) was discussed in section 2.1.2, which leads to professionals to consciously or unconsciously communicating a pessimistic outlook and low expectations to service users, which in turn creates dependence and chronicity (Allott et al. 2002). Sharing of service user narratives of success to generate hope has also been proposed as a counter balance (Bassett and Repper 2005).

Overall, the key practice elements include recognising and valuing service user experience, and authentically conveying hope to the goal of recovery and preferred future.

Organisational commitment

In addition to the practices discussed, wider organisational commitment is required to support mental health system transformation to recovery-orientation (Farkas et al. 2006). Organisational commitment includes a recovery vision, workplace support structures, quality improvement (based upon service user involvement and feedback), care pathways which support recovery, and workforce redesign (Le Boutillier et al. 2011).

There is a need for commitment to the values and principles of recovery, not as an 'add on', but intrinsic to the way the organisation or service runs, with recovery values reflected within mission statements, operational policies, and forming part of staff recruitment and training (Farkas et al. 2006).

One approach to supporting change towards recovery orientation is the ImROC programme which has been established to support mental health services in England to become more recovery-oriented (NHS Confederation and Centre for Mental Health 2012). The ImROC programme (Boardman et al. 2011) has identified a number of areas of organisational change, including:

- Changing the nature of service user experience
- Establishing 'Recovery Education Units' or 'Recovery Colleges'

- Creating a recovery culture
- Workforce redesign
- Changing risk assessment approaches
- Developing meaningful service user involvement

Organisational self-assessment and ownership is a key feature of the subsequent implementation programme (Shepherd et al. 2010), with team level change identified as a key building block (Repper and Perkins 2013). Training in recovery principles is seen as a crucial component within organisational transformation (Rogers et al. 2007, Crowe et al. 2006, Roberts and Boardman 2014).

In summary, supporting the recovery of service users represents a change from existing ways of working for professionals. Changes range from the need for a community-oriented outlook as well as change in the nature of the professional/service user relationship to one which actively prioritises agency, increased focus on the aspirations and experiences of service users, as well as providing interventions which support actively support recovery and self-management.

2.4 Recovery for other clinical populations

The concept of recovery has been adapted for other clinical populations. The concept of recovery evolved from adults of working age, primarily those with psychosis, and its potential applicability has been investigated in other groups of service users. The need for investigation to understand how the process of recovery might manifest itself in different groups, different social contexts and across the life-span has been advocated (Lal 2010, Leamy et al. 2011, Slade et al. 2014).

The wider implications of recovery will be illustrated using three examples. First, an expert opinion article on the relevance of recovery for offenders has made clear the relevance of hope, particularly in seeing people with a history of offending as capable of change, as well as the need for self-acceptance, and being able to incorporate a forensic history into one's personal narrative (Roberts 2011).

Second, a study which sought to explore what recovery means for people with major addictions (Laudet 2007) was carried out with 354 participants with resolved dependence on heroin. The researchers carried out quantitative measures on three occasions at 12-monthly periods, as well as in-depth qualitative interviews (n=50). The

researchers found that opinions about recovery were associated with complete abstinence, in addition to a goal by many participants to regain a lost identity, and get 'back to me' rather than to a new or revised sense of self.

Finally, in exploring what recovery means for children, a study which involved telephone interviews and a stakeholder event to explore emerging themes about recovery, found that resilience, hope and future planning were components which were positively perceived by children and their families. Differences included the need to consider and work with family and economic contexts, and to use a child development approach, particularly towards the taking of personal responsibility (Friesen 2007).

The applicability of recovery has been explored for a number of other groups; people with eating disorders (Zerwas et al. 2013), those from black and minority ethnic communities (Sass et al. 2009) and people with learning difficulties (Handley et al. 2012).

From this emergent literature, it is apparent that recovery does have wider meaning and applicability beyond those with psychosis, but that some differences apply. The emerging literature on recovery and older people is now outlined.

2.5 Recovery and older people

Literature on the applicability of recovery for older people with mental health problems has begun to emerge. Additionally, current UK mental health policy is supportive of the implementation of recovery-oriented practice within OPMHS (Department of Health 2011).

A mapping review of the literature on recovery and older people was carried out. This methodology categorises existing literature, and identifies knowledge gaps (Grant and Booth 2009). Two data searches were undertaken. First, an electronic database search (CINAHL, EMBASE, HMIC, Medline, PsycINFO, Scopus and Web of Science). Second an intranet search via Google Scholar to include policy and pressure group reports. The search was conducted in November 2008 and was updated in January 2014. The search sought to identify literature related to recovery and older people developing mental illness, including dementia in later life.

In total, 22 documents and articles were found, comprising policy documents (n=5) lobby group reports (n=4), expert opinion pieces (n=11), and empirical research articles (n=2), as shown in Table 2.3

Table 2.3 Summary of mapping review (recovery and older people)

Category	Year	Author	Title
Policy	2011	Department of Health	No health without mental health
	2005	Care Services Improvement Partnership	Everybody's Business: Integrating mental health services for older people
	2007	Care Services Improvement Partnership	10 high impact changes for mental health services: Guidance for OPMHS
	2005	National Institute for Mental Health Excellence	Guiding Statement on Recovery
	2006	Social Care Institute for Excellence	Assessing the mental health needs of older people
Lobby Groups	2005	Bowers et al	Moving out of the shadows
	2006	Age Concern and Mental Health Foundation	Promoting mental health and well-being in later life
	2007	Age Concern	Improving services and support for older people with mental health problems
Opinion	2011	National Development Team for Inclusion	A Long Time Coming – achieving age equality in mental health services.
	2010	Irving and Lakeman	Reconciling mental health recovery with screening early intervention in dementia care
	2011	Gavan	Exploring the usefulness of a recovery-based approach to dementia care nursing
	2012	McKay et al	Reclaiming the best of the bio-psychosocial model of mental health care and 'recovery' for older people through a 'person-centred' approach
	2013	Cheffey et al	Supporting self-management in early dementia: a contribution towards 'living well'

	2010	Adams T	The applicability of a recovery approach to nursing people with dementia
	2010	Hill et al	Recovery and Person-centred care in dementia: common purpose, common practice?
	2009	Martin	Recovery approach to the care of people with dementia: decision making and 'best interests' concerns
	2007	Woods	Recovery: is it relevant to older people?
	2013	Jeste and Palmer	A call for a new positive psychiatry of ageing
	2009	Daillaire et al	Representations of Elderly with mental health problems held by psychosocial practitioners
	2009	Sole and Read	Person-centred care and recovery
Empirical Research	2013	Jha et al	Effectiveness of a recovery-oriented psychiatric intervention package on the well-being of people with early dementia
	2013	Tepper et al	Older Adults' perceptions of recovery from mental illness

Ten of the articles specifically related to the potential applicability of recovery for people with dementia, particularly the potential overlap with the practice of person-centred care (Kitwood 1997). Following review of the key themes within the literature, a further five articles on self-management and physical health were identified. The policy and pressure group literature refers broadly to recovery and older people who develop functional mental health problems in later life. However the potential differences in the experience of recovery for older people compared to the adults of working age are not explored. Two articles specifically explored recovery with older people with functional mental health problems, however the emphasis was on older people with a history of persistent mental illness, rather than those developing mental illness in later life.

The literature on recovery and older people is now synthesised.

2.5.1 Policy supporting recovery and older people

A number of specific policy drivers make clear the need for OPMHS to implement recovery-orientated practice for older people with mental health problems (Department of Health 2011, Care Services Improvement Partnership 2005, Care Services Improvement Partnership 2007, National Institute for Mental Health Excellence 2005, Social Care Institute for Excellence 2006). This includes a practice guide on assessing the mental health needs of older people (Social Care Institute for Excellence 2006) which states:

'Even for conditions where there is as yet no cure, as with dementia, improvements in care and treatment are achievable and can make a difference

to older people's quality of life.... Recovery and well-being approaches to mental health issues developed by younger adult service users and working age mental health services are equally applicable to older people.' (p.19)

There is however a lack of evidence and practice guidance within these policies as to what recovery for older people with mental health problems, including those with dementia, might look like in practice, and how it might be different from recovery as described by adults of working age. There is a risk that an 'age-blind' approach to this area of policy development will lead to the differing needs of older people with mental health problems not being considered sufficiently (Cheffey et al. 2013).

Lobby groups concerned with the mental health of older people have produced reports which make a number of recommendations for changing the way in which OPMHS deliver services.

The Moving out of the Shadows report on mental health and well-being in later life identified three areas of improvement for OPMHS (Bowers et al. 2005). First the report expressed concern about the lack of community engagement and delivery of mental health awareness training by OPMHS as a means to change widely held views that older age is inevitably associated with illness, loss of function and dementia. Second, the report indicated that staff should know 'the essential me' of their service users. Finally, the report recommended that OPMHS should develop mechanisms and cultures to promote social inclusion, active service user engagement and self-management.

A report on achieving equality in mental health services (National Development Team for Inclusion 2011) stressed the need for:

'The promotion of wellbeing, recovery and inclusion so that people of all ages are enabled to lead their lives, exercise choice and control, and contribute to family, community and civic life.' (p.40)

Within this report, OPMHS are encouraged to follow the developments within mental health services for adults of working-age, in shifting power and control to service users. Access to user and peer led support, information, and advocacy are suggested. Concern was expressed about the negative outlook about mental health and ageing held by service users, carers, staff in OPMHS and the wider community.

Two reports were published as part of the UK Inquiry into Mental Health and Well-Being in Later Life. Evidence was drawn from comprehensive literature and policy review, the views of 900 older people and carers as well as 150 organisations and professionals. The first report identified the double discrimination of both mental health and ageing, the benefit of participation in meaningful activities and relationships, as well as the impact of physical ill-health and poverty upon mental health and well-being in older age (Age Concern and Mental Health Foundation 2006). The overall recommendations for OPMHS included the need to engage in community development and peer support, development of collaborative working with service users, and improved service user and carer involvement within the planning and redesign of services (Age Concern 2007).

Policy and lobby group focus can be summarised as a demand for community engagement, as well as interventions which promote self-management, such as peer support, as well as meaningful service user and carer involvement. Further, there is a need to overcome negative and pessimistic attitudes by staff working in OPMHS as well as those of the general public.

2.5.2 Overlap between recovery and person-centred care

The link between recovery-oriented practice and person-centred care for people with dementia (Kitwood 1997) has been made in a number of opinion pieces (Hill et al. 2010, Woods 2007, Sole and Read 2009, McKay et al. 2012, Gavan 2011, Martin 2009).

Whilst the concept of person-centred care is not distinct to dementia, the work of Tom Kitwood and the Bradford Dementia Group is widely recognised as having a significant impact on dementia care theory, education, policy and practice (Irving and Lakeman 2010). Within this approach, also known as the Enriched Model of Dementia Care, the experience of dementia is conceptualised as being more than a neurological event, but rather a combination of bio-medical and social-psychological factors, involving five components which affect a person with dementia. These are summarised in Figure 2.1

Figure 2.1 The experience of dementia

Dementia = NI + H + B + P + SP		
NI	=	Neurological Impairment (upon the person from dementia)
H	=	Health and physical fitness (acute or long-term conditions)
B	=	Biography/Life History
P	=	Personality

The intended outcome of person-centred care is the maintenance of personhood, which enables well-being in dementia. This is achieved by meeting five basic needs which comprise: attachment, identity, inclusion, occupation and comfort (Kitwood 1997). As dementia progresses, the capacity of the person with dementia to meet these needs autonomously diminishes, therefore it is seen as the role of staff to facilitate the meeting of these needs and support personhood. Four essential person-centred working practices (Brooker 2004) are:

- a) Valuing people with dementia and their carers
- b) Recognising the uniqueness (history and personality) of people with dementia
- c) Seeing the world from the perspective of the person with dementia
- d) Recognising the significance of relationships and the social environment for people with dementia

Adams (2010) suggests that mental health services for adults of working age have primarily taken a recovery-oriented approach, whereas OPMHS take a person-centred care one. From the six opinion pieces, nine potential areas of overlap recovery and person-centred care are identified. An integration of the two perspectives is shown in Table 2.4

Table 2.4 Overlap between person-centred care and recovery

Personhood needs	Overlap with Recovery	Identified by
Attachment	Significance of relationships with others	Hill et al, 2010
Identity	Knowing the person Seeing beyond the diagnosis Revised sense of identity	McKay et al, 2010 Sole and Reed, 2009 Adams, 2010 Sole and Read, 2009
Inclusion	Impact of exclusion for people with dementia as well as those with serious mental illness Support to enable on-going community dwelling and inclusion	Gavan, 2011 Hill et al, 2010
Occupation	Importance of meaningful activities	Sole and Reed, 2009
Comfort	Seeing the world from the perspective of the person with dementia Use of life history to understand what is important to the person	Hill et al, 2010 Martin, 2009

The potential overlaps can be broadly summarised as the importance of relationships, knowing the person's narrative, promoting inclusion, engagement in meaningful activities and seeing the world from the person with dementia.

There is a risk that an assumption could be made that person-centred care and recovery are broadly the same perspectives. However significant differences exist and four areas of difference are noted.

First, as one of six articles makes clear, whilst person-centred care does emphasise listening to the person with dementia and responding to their preferences and wishes, this is not equivalent to the partnership relationship described in section 2.3.1 where the lived experience of dementia is viewed equally to the experience gained from professional expertise (Gavan 2011). The assumption that the professional knows best can often be observed within person-centred care. Recovery potentially enhances the scope for reciprocity in the relationship between the person with dementia and staff, and 'hearing the story of the person' has the potential to promote a care approach which is user-defined (Gavan 2011).

Second, it has been suggested that both philosophies have evolved from a common social movement (Irving and Lakeman 2010). This is misleading as person-centred care was developed by professional interest, admittedly in response to the harm done to people with dementia by institutional care. However, it was not instigated or substantially influenced by the narrative accounts of people with dementia.

Third, unlike recovery, the wider political and social context for people with dementia has not been addressed by person-centred care either in a change of public attitudes towards dementia (Irving and Lakeman 2010) or in promoting agency in people with dementia (Bartlett and O'Connor 2007).

Finally, person-centred care tends to be focussed on the needs of people with advanced dementia, and the delivery of care by staff to meet the personhood needs of the person with dementia. The early stage of dementia, utilisation of personally-instigated coping strategies and personal resilience of people with dementia, and how these might be maintained are not reflected in the literature.

2.5.3 Recovery and people with dementia

In addition to person-centred care, there has been wider speculation as to how recovery might apply to people with dementia. Five themes were identified in the mapping review as having applicability in the concept of recovery for people with dementia:

- a) generating hope
- b) recovery at the point of diagnosis of dementia
- c) facilitating self-management

- d) providing opportunities for positive risk-taking and choice
- e) supporting wider cultural change in OPMHS.

Generating Hope

Hope is important. The importance in recovery upon personal stories maps on to the sharing of narratives of people with dementia (Hill et al. 2010). Other areas of overlap include focussing on preserved strengths (Sole and Read 2009), recognising that change is possible and that small things can make a difference to somebody with advanced dementia (Woods 2007). The final area of overlap is the significant impact which hopefulness in staff attitudes has upon the quality of life (QoL) for people with advanced dementia in residential settings (Woods 2007).

Recovery at the point of diagnosis of dementia

There is potential for recovery at the stage of diagnosis of dementia (Gavan 2011, Adams 2010, Cheffey et al. 2013, Martin 2009). Ensuring personal agency at this stage is important (Irving and Lakeman 2010), with emphasis upon the person with dementia both being told about, and understanding their diagnosis (Adams 2010). Early diagnosis of dementia is one of the objectives for the UK National Dementia strategy (Department of Health 2009) and in this respect, the standards for pre-diagnostic counselling such as those developed by the UK Memory Services National Accreditation Programme (Royal College of Psychiatrists 2009) are helpful in clarifying how the process should be undertaken. These standards make clear the responsibility of services to make sure that all people referred to memory services understand the implications of the assessment and diagnosis process and have their questions answered before proceeding with the assessment. Such discussions before assessment allow for issues of concern to be addressed, for example, the potential service user not wishing to know a diagnosis but a family member asking for assessment.

There is a risk that early diagnosis may run counter to some of the principles of recovery, due to psychiatric labelling and potential of embedding a 'patient' role too early in the journey of dementia (Irving and Lakeman 2010). Further, the policy assumption that early diagnosis is inherently a positive step is unsupported by

evidence (Le Couteur et al. 2013). There is a need for further research to investigate whether being given an early diagnosis is what people with dementia want or benefit from (Irving and Lakeman 2010).

Other suggestions include using the practice tools such as the framework developed by Shepherd and colleagues whereby the professional is encouraged to reflect on each interaction with a service user in order to consider 10 possible ways of facilitating recovery (Shepherd et al. 2008). Using such a framework at the point of diagnosis might help staff to promote recovery, for example, encouraging social inclusion by using mainstream rather than 'dementia-only' services (Irving and Lakeman 2010).

One empirical research article was found. This was a feasibility RCT, in which a recovery-oriented intervention package for well-being in people with early dementia was tested (Jha et al. 2013). The intervention comprised a pre-diagnostic well-being questionnaire and action planning, diagnostic feedback and written support, and post-diagnostic support. The well-being questionnaire was designed for the study, based on the NICE guidance for mental well-being for older people (National Institute for Health and Clinical Excellence 2008) and included 10 domains of well-being. The well-being questionnaire was administered by a research nurse during the pre-diagnostic counselling session, and areas of difficulties were identified and ways of overcoming these explored and incorporated into a well-being based recovery plan. The therapeutic diagnostic assessment involved an hour long session with a psychiatrist, whereby a collaborative approach was used, which placed emphasis on the subjective experience of the service user and their strengths, the giving and exploring of the diagnosis and development of a collaborative treatment plan, which was followed up by written feedback. The final recovery phases, involved post-diagnostic counselling and support offered through monthly domiciliary visits for six months. No specific model was used, and the content of these sessions involved following up on unresolved issues from the diagnostic session as well as supporting service users with their well-being based recovery plan.

The study used a single-blind randomised controlled study design, 60 service user participants were approached, and 48 participants were recruited at baseline. The intervention was fully delivered to 17 participants, compared to a control group (n=17) who received treatment as usual. The primary outcome was the WHO Well-Being Index (WHO-5) (Heun et al. 2001) and secondary outcome measures included other clinical outcomes. The baseline socio-demographic and clinical characteristics between

each group were comparable at baseline. Significant change ($p=0.03$) was found in the WHO-5 change scores, but not in other measures.

There are four limitations to this study, first as the researchers acknowledge the size of the sample in the study was problematic as well as the small number of staff ($n=2$) involved in delivering the intervention. Second, the lack of a process evaluation meant that factors contributing to the outcome were unknown, for example, whether it was the way in which the diagnosis was delivered or the focus on well-being in the follow up sessions which impacted upon outcome. Third, there was insufficient detail about the components of the intervention, for example, what collaboration involves in practice. Finally, beyond attention towards well-being and a collaborative approach in providing the diagnosis to the person with dementia, it was not possible to assess the extent to which the intervention was truly recovery-oriented.

Facilitating self-management

Self-management for people with dementia could help with understanding how recovery might be applicable to people with dementia (Cheffey et al. 2013). Literature on self-management for people with dementia is only recently beginning to emerge, perhaps because the needs of informal carers have traditionally been emphasised over the needs of the person living with dementia (Mountain 2006). It is important to note, that neither recovery nor the lived experience of people with dementia are routinely mentioned within the available literature on self-management.

In one opinion piece on self- management for people with dementia, the lack of specific tools to support recovery was identified (Cheffey et al. 2013). The use of dementia cafes, Wellness Recovery Action Planning (WRAP) and advanced directives for future care preferences were suggested. Areas proposed for consideration in a self-management programme included:

- 1) Understanding and disclosure of diagnosis
- 2) Increased awareness of support services
- 3) Eliciting personal preferences
- 4) End of life planning

Two studies have empirically investigated the components for a self-management programme for people with dementia. First, a participatory research framework was used in one study (Mountain and Craig 2012). This involved qualitative interviews with people with dementia, both individually (n=5) and jointly with their carers (n=5). A research group of people with dementia (n=7) and carers (n=8) was set up and met together with the researchers over six sessions to explore and understand the findings emerging from the qualitative interviews. Emergent themes included:

- 1) the need for more information for people with dementia, evolving from a perception that most information was targeted at carers
- 2) the need for people with dementia to be able to manage their dementia alongside other conditions
- 3) the importance of maintaining meaningful roles
- 4) the need for interventions which address the needs of people with dementia separately from those of their carers.

Eight components for a future self-management programme for people with dementia were identified: Understanding and rethinking dementia, Living with dementia, Keeping mentally well and well-being, Daily living and building skills, Keeping physically well, Relationships and keeping connected, Maintaining a sense of self and Planning for the future.

In a second study, the development of components for a self-management intervention for people with early stage dementia involved qualitative interviews with people with dementia (n=7), carers (n=2), voluntary sector workers (n=2) and professionals working in dementia services (n=8) (Martin et al. 2013). A focussed literature review was carried out in light of possible intervention areas which emerged as themes from the interviews, and the following components were identified for inclusion within a future self-management programme:

- 1) Relationships with others
- 2) Maintaining an active life
- 3) Psychological well-being
- 4) Memory techniques
- 5) Information about dementia

A literature review of the effectiveness of interventions in these five areas was carried out, and review of potential components of a future programme involved an unspecified number of professionals and researchers, and one person with dementia.

Themes common to all three proposed self-management programmes include:

- i. Understanding dementia
- ii. Living with dementia
- iii. Psychological well-being
- iv. Relationships with others
- v. Advanced directives.

These themes can be seen as supporting recovery, however a key factor would appear to be the extent to which such programmes are professionally driven, and whether the narratives of people with dementia influence both the development and facilitation of such programmes. This makes clear the risk that some, but not all of the elements of recovery-oriented practice may be selected by OPMHS, leading to a somewhat diluted approach to recovery.

Providing opportunities for positive risk-taking and choice

Using a recovery-oriented approach could support positive risk-taking and choice for people with dementia. Four areas where a recovery approach may be beneficial have been identified. First, to underpin improved use of the Mental Capacity Act, as the means to ensure that individual preferences are recognised, least restrictive options are considered and independent mental capacity advocates (IMCAs) are involved when there is difference of opinion (Martin 2009). Second, the use of advanced directives in the early stages of dementia, particularly in recording people's preferences regarding care, what is important to them, and wishes for end of life care, (Cheffey et al. 2013, Sole and Read 2009). Third, as an approach to promote increased involvement in decision making by service users, especially relating to placement into residential care (Woods 2007). Finally, as an approach to enhance empowerment and promote a user movement (Irving and Lakeman 2010), such as the International

Dementia Advocacy and Support Network, which aims to share the narratives of people with dementia so that they are more empowered to actively participate in their own care and treatment (International Dementia Advocacy and Support Network 2014).

Supporting wider cultural change in OPMHS

The use of a recovery approach in supporting a wider culture change in dementia care delivery is stressed by a number of writers. Recovery as a means to overcome the 'therapeutic nihilism' which can accompany dementia care (Sole and Read 2009, Adams 2010). The goal of treatment as being redefined as well-being as opposed to 'cure' (Woods 2007, Cheffey et al. 2013). And finally by re-enforcing an overall vision to professionals that clinical recovery is only a small part of recovery, and by doing so, encouraging working practices amplifying strengths to minimise the creation of dependency (McKay et al. 2012)

2.5.4 Recovery and older people with functional mental health problems

Limited literature exists for older people with persistent mental illness.

In one study, which explored whether older age affects service user attitudes towards recovery, 71 users of a rehabilitation programme were asked to rate satisfaction with their own recovery, as well as their current mental and physical health status (Tepper et al. 2013). Service users over the age of 50 years were twice as likely as those under 50 years to include their current mental health status in their assessment of their own recovery. The older group were more like to have had their first psychiatric admission prior to the 1990's and therefore prior to the recovery movement. Their attitudes would have been shaped by connection with mental health services at a time where recovery would be oriented towards clinical outcomes, as opposed to a more contemporary definition of recovery. The authors suggested that older people might be less likely to respond to recovery-oriented practice which places emphasis on non-clinical outcomes. The potential for reviewing previous life experiences and coping strategies of older people was also identified.

Interventions need to address the social functioning, community living skills, as well as the medical co-morbidity needs of older people with mental health problems (Pratt et al. 2008). An integrated recovery and (physical) illness management intervention - called

the HOPES (Helping Older People Experience Success) programme was developed from a conceptual model which included both psychosocial skills and health behaviour. The modules comprised:

- 1) Making the most of leisure time
- 2) Living independently in the community
- 3) Communicating effectively
- 4) Making and keeping friends
- 5) Healthy living
- 6) Making the most of a physical healthcare appointment

A similar programme which incorporated both recovery and physical healthcare for older people (people over 50 years), was the I-IMR program (Mueser et al. 2012). This was created by adding two additional components - common physical health problems and preventative physical health interventions to the pre-existing IMR program discussed in section 2.3.1

Both of the programmes discussed involve emphasis on physical health needs in older age, rather than the process of recovery in older age.

One opinion piece conceptualised recovery as a life-course experience and as a way of understanding how a service user might see the world, and not as an end state (Dallaire et al. 2008). Recovery, empowerment and social inclusion were seen as important factors in meeting the needs of older people with mental health problems, and integration of these concepts into service delivery was advocated. In addition to the barriers which may affect the implementation of recovery-oriented practice in all services; attitudes towards older people with mental health problems were identified as a specific barrier within OPMHS. Concern was expressed about the social representations of older people with mental health problems, namely how the underlying assumptions, images and meanings about older people underpin both professional practice and service delivery to older people. Negative social representations are underpinned by the double stigma of both having a mental health problems and old age, with connotations of decline and further deterioration towards dependency. The authors suggested that such views are present both in staff and services working with older people, and lead to pessimism about the future for older people with mental illness. The need for research into the underlying attitudes towards

older people with mental health problems was recommended, in order to understand how such attitudes may affect the delivery of care, and the implementation of recovery-oriented practice.

No literature was found on the specific applicability of recovery for older people who develop mental illness in later life.

In summary, literature on the potential applicability of recovery for older people with mental health problems exists, but is made up of predominantly opinion pieces. These have been categorised into in three broad areas: policy and lobby group pressure, recovery for people with dementia and recovery and older people with functional mental illness. Policy and lobby group pressure has encouraged OPMHS to adopt practices which are common within mental health services for adults of working age, but specific differences for older people have not been identified. Recovery for people with dementia has included the potential overlap with person-centred care (Kitwood 1997), and the benefit of using a recovery approach for people with dementia to generate hope, for use at diagnosis and for self-management, to promote choice and positive risk taking and to support wider cultural change within OPMHS. The literature on older people with functional mental problems relates to those with persistent mental health illness, and the need to address their physical co-morbidity needs. No literature has been found on the specific applicability for older people who develop functional mental health problems in later life.

2.5.5 Why has recovery not been taken forward within OPMHS?

It is not clear why OPMHS have not been more responsive to adopting recovery-oriented services given the policy and opinion-leader support. However a number of possible reasons can be identified.

First, low uptake may relate to the lack of empirical evidence about the relevance of recovery for older people, especially those who have developed functional mental health problems in later life. This contrasts with the substantial and growing evidence base on recovery for adults of working age. Staff working in OPMHS might simply conclude that the differences between this group of service users and those who use OPMHS are too great.

Second, the terminology of recovery may lead to discomfort for professionals and for carers of people with dementia (Hill et al. 2010). They may raise expectations for clinical recovery or introduce a jargonised language which does not fit with the narratives of people with dementia (Adams 2010). It has been suggested that the term

'recovery' should be avoided, but rather that the principles should be used (Cheffey et al. 2013).

Third, it could be suggested that the clinician's illusion (Cohen and Cohen 1984) is not necessarily an illusion within OPMHS in the context of working with service users with dementia, which is a progressively deteriorating condition. This point is reinforced by other writers (Irving and Lakeman 2010, Martin 2009) who suggest that there will be limits to recovery in the face of steady deterioration, and that recovery may only be applicable in the early to moderate stages of dementia, and that at the later stage of dementia the 'flame of recovery' might be offered to family members to hold (Irving and Lakeman 2010).

Fourth, person-centred care is familiar to many health and social care practitioners, whereas recovery is not (McKay et al. 2012). As discussed in section 2.5.2, overlaps between person-centred care and recovery have been identified. It is possible that an assumption could be made that the two approaches are broadly similar, although as discussed in section 2.5.2 a number of significant differences exist.

Fifth, it has been proposed by a number of authors that OPMHS and professionals working within these services have internalised the discrimination of the wider community about older people with mental health problems and hold an inherently pessimistic outlook for users of services (Bowers et al. 2005, National Development Team for Inclusion 2011, Dallaire et al. 2008). Such attitudes could underpin the reluctance of OPMHS to not more fully embrace recovery (Dallaire et al. 2008).

Sixth is that in contrast to mental health services for adults of working age, there is not a well organised service user movement within OPMHS. Furthermore many service users and carers may be unfamiliar with the recovery discourse. Therefore bottom-up pressure to adopt recovery-oriented practice has been minimal.

Finally, recovery has not been a UK commissioning requirement for OPMHS, in the way it has for mental health services for adults of working age. This is however changing, for example, through targets to use Wellness and Recovery Plans (WRAP) within OPMHS from 2014/15 onwards as part of the CQUIN commissioning framework. The CQUIN framework gives financial incentives and penalties for quality targets to NHS organisations (Turner and Powell 2010).

A number of possible reasons for the lack of implementation in OPMHS have been explored including the lack of evidence, concern about language, fit with advanced

dementia, lack of understanding, underlying attitudes, lack of a user movement and the absence of a commissioning requirement.

2.6 Rationale for research

Empirical research into recovery and older people does not yet exist, and it is proposed that such investigation is warranted.

The impact of the recovery approach upon mental health services for adults of working age has been substantial, and is likely to continue. The UK mental health policy direction, which has promoted recovery for all age groups, means that OPMHS will need to respond to the recovery agenda. This response needs to be informed by an understanding of which components of recovery are valued by older people, given that its development has taken place without consideration of differences across the life-span.

It is not yet evident whether the concept of personal recovery holds relevance for older people with mental health problems. The concept was developed for adults of working age with a predominantly psychosis diagnosis, as opposed to a degenerative organic condition such as dementia. Additionally, many users of mental health services for adults of working age would have experienced their first episode of illness in their early adulthood, and as a consequence lived with mental illness over many years. In contrast, many users of OPMHS have not experienced any type of mental illness until later life. It is difficult to predict, therefore which of the components of recovery will map over to older people, and whether these may be different for those with dementia. Furthermore, if some and not all components are found to be relevant, it is not clear whether adopting some, but not all of the components of recovery will produce a diluted version of recovery with less meaning and value.

Research investigating recovery in older adults could have important implications for practice, service provision and service user experience within OPMHS. The need to define what recovery means for older people with dementia, and come to a shared understanding by service users, professionals and carers is a legitimate goal for research and development (Hill et al. 2010, McKay et al. 2012). This need is addressed in Chapter 3.

Chapter 3 Development of Conceptual Framework

The aim of this chapter is to present a conceptual framework for recovery for service users of OPMHS. The framework was developed from a series of qualitative interviews. The methodological considerations and the methods used in undertaking in-depth qualitative interviews with service users and carers are described. The findings from these interviews are presented.

The aim of the qualitative interviews was to investigate the applicability of the concept of recovery to the experience of mental illness for older people. The two specific research questions were:

1. Are existing components of recovery meaningful to older people?
2. What are the dementia-specific aspects of recovery?

Findings from the analysis of these interviews will be discussed and compared to the components of recovery for adults of working age described in Section 2.2. Using these findings, a conceptual framework for the experience of personal recovery for users of OPMHS, including those with dementia is presented. Strengths and limitations are explored.

3.1 Methodological considerations

A qualitative approach was used to develop a conceptual framework for recovery for older people. Qualitative enquiry encourages an understanding of the experience from the perspective of the participant (Patton 2002) and has been used widely within the theoretical development of the concept of recovery because of its emphasis on personal experience and meaning.

Techniques from grounded theory were used. It is important however to note that the research was not a formal grounded theory study. This is because the concept of recovery has already been developed, as discussed in Sections 2.1.2 and 2.2, and the research aim was to test the relevance of this concept in relation to older people with mental health problems.

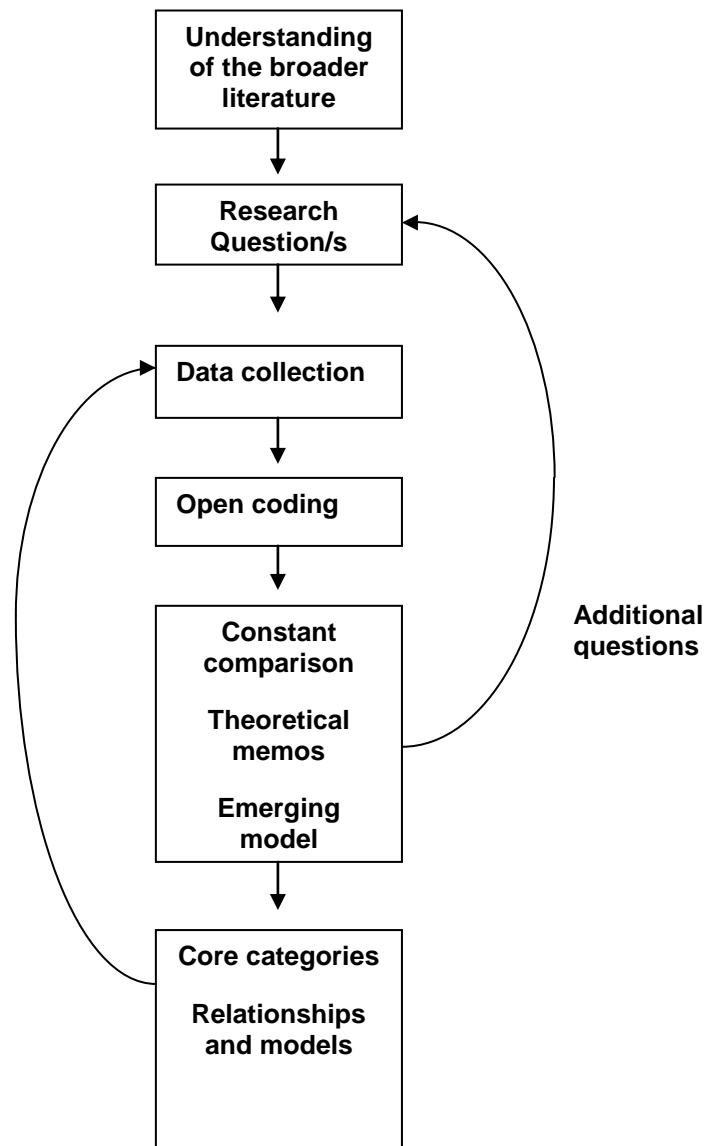
3.1.1 What is grounded theory?

Grounded theory was developed by Barney Glaser and Anselm Strauss in the late 1960's (Glaser and Strauss 1967). Grounded theory is a methodology which induces meaning from data using a systematic method of analysis in order to construct theory (Willig 2013). Grounded theory allows for a more thorough understanding into a given experience and encourages inquiry into the processes underpinning the experience, how they might be connected, and how they might change over time (Morse et al. 2008). It also uses a systematic approach to the collection and analysis of data, which allows for the construction of new or revised theory from the data. Key elements of grounded theory (Charmaz 2006) include:

- a) Simultaneous data collection and analysis
- b) Construction of analytical codes and categories from data and not from pre-conceived deductive hypothesis
- c) Use of constant comparison and memo writing techniques
- d) Advanced development of theory at each stage of data collection and analysis
- e) Sampling aimed at theory construction not representativeness

Whilst Glaser and Strauss worked closely together to develop and introduce grounded theory, there was a separation in their collaboration, and there are differing views about how grounded theory techniques should be used, for example, at which stage in the process a literature review should take place (McGhee et al. 2007). Strauss in his later writing with Corbin recommended earlier review of the literature to support the generation of questions and theoretical sampling (Strauss and Corbin 1990), whereas Glaser maintained the position that literature should not be reviewed until the analysis is coded (Glaser 1992). In this thesis, the literature was reviewed before data collection in keeping with the framework developed by Strauss and Corbin. An overview of grounded theory techniques used in this thesis is provided in the following section, and the process of analysis is presented in section 3.2.3. The approach to data collection and analysis was informed by an adapted framework (Hardy and Bryman 2004) as shown in Figure 3.1.

Figure 3.1 Data analysis within grounded theory



Following data collection, data are first coded using opening coding. Transcripts are read repeatedly and meaningful sections of narrative are labelled with descriptive codes.

Further data are analysed, using an initial coding framework and progressing towards the development of a more focussed coding framework. This is achieved through using the technique of constant comparison, which involves comparing coding and data between existing and new transcripts in order to check on the use of codes for consistency and also to begin to identify which relationships might exist between different codes. Theoretical memos (or memo writing) are also used to support analysis and to build theory. Theoretical memos are notes written by the researcher during

analysis, which articulate possible theoretical explanations, areas of uncertainty, knowledge gaps and relationships between existing codes (Charmaz 2006). Coding is continually reviewed in the light of emerging data and on-going analysis, in order that a more focussed coding framework can be developed. As the need for clarification of relationships between codes is recognised further data collection may take place through the use of theoretical sampling. Theoretical sampling involves further data collection with participants with specific features, which are identified through the analysis, in order to further explore and refine areas of uncertainty and emerging theory, or disprove emerging ideas (negative case analysis). Finally a core category or categories are identified. A core category can be seen as an overarching classification of related themes (Charmaz 2006).

3.1.2 Rationale for using grounded theory

It was decided that grounded theory techniques could be employed in order to increase rigour in the analysis as well as providing a bottom-up (i.e. data-driven) approach to the construction of a revised theory of recovery, in relation to older people. Grounded theory techniques were chosen to meet this aim, for three reasons

- 1) The use of an explicit methodology would support rigour in the analysis.
- 2) The research and the related programme of work was initiated by professional interest, and sought to introduce the concept of recovery to older people and to their carers. This led to a credibility concern as the concept of recovery has evolved for the most part from first-person narratives and not from professionals. Furthermore, there has been concern that professionals have commandeered and professionalised the concept of recovery (Mind 2012, Trivedi 2010). The use of grounded theory techniques as an inductive approach to the generation of theory was intended to help to address this concern, as it sought to develop a conceptual framework for understanding the experience of recovery for older people influenced primarily by the direct narratives of service users and their carers. This was seen as enhancing the credibility of the research with the wider service user community and recovery opinion leaders.
- 3) Grounded theory was considered to be the most robust form of qualitative inquiry, which also allows for the building of theory (Charmaz 2006). A

conceptual framework for understanding the experience of recovery for older people was considered a fundamental output in this programme of work.

3.2 Method

3.2.1 Sample and setting

Service user participants were over 65 years of age, had a clinical diagnosis of dementia or another mental disorder, and were users of an OPMHS. The OPMHS was part of an NHS Foundation Trust in South London. All service user participants were in the judgement of their clinician able to give informed consent. The carer participants were identified by service users with dementia, and all provided informal care. Informal carers were involved due to their crucial role in providing support to people with dementia. Seven of the interviews took place with dyads.

3.2.2 Procedure

NHS Research Ethics (reference: 09/H0722/66) and local service Research & Development approval were granted in December 2009 (Appendix A and B).

The researchers comprised the principal investigator (SD) and one research worker (DN). The researchers met with eleven clinical teams from across the OPMHS. They asked clinicians to approach current service users about involvement in the study. Clinicians gave service users a study information sheet, which explained what participation in the study involved. The contact details of service users who expressed an interest in involvement in the study were passed to the researcher worker. Care co-ordinators were asked to provide the clinical diagnosis. For participants with dementia, the most recent Standardised Mini-Mental State Examination (SMMSE) score (Folstein et al. 1975) was also requested in order to investigate whether differences relating to the severity of dementia existed. The researchers then contacted individual service users to explain the study and discuss involvement in more detail. An appointment was made with those expressing an interest in participation.

All service users with dementia were asked to identify their main carer. Identified carers were invited to take part in the study.

Separate draft topic guides for service user and carer participants were developed from the review of the components of recovery identified in relation to adults of working age described in Section 2.2. The draft topic guides were reviewed for acceptability by a senior independent qualitative researcher (JM), who provided academic supervision on the research. The topic guides are presented in Appendix C (service user guide) and Appendix D (carer guide). Key topic areas for service user and carer participants were similar, but questions were worded differently in order to obtain personal accounts from service user participants, and observed accounts from carer participants. Topics included day-to-day life, use of time, the impact of illness upon daily life, ways of managing illness and future plans and goals. The topic guides for both service user and carer participants were amended after the sixth interview to include a specific question to ascertain how service user participants described their main roles and activities in day-to-day life. The topic guides were further amended for the final eight interviews in order to gain further understanding of developing themes. This is discussed in more detail in the process of analysis in section 3.2.3.

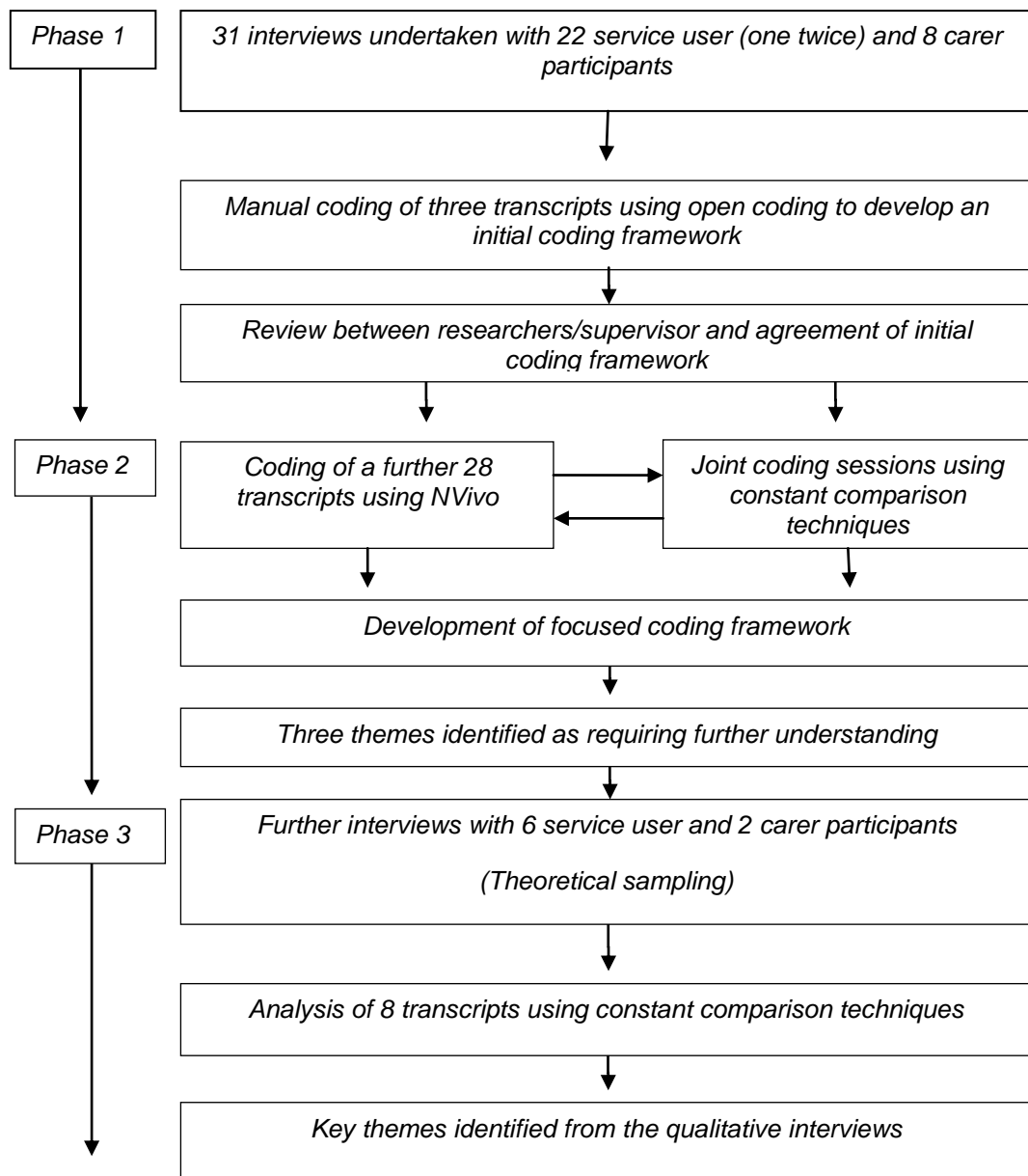
Interviews were carried out in 2010 by the principal investigator (n=16) and the research worker (n=23).

The majority of interviews were carried out in participants' own homes. Before starting interviews, the information sheets were given and questions about the study were invited. Written consent was obtained separately from service user and carer participants. Service user participants with a diagnosis of dementia and their identified carers were interviewed concurrently in different rooms. Each interview lasted between 45 and 60 minutes. All interviews were audio-recorded, transcribed verbatim and checked for accuracy by the interviewer.

3.2.3 Process of analysis

All transcripts were analysed using grounded theory techniques, as described in section 3.1.1. The process of analysis used within the research is shown in Figure 3.2, and is followed by a more detailed description of each phase.

Figure 3.2 Process of analysis



Phase one

The analysis commenced with descriptive coding, in which the two researchers independently coded three transcripts. The researchers met to review their respective preliminary codes to identify areas of differences and agree upon an initial framework. This framework was reviewed with the independent qualitative researcher who coded one of the three transcripts. An initial coding framework was agreed (Appendix E).

Phase two

The second phase involved the coding of the next 28 transcripts by the principal investigator (n=21) and the research worker (n=7). Initially, no distinction was made in the coding framework between service user and carer data. The coding was reviewed on an on-going basis using constant comparison techniques (Glaser and Strauss 1967). The computer software package, NVivo 8 (QSR International, 2008) was used from this phase onwards to allow the researchers to systematically collate and review data grouped within each code. To support this process, the researchers held analysis sessions to jointly review data collated within each code and to identify relationships between codes. Towards the end of this phase, the researchers began to distinguish between data from service user and carer participants, and from those with mild and moderate dementia. Eleven prominent themes were identified within the data during this phase and a focused coding framework was produced, shown in Appendix F. At this stage, the researchers identified that further interviews would be necessary in order to gain further understanding of developing themes.

Phase three

This phase of the analysis commenced with the completion of a further eight interviews (principal investigator n=5 and researcher worker n=3) using theoretical sampling in the approach of participants. A summary of the type of participant and key theoretical questions addressed is presented in Table 3.1

Table 3.1 Summary of theoretical sampling

Participant type (number)	Key theoretical questions for developing themes
Service users with psychosis (n=2)	Is the experience of managing illness for an older person with psychosis similar or different from the experience of those with affective or organic disorders?
Service users with affective disorders (n=2)	What are the factors involved in the initiation of active coping strategies for older people with affective disorders?
Service users with mild dementia (n=2)	What are the factors involved in the initiation of active coping strategies for people with dementia?
Carers (n=2)	At what point do spousal carers take over responsibility and control for people with dementia?

A more detailed breakdown of the specific changes to the topic guides is shown in Appendix G. These interviews were analysed by the principal investigator, using constant comparison techniques. Incorporating the analysis of these additional interviews produced five key themes, which were used to build the overall core category for the experience of recovery in older people.

3.3 Rigour in the research process

Both researchers maintained fieldwork diaries. The researchers met frequently to compare their experiences and impressions of the interviews as well as for constant comparison by coding and recoding the transcripts. They also met on a regular basis with the independent qualitative researcher for supervision during the fieldwork and analysis of the interviews to review coding and the development of themes. Both researchers created theoretical memos (Glaser and Strauss 1967) to support the analysis and building of theory, by noting possible relationships between codes, areas of uncertainty, as well as comparison with existing theory. This process allowed transcripts to be further checked, in order to strengthen and in some cases disprove emerging hypothesis. The supervision also supported the process of reflexivity for the researchers in order that their impact upon the research could be explored (Neil 2006) Examples of memos written during the research are given in Appendix H.

3.4 Results

3.4.1 Participant characteristics

39 interviews were completed, with 28 service user and 10 carer participants. One service user participant was interviewed twice, first during the initial stage of data collection, and second due to the relevance of their experience to one of the developing themes. There was a range of different service users in the sample in line with ground theory methodology. The characteristics of service user participants are shown in Table 3.2

Table 3.2 Socio-demographic and clinical characteristics of service user participants (n=28)

Characteristic	Type (Impairment)	Number (%)
Gender	Female	16 (57)
	Male	12 (43)
Age	65 - 75 years	12 (43)
	76 – 85 years	13 (46)
	86 years	3 (11)
Ethnicity	White British	20 (71)
	White other	3 (11)
	Afro-Caribbean	2 (7)
	Asian	3 (11)
Living Situation	With spouse	9 (32)
	Lives with family	2 (7)
	Residential care	1 (4)
Diagnosis	Dementia	11 (39)
	Psychosis	3 (11)
	Affective Disorders	14 (50)
SMMSE Score	21-30 (Mild)	7 (64)
	11-20 (Moderate)	4 (36)

The characteristics of carer participants are shown in Table 3.3

**Table 3.3 Socio-demographic and clinical characteristics of carer participants
(n=10)**

Characteristic	Type	Number (%)
Gender	Female	6 (60)
	Male	4 (40)
Relationship	Spouse/partner	9 (90)
	Son/ daughter	1(10)
Ethnicity	White British	9 (90)
	Asian	1 (10)

3.4.2 Overall core category and key themes identified from the qualitative interviews

The analysis identified a single core category of ‘Continuing to be me.’ This encompassed five inter-related themes: Identity, Impact of Illness, Making Sense of the Experience, Dealing with Illness and Recovery of Self.

An overall core category of ‘Continuing to be me’ was identified through the analysis as being significant in the experience of mental illness for older people, including those with dementia. Components of this core category included:

- The person I was, and the experience of illness in relation to the context of my life
- The impact of the illness on who I am
- Doing what I have always done as a way of dealing with the illness and reinforcing a sense of self
- ‘Continuing’ or ‘regaining a sense of me’ as a successful outcome or measure of progression

A summary of the five inter-related themes identified from the analysis of the qualitative interviews is provided in Table 3.4

Table 3.4 Summary of five inter-related themes

Themes	Content
Identity	The person I was, the person I still am: defined by what I have done in my life: significant relationships, roles, occupations and preferences, pre-existing coping styles and personal attributes
Impact of Illness	Impact upon established roles, social networks and meaningful activities, impact of dementia, withdrawal from the world, physical illness
Making Sense of the Experience	Acceptance or non-acceptance by the person with mental illness, perceived responsibility for getting better and managing the impact of the illness, the role of spousal carers in taking over responsibility for managing the impact of dementia
Dealing with Illness	Active coping strategies: compensatory techniques, knowledge and information, continuation of social networks, roles and meaningful activities, self-help activities, connecting with the world, role of carers, role of mental health services
Recovery of self	Recovery of sense of self, hope, recognising progress, future goals, facing the future with fear

The core category and five inter-related them are now discussed in more detail.

Core category ‘Continuing to be me’

The single core category ‘Continuing to be me’ related to the permanent and established sense of identity which participants appeared to have. An established sense of identity was very significant in the experience of mental illness. Participants had a clear sense of identity and how they defined themselves. This permeated the interviews and appeared to be key in buffering the impact of the illness. The goal of ‘continuing to be me’ or ‘getting back being me’ was evident in the activation of coping

strategies which directly reinforced a sense of self. 'Getting back to being me' was used as measure of progress and therefore as an indication of success. Identity is discussed throughout the findings because it emerged as a recurrent theme in the experience of mental illness for users of OPMHS, including those with dementia.

Theme one: Identity

Many participants provided rich descriptions of themselves and their lives before they became unwell. Participants talked about their marriages, their children and grandchildren, friendships and working lives.

The majority described established roles, occupations and preferences, and examples were given of personal achievements and skills of which the participants were particularly proud.

'I was a music teacher all my life and that helped because I used to hop into work. I was very respected and that helped because I had to work.' (No.5, depression)

'I worked down a coal mine first, something of an achievement, I was 15 or 16 so I was quite proud of that, and I left the coal board and joined the army; became the army champion, and I was cracking at that too.' (No.20, mild dementia)

'She said "Will you please come back and help us X, one year after I retired.' (No.24, mild dementia)

There were also rich descriptions of current roles, occupations and social networks.

'We have always been church people and as I say, X's in the choir and I'm in the Mother's Union.' (No.26, mild dementia)

'So I like all aspects of cycling, you know. Yeah, but cycling has been my big thing. Unless I was completely unable to do it any more, I'd always do it, you know. I'd always have a bike or bikes.' (No.2, depression)

Participants described previous life events which they had needed to manage, indicating long-established coping styles and mechanisms for dealing with emotional

and practical difficulties. These pre-existing coping styles were identified as helping to counter the impact of their illnesses on their lives.

'I am not stoic I wouldn't say I am stoic but I have the ability to get my head down and bash through. Yeah, so you know I will try to improve things and I don't want to be a stoic and I always feel bash on, bash on and see what happens and that's me really.' (No.36, psychosis)

"I've always been one of those kind of blokes where whatever happens; I don't try and put it right I just let it happen" (No.13, moderate dementia)

I don't think about it (the future with dementia)...No, because for me I just feel that planning, the best made plans by men and mice... so I deal with whatever and whenever when it happens.' (No.40, mild dementia)

Theme two: Impact of illness

The majority of the service users interviewed, including those with dementia, described the experience of having a mental illness as having a significant impact on their lives. The majority of carer participants also described the impact of mental illness as being significant, both for the service user participant and for themselves. However there was a difference in the account given by some of the carers of the impact of the dementia upon their spouses and the observations of the researchers, with carers at times downplaying difficulties.

A number of sub-themes contributed to this overall theme. These included the impact of illness upon established roles, social networks and meaningful activities, the impact of dementia, withdrawal from the world, and physical illness.

Sub-theme 1: Impact upon established roles, social networks and meaningful activities

The majority of participants discussed in great detail the overwhelming sense of loss which accompanied the experience of mental illness. Participants described losing interest in the people and activities which were important to them.

'In fact the things that are most important really are the things you go against more I think. You go against more the things you've enjoyed than anything else for some reason.' (No.2, depression)

'No I don't enjoy it, I'm just very thankful to be able to get through a day, so that is a form of enjoyment, but there is none of that excitement and I don't want it because it makes it more difficult to concentrate on reading and stuff.' (No.30, bipolar affective disorder)

'But I'm not connecting with anyone. I'm not, if you ask me how many friends I've got, but for my missus, I couldn't mention one.' (No.20, mild dementia)

Sub-theme 2: Impact of dementia

For people with mild dementia, the impact of the illness appeared to be experienced most strongly in relation to the completion of every-day tasks and activities, as well as their short-term memories.

'I still do cook. I liked cooking when I was normal I did a lot of good fancy cooking, because I enjoyed it. Well now I only do the basic stuff.' (No.26, mild dementia)

'Well that's a funny thing. I can sometimes remember everything that I did when I was a child. No purpose in it because you can't do anything. But another time I can forget anything that I did yesterday. Wouldn't have known I had done it. But you get used to these things.' (No.13, moderate dementia)

In general, these subjective accounts were corroborated by carers

'At the moment, her worst periods of confusion are when she gets out of bed in the morning and she will often say "I don't know what is happening" and so on. I have to prompt, very frequently, and indeed sometimes she will speak, "what shall I do next?" She seeks direction.' (No.25, carer)

It was noted by the researchers however that some of the accounts given by carers did not seem to correspond with the degree of cognitive impairment evident in their spouses. For example, in answering a question about the impact of the dementia upon her husband, the wife of a man with moderate dementia, appeared reluctant to acknowledge the presence of the illness:

Well he is 88 and I think it's just the physical. I think probably the thoughts are still there, but the physical ability is not, it doesn't seem to worry him too much. When the weather's good, he's quite happy to be out there and just looking (at the garden). That's our way of life and our age, it's not going to change much, as long as our health is good.' (No.19, carer)

Sub-theme 3: Withdrawal from the world

Participants with affective disorders described how they withdrew from the world, and cut themselves off from others.

'When I do get depressed, I do, I go quiet and I just shut myself indoors like. I don't talk to anyone.' (No.7, depression)

'Well you lose interest in living really. That's what it's about. You don't want to meet your friends. You try and avoid them. That's what I've done. I just disappear basically, you know.' (No.2, depression)

Sub-theme 4: Physical illness

A number of participants with functional mental health problems described difficulties with their physical health, whereas participants with dementia did not. The presence of physical health problems appeared to increase the impact of the mental illness, particularly in relation to being able to continue with the roles and occupations which were perceived to be important. Joint strategies were established which mitigated the impact of both mental and physical illnesses jointly.

This can be seen in the case of Mrs A, a 76 year old widowed participant, who had both depression and epilepsy. Mrs A described in her interview, how she would ensure that she had very frequent social contact, in order to manage her depression, but how she would have to accommodate this within her strategies for managing her seizures (lying on her bed). She described having to try to monitor the frequency and timing of her seizures in order that she was able to get out of her flat, as staying at home too much, would in her opinion, increase her depressive symptoms and generally not enhance her well-being. She also described how her physical health (namely her seizures) directly impact upon her depression.

I (am) still sort of depressed, but not frightened, because I feel it coming, I always feel... Yes, until it is finished, yes but it is always in my mind, 'come,

come, come, it is really awful.’ (No.31, depression)

Theme three: Making Sense of the Experience

How service users made sense of the experience of having a mental illness appeared to be a critical factor in overcoming the impact of mental illness. Participants who appeared to have accepted the illness and believed that they were managing their illnesses themselves rated their quality of life as good. In comparison, those who did not appear to have come to terms with their illness did not rate their quality of life positively. Attitudes towards illness and beliefs about personal responsibility for managing the impact of the illness appeared to influence coping.

A number of sub-themes were evident in the data, which appeared to facilitate or hinder the process of making sense of the experience. These comprised acceptance and non-acceptance by the person with mental illness, perceived responsibility for getting better and managing the impact of the illness, and the role of spousal carers in taking responsibility for managing the impact of dementia.

Sub-theme 1: Acceptance or Non-acceptance

Service user accounts of the experience of mental illness revealed whether they acknowledged the presence and/or the impact of illness. Some participants expressed a passive coping style in their acceptance of illness.

‘Yes I feel you know I just have just accepted it and you know I just hope the medication obviously will keep things at bay you know.’ (No.40, mild dementia)

More active coping styles were described by other participants.

‘I do my best to pull myself together, to put it all in a nutshell, I go out even though I don’t feel like it sometimes, I go, I go with my friends or on my own.’ (No.34, depression)

‘I am quite determined to read books. I never used to have to be determined. It was a habit. I was constantly at the library. I did an awful lot of reading from being a schoolboy all the way through my life, until recently. And now I’m having to say to myself, “I can and I will, I will and I can and I’m going down to the library finding various books.’ (No. 20, mild dementia)

The majority of people with a moderate dementia appeared to exhibit anosognosia, either by not believing that they had memory problems, or that it did not have any impact upon them. It was also evident that subjective awareness was more evident in people with mild dementia, suggesting that awareness of the impact of the illness decreased with increasing severity over time. Those with mild dementia were able to describe the impact of the dementia upon their memory and upon themselves, whereas those with moderate severity generally were not.

Researcher: *'At the time when you became unwell do you remember how that impacted on you and your own life?'*

Service user: *'No it didn't, not so much, it didn't have a big impact... It hasn't impacted on me as much as last year. I am able to override them'*

Researcher: *'Why do you think that was?'*

Service user: *'Because I have returned to as I used to be.'* (No. 27)

Two of the three participants diagnosed with a psychosis did not accept that they had a mental illness, and both believed that their difficulties occurred for other reasons:

Researcher: *'I was wondering what impact your mental health has on everyday life?'*

Service user: *'No, no, because I've never considered myself as a mental patient...While I was in the hospital, I see people who are mentally ill which I relate to and never considered myself as such. I could understand them and I know that they aren't well. They do have faith and it did not apply to me.'* (No 38)

Sub-theme 2: Perceived responsibility for getting better and managing the impact of the illness

A range of views were expressed about responsibility for getting better and managing the impact of illness. Some regarded this as their personal responsibility while others believed it was the responsibility of either mental health services or family members.

'I think there are a lot of people when they have mental illness or especially depression they seem to rely on the pills and that's it. They don't want to help

themselves. You've got to help yourself as well. You've got to push yourself to do things. You've got to have some sort of goal.' (No.2, depression)

'It is up to the people themselves, isn't it? You can't help a person, you can't make them do it.' (No.13, moderate dementia)

'It was a slow job but I got there and then I realised that it was me that had to do it.' (No.8, panic disorder)

In contrast, three service user participants believed that it would be mental health services staff or treatment which would enable them to get better, rather than their own efforts. This belief appeared to limit the extent to which they were able to manage the impact of their illnesses.

'I am not very creative because I am suffering from alcoholism but even if I wasn't, I still wouldn't do very much. I just find that I am unmotivated and I have a terrible depression. I have been depressed for years. Dr X is trying to cure it.' (No.5, depression)

'I am just sorry to say that, even if someone is to ask me if I am happier, it is only medication that really does it, now.' (No.31, depression)

Sub-theme 3: The role of spousal carers in taking responsibility for managing the impact of dementia

It was apparent that carers took on increased responsibility for their partner as the dementia progressed. This was a gradual process of change in their established roles and activities, and development of their skills with specific tasks. It did not appear to be a response to immediate concerns about safety or risk.

'I suppose it built up, it was gradual.' (No.38, carer)

'Well, there was no definite, it was the 21st February... Oh no, it was gradual, it was a gradual process. She became less and less able to cope and I become more and more able to cope with the cooking' (No. 34, carer)

Theme four: Dealing with Illness

Different ways of dealing with illness which were based on pre-existing beliefs, availability of support and previous experience. Acceptance and perceived personal responsibility for managing one's illness were linked to active coping strategies including: compensatory techniques, knowledge and information, continuation of social networks, roles and meaningful activities, self-help activities and connecting with the world. Additionally the important role of spousal carers and, to a lesser extent, mental health services were identified.

Sub-theme 1: Compensatory techniques

Service user and carer participants described compensatory techniques which they had developed to reduce the impact of their illnesses upon activities of daily living. For people with dementia such strategies were often initiated by spousal carers, and included the use of diaries, lists and the re-organisation of the home environment. Other strategies included obtaining practical help for the housework and gardening, allowing more time to complete tasks, and using ready-made microwave meals instead of cooking with fresh ingredients. Most of those interviewed had developed these strategies from their own experiences rather than from professional advice.

'If she sends me down the shops and she's constantly doing that, she has to write it down on bits of paper what I want. I can't remember jelly or a loaf of bread or something like that; I'll forget these things. If she writes the items down, I'll be alright. I'll get the items then and I'll be alright.' (No.20, mild dementia)

'Then normally, we'd have a roast joint on Sundays, so I come back and put it in the oven, but recently we've been going out to lunch quite often on Sundays so from that we have booked a lunch somewhere and I haven't had to bother with the cooking.' (No. 26, mild dementia)

Sub-theme 2: Knowledge and information

For some, finding out more about their illness, and fully understanding their diagnosis and related problems appeared to help participants to deal with their illnesses better. This also appeared to be a key requirement of mental health service provision both for service users and carers.

'I need more understanding about what is happening because it doesn't make sense from what I've picked up from what the previous consultant told me. It's not making physical sense.' (No.30, bipolar affective disorder)

'Well he is a botanist sort of I can't think of the proper word but he is well known, and he'd written a book having had depression himself. Well I had heard him on the radio as well. He described what it was like and I was so relieved because there were various things that absolutely applied to me. They were the few things he had and he got completely better. So that comforted me in a certain way.' (No.33, depression)

'I thought 'thank god' I like knowing, the Alzheimer's - I know what is me, and I am not like every other people that I didn't know what my brain was doing.' (No.23, mild dementia)

I think it's helpful to know that I am not a freak. I am not, that there are other people, quite normal people that have the same problem and I am not abnormal.' (No.39, mild dementia)

Sub-theme 3: Continuation of social networks, roles and meaningful activities

The continuation of existing social networks, roles and established activities appeared to help retain self-identity in the face of mental illness. Very few of those interviewed expressed a wish to build new networks or to undertake new activities.

'We have always been church people and as I say, X is in the choir and I'm in the Mother's Union. We go to church every Sunday morning; all things being equal. And we get there at 9.30 am because X is in the choir and they have a choir practice before ten o'clock. At 9.30 a friend of mine who has no other reason to be, but is always there early, so she and I have a lovely natter.' (No.27, mild dementia)

'Well yeah, having loyal friends and um, not being completely on your own is important because when you start getting better that you got a focus haven't you. You've got friends to focus on, haven't you?' (No.2, depression)

'I didn't start doing something I hadn't done before. I was organising things, socially meeting people and that sort of thing really.' (No 36, psychosis)

Sub-theme 4: Self-help activities

A number of those interviewed described activities which they believed to be helpful to their overall health and well-being, including a healthy diet, fresh air and exercise.

'I keep myself going as much as I can, and I've got a great diet' (No.15, moderate dementia)

'If they are able to get out, you can't just shut yourself in all day though, you are on your own. It's the worst thing. If you are able to get out, then you should go out.' (No.12, mild dementia)

'Every day, except Mondays, I will take a walk up to X Road and walk back. That's if it's not raining. If it's cold I don't mind because I can put my hood up and warm up but then I do make a habit of going out.' (No 8, panic disorder)

Reciprocity, giving to others and gaining something back in return, was perceived to be useful.

'I am a member of an institution called Timebank in which you give a certain amount of hours for other people and they return it. So I give 2 hours teaching they will give me 2 hours washing up or something. It's very basic and I tend to give more than I receive which is fine by me because I am giving something, I am doing something for the community. Every fortnight I do a creative writing class in the local library.' (No.5, depression)

Sub-theme 5: Being part of the world

A number of participants described reconnecting with the world as a way of helping them to deal with their illness. This included going out, being in the presence of other people and also being aware of current news events. For some people, this was seen as an indication of progress in their own recovery.

'You know to be back in the world, to have things going on, to go out when you want to and so on.' (No.7, depression)

'I don't want to sit here all day and wait for the news to come on. I'd rather get a newspaper; find different things are happening, as I say I'm still interested in. I'm still part of the world...So I don't feel neglected or out in the cold'. (No.12, mild dementia)

Sub-theme 6: The role of spousal carers of people with dementia in reinforcing the sense of identity

For people with dementia who were married or in long term relationships, the experience of having dementia and of needing to find ways of managing the impact took place within those partnerships, not as an individual experience. In particular, spousal carers appeared to reinforce the sense of identity, either through direct prompting or compensatory techniques to maintain existing roles, meaningful activities and relationships. Additionally, for the person with dementia, the on-going spousal relationship reinforced the sense of identity. The partner or spouse had a key role in managing the impact of the illness of the person with dementia. The following illustrations from three dyads are given:

'He has me well in hand. I think he is in hand with the X service. So from them he passes it onto me.' (No.24, service user)

'I think it is just the fact that we work together. We accept it and we are very affectionate towards each other.' (No. 25, carer)

Even where the relationship appeared strained to the researchers, such as in the following dyad, this did not appear to stop the carer from supporting their spouse to manage the impact of dementia and retain their sense of identity.

'She is, there is one memory in the family and that's her.' (No.20, user)

'Well, look X see what's in there. You've got your porridge, your cereal and I still don't do it for him.' (No.21, carer)

In the final illustration, it was apparent that the female service user and her spouse perceived that she continued to look after her husband in her role as homemaker, despite their description earlier in their separate interviews about her difficulty in managing household tasks.

'I don't do very much now at all apart from looking after my beloved.' (No.26, mild dementia)

Researcher: *'Can you tell me what X would see as her role?'*

Carer: *'Looking after me.'*

Researcher: *'Was it?'*

Carer: *'It still is.'* (No 27, carer)

This continued to be the case for participants with advanced dementia, as in the case of Mr J, who had advanced dementia and his wife, Mrs J. It was apparent that Mrs J continued to reinforce the identity of Mr J, as grandfather and gardener. This was achieved through the on-going inclusion of her husband in discussion concerning their grandson, as well as through adaption of her husband's involvement in an advisory capacity regarding the maintenance of the garden, which was a long-standing passion of his.

'And we talk about when we need somebody in to do this and do that, you know... he still takes a great interest in it and he is able to decide, you know help me decide what's right, what we need doing (in the garden).' (Carer, No 19)

Sub-theme 7: Role of Mental Health Services

For both service user and carer participants some elements of mental health service provision were perceived to help with dealing with the impact of illness. The most valued aspects of service provision appeared to be:

- Acting as a safety net, particularly signposting to other services
- Enabling increased understanding of illness
- Providing information and expert advice regarding the illness
- For those who had very limited social networks, providing opportunities for service-linked networks

Those who believed that it was their responsibility to overcome their illnesses appeared to have fairly low expectations of the ability of services of being able to improve things. Conversely, participants who believed that improvement was the responsibility of services appeared to hold very high expectations of service provision. It was however unclear from these interviews whether these beliefs existed before there had been contact with mental health services.

It is also worth noting that for many of those interviewed, mental health and other statutory services featured very little in their descriptions of how they managed their

illnesses. Additionally, many described having developed compensatory techniques through personal experience, especially through 'trial and error', rather than from specific professional advice.

Theme Five: 'Recovery of self'

For people who perceived that they were managing their illnesses well, a key outcome appeared to be the extent to which they felt they had maintained or regained their sense of self. Most of those interviewed saw a successful outcome following mental illness as becoming or progressing towards being themselves again.

'and I say well I used to be in the business you know. And I saw something the other day and he wanted £2.50 and I said would he take £2,' oh alright then.' So it's good. I couldn't have done that six months ago.' (No.7, depression)

'Getting back to being me...it was just that I was slowly reverting back to my former self really.' (No.36, psychosis)

Regaining hope appeared to be a factor in overcoming mental illness.

'Well I hope it does because as an older patient I am going to hope it does. Older patients can recover.' (No.5, depression)

For people with functional mental health problems, planning active goals for the immediate future were evident.

'I have been there 8 times (Australia). I was thinking of going there in the next 2 or 3 months for the ninth time which is good going really if you go there 9 times isn't it?' (No.5, depression)

'I mean my goals are to get back onto the bike and get fit again. I wouldn't mind getting fit enough to race again.' (No.2, depression)

For people with dementia, more passive aspirations about the future were evident. Many of these tended to relate to the timing of their own death, for example, wishing to reach an important wedding anniversary, or a desire to die before the dementia progressed significantly. For people with a mild dementia, fear about the future appeared to be widespread, but a key factor appeared to be the extent to which they were able to live with this fear and not let it impact upon day to day life.

'No I wouldn't say it worries me (the future), so what will be, will be and I think the only thing I will say is that I would like my husband's way out (a sudden death) and not to be stuck in a home to be fed or watered...I would rather someone gave me a pill. I suppose a lot of people feel like that?' (No.40, mild dementia)

'Yes, I know it is getting on...I know that when I can't speak, and don't know who my husband is, or my daughters, I want to go...now this is making me very anxious, that I want to go when I want to go...I don't want to be with other people, not knowing who am I, or like the other people out there (No.23, mild dementia)

'I'm quite; really I'm quite happy as long as I've got X. I mean one of us will die I know but I sometimes think if only if we could die together because I mean we love each other and neither of us wants to be without the other.' (No.26, mild dementia)

3.5 Discussion

This qualitative research was undertaken in order to understand the relevance of the concept of recovery for older people in relation to their own experience of mental illness, including those with dementia. From the analysis, an over-arching category of 'continuing to be me' was identified. This overarching category was made up from five inter-related themes, all of which made clear the significance of a sense of identity and of continuity, in the lived experience of having a mental illness for people who use OPMHS. These themes comprise Identity, Impact of Illness, Making Sense of the Experience, Dealing with Illness and Recovery of Self.

These findings indicate similarities with and differences in the concept of recovery as derived from the experiences of adults of working age. Key similarities include the impact of illness, the significance of personal responsibility and a number of specific coping strategies. Differences for older people included the prominence of an established and permanent sense of identity, continuity of social networks, valued roles and occupations as both coping strategies and mechanisms to reinforce identity. Additional areas of difference exist for people with dementia, relating to the stage of illness, and the role of carers in facilitating opportunities for recovery to take place. These differences are discussed in relation to the two research questions.

3.5.1 Are existing components of recovery meaningful to older people?

Components of recovery which appear to be meaningful to both adults of working age and older people include the impact of illness, the significance of personal responsibility and acceptance as well as number of specific coping strategies, most notably using knowledge and information, self-help activities and being part of the world.

Components of recovery which do not appear to be meaningful for older people include the development of a new and revised sense of identity and peer support from others with a lived experience of illness.

New components of recovery which appear to be distinct to older people include the significance of an established and permanent sense of identity in the experience of mental illness, both in terms of mediating the impact of illness, as well as providing resources to deal with illness. Coping strategies which appear to be specific to older people are those which provide continuity through the utilisation of existing networks, roles and activities, including peer support from long-term friendships. Furthermore, the need to manage the impact of both physical and mental illness is a factor for older people which is not routinely mentioned in recovery literature for adults of working age.

For older people, including those with dementia, the experience of recovery from mental illness appeared primarily to be connected to the perceived impact of illness upon the sense of self and the extent to which a sense of self could be maintained or regained. This highlights a difference in the experience for older people compared to adults of working age where recovery is often described as being related to personal growth and development, whereby the individual does not always return or wish to return to the 'old me.' (Ridgway 2001).

For younger adults a sense of identity may not be fully developed when a first episode of illness takes place. Narrative accounts from younger people experiencing their first episode of mental illness tend to focus upon the loss of aspirations or plans for the future, as illustrated by Patricia Deegan in her description of an encounter with a psychiatrist early in her illness (Deegan 1993):

'And he spoke these words, I could feel the weight of them crushing my already fragile hopes and dreams and aspirations for my life...In essence the psychiatrist was telling me that my life, by virtue of being labelled with schizophrenia, was

already a closed book...The goals and dreams that I aspired to were mere fantasies according to his prognosis of doom (p. 92)

For people who have used mental health services over many years, the label of 'mental patient' may become entrenched in their sense of identity. Recovery can often be seen as being able to see oneself as distinct to the mental illness (Davidson et al, 2005). Conversely, identity has been defined as the characteristics which make us unique (personal identity) and those which connect us to others (social identity) (Slade 2009).

For the older people in this research, the impact of mental illness was assessed in relation to their established sense of self and in relation to life-time achievements as opposed to future aspirations. With one exception, participants did not define themselves in terms of their mental illness. Therefore this self-defining task of recovery does not appear to be necessary for older people. This may be because a more established sense of self (and a sense of uniqueness) may mediate against an internalisation of a mental illness diagnosis. Further, social identity by connecting with others through established social networks, activities and roles appeared to act as a protective factor for participants. Continuity of relationships, activities and roles acted as a mechanism to manage both the illness and reinforce a sense of identity through 'continuing to be me'.

Narrative accounts given by older people about the impact of mental illness upon social networks, roles, occupations and connection to the world were similar to the accounts of adults of working age (Andresen et al. 2003). The majority of participants discussed in great detail the overwhelming sense of loss which accompanied the experience of mental illness. This is consistent with the framework developed by Hendersen (2010) which identified loss being a central factor in the process of recovery. It is also in keeping with the study on recovery for people with substance misuse problems which identified 'getting back to the old me' as a desired outcome (Laudet 2007).

The accounts provided by service user participants within this research highlight both the impact of physical health problems upon their mental health, and the use of a dual approach towards managing both. This is consistent with research on the relationship between physical and mental health, which is unrelated to age, whereby positive self-rating of recovery is more likely if physical health is self-rated positively (Tepper et al. 2013). However, the use of dual strategies to manage both physical and mental health appears to represent a component of recovery which is distinct to older people. This may be because in older people, physical health problems are more likely to have

developed independently from, or before the existence of a mental health problem. Whilst, it is known that adults of working age with mental health problems have a higher than average level of physical health problems (Robson and Gray 2007), there is little reference as to the strategies used by individuals with lived experience to manage both aspects of health. The literature which does exist focusses primarily on combined (physical and mental health) interventions such as those discussed in Section 2.5.4 (Pratt et al. 2008, Mueser et al. 2012). This may be an area where good quality research in older adults might inform practice in services for adults of working age

The degree to which the illness is accepted and whether personal responsibility is taken for recovery or for managing one's illness appears to be a consistent theme for both older and adults of working age (Andresen et al. 2003). Further, the use of compensatory techniques, making sense of illness, self-help activities, including reciprocity, and connectedness with the outside world are all components of recovery which appear to be similar between older people and adults of working age (Henderson 2011, Leamy et al. 2011).

However, the continuation of pre-existing social networks, roles and activities as a coping strategy and the lack of reliance upon peer support from those with lived experience of illness would appear to be distinct to older people. Overall, these data suggest that coping strategies used by older people can be categorised as supporting continuity of self-identity. Active continuation of social networks, roles and activities as a coping mechanism and as a means to reinforce identity appears to be important for older people. Established social networks, roles and activities are more likely to be available to people who have not experienced mental illness until later life. This is consistent with continuity theory, which describes the process of maintaining or adapting as necessary those established social networks, activities and roles which enhance a sense of identity in order to support successful adjustment to ageing (Atchley 1989). Furthermore, continuity theory suggests that a stable sense of self can be maintained by utilising continuity in roles, meaningful activities and relationships which provide a sense of continuity between the past and present. Continuity theory was developed in order to explain positive adjustment to the challenges of older age without reference specifically to mental illness. Continuity appears to be a major component of recovery for older people, in contrast to adults of working age where recovery focuses upon building new relationships, meaningful activities and valued social networks rather than maintaining existing ones (Davidson et al. 2005). These

data suggest that continuity is a significant component in the experience of recovery from mental illness for older people, including those with dementia.

Peer support between those with a lived experience of mental illness is frequently described as a key component of recovery for adults of working age (Repper and Carter 2011). For the older people interviewed in this research a strong preference was expressed for support from existing friends as opposed to others with a lived experience of mental illness. Only one participant attended a support group for people with mental health problems, and this type of support was not identified as something which participants had used or would like to have access to. This may relate to a lack of knowledge about peer support as this is not routinely offered by the local OPMHS. Alternatively, this may relate to the participants' view of themselves, in particular as not having an identity as a 'mental patient' and therefore perceiving themselves as having little in common with other people with mental health problems.

For many of the participants in this research, peer support had been received within the context of long established friendship, which had been reciprocal over many years, thus allowing support during and after an episode of mental illness to be readily available. The shared experience is therefore one of friendship, as opposed to an experience of mental illness. Further, reciprocity in long-term relationships is less likely to lead to a sense of 'indebtedness', as reciprocal balance is likely to be assessed across the life-course of the relationship and not simply in the present (Fyrand 2010). Long-established supportive friendships, along with the continuation, roles and activities are more likely to be available to users of OPMHS, as the majority have lived a life without mental illness.

The lack of desire for new relationships is supported by the literature on successful ageing, particularly socio-emotional selectivity theory (Carstensen et al. 1999). This theory proposes that older people become more selective in how they use their time as they age, choosing to invest time in relationships and activities which are more emotionally satisfying, and which also carry less emotional risks and promote a link from the past to the present. Peer support from long-term relationships can be seen therefore as having a dual effect: offering support and also reinforcing the maintenance of, or return to, an established sense of identity.

In comparison, adults of working age who have experienced persistent mental illness may be more likely to have experienced difficulties in both establishing and maintaining

meaningful relationships including partnerships with other people without mental illness. The importance of relationships with those without mental illness in the journey of recovery is stressed both in terms of developing valued social roles (as a friend) and also as a means to enhance a sense of an identity separate from illness (Davidson et al. 2005). Reciprocal relationships with those outside of the mental health services have been identified as a component of recovery (Song and Shih 2009, Henderson 2011). However, reciprocal relationships may be difficult for younger people in less well established relationships, where reciprocal balance may not exist (Antonucci and Akiyama 1987). In comparison, the older people in this research described long-term relationships in which reciprocity has taken place over many years, and preceded the onset of mental illness.

In summary, it is unclear as to whether older people do not use or identify peer support because it is unavailable, or because they prefer support from long-term reciprocal friendships. It is beyond the scope of the research to establish whether peer support from long-term relationships is more advantageous to recovery than peer support from others with a lived experience of mental illness. The latter form of support is very strongly emphasised as a coping strategy within the recovery literature (Lette 1989, Repper and Carter 2011). Benefits include positive outcomes on re-admissions rates following discharge from hospital (Forchuk et al. 2005), an increase in perceived empowerment (Resnick and Rosenheck 2008), improved social functioning and social inclusion (Ochocka et al. 2006). It has also been suggested that provision of peer support provides positive role models and helps to reduce the stigma of mental illness (Walker and Bryant 2013) as well as promoting the establishment of new relationships and the potential for an identity outside of illness (Mead et al. 2001).

There are practice implications for OPMHS. These data suggest that there is a need to more strongly focus upon encouraging and supporting service users to maintain or re-engage in long-established relationships, as opposed to establishing and promoting the use of, and facilitating the establishment of peer support services with others with a lived experience of illness.

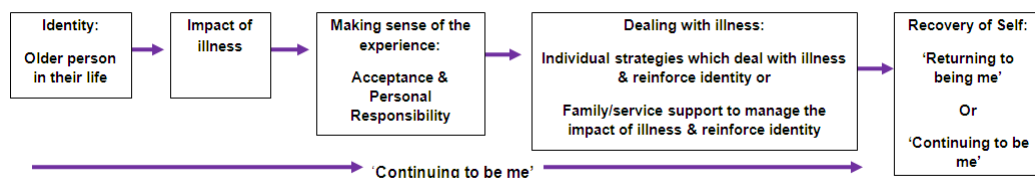
In summary, these findings demonstrate that whilst some components of recovery as described by adults of working age are meaningful to older adults, some are not. Additionally new components of recovery have been identified which appear to be distinct to older people. This research makes clear the potential benefits experienced by older people, compared to their younger peers in the process of recovery. This is

derived from having an increased likelihood of support in the form of long-term reciprocal relationships. As such, this offers older people both social and relationship capital. As discussed in Section 2.2, such capital can be seen as providing recovery capital (Tew 2013), an opportunity which is perhaps enhanced for older people, who as discussed earlier in this section may also have higher levels of identity capital compared to their younger peers.

Overall, the data suggests that mechanisms for supporting recovery which are utilised by users of OPMHS can be categorised as continuity and adaptive approaches which enable users to maintain or regain a permanent sense of self. Such approaches differ significantly to existing developmental and integrative approaches described by adults of working age which focus on a new and revised sense of identity.

The overarching category of ‘continuing to be me’ and the five inter-related themes concerning identity and continuity were synthesised into a conceptual framework for understanding the experience of recovery in users of OPMHS. A conceptual framework is a structure, which has a number of inter-related components which fit together in order to explain a particular phenomenon (Jabareen 2009). This was summarised in a peer-reviewed publication (Appendix I) and is made clear in Figure 3.3

Figure 3.3 Recovery for users of OPMHS



3.5.2 What are the dementia-specific aspects of recovery?

From this research, it is apparent that the concept of recovery as defined by adults of working age holds value for people with dementia. In particular, the impact of illness, and significance of personal responsibility and acceptance (of illness) are meaningful components. Additionally, the use of coping strategies which focus on gaining knowledge and information, self-help activities and being part of the world form part of the experience of recovery for people with dementia. It is also evident that identity and continuity as central components in the experience of recovery for users of OPMHS, apply equally to people with dementia. The findings from this research, of the

importance of 'continuing to be me' and the use of strategies involving compensation and continuity to re-enforce self are consistent with other studies on the experience of dementia. In particular, the use of active coping strategies to support the process of adjustment to having dementia (De Boer et al. 2007), as well as the wish to maintain a sense of self (Steeman et al. 2006, Bunn et al. 2012). A transition for people with early dementia from 'self-maintaining' to 'self-adjusting' (Clare 2003), and between 'I am still me' to becoming 'a person with dementia' (Caddell and Clare 2011) was not identified within this research. This may be due to the fact that only seven of those interviewed had a diagnosis of an early dementia.

The results suggest that recovery for people with dementia relates to the extent to which the sense of self as held by the person with dementia, and by reinforced by significant others can be maintained. There would appear to be two key components which influence this outcome and as such are specific to people with dementia: first the changing experience of recovery as the illness progresses, and second the key role of carers, and to a lesser extent services, in facilitating the process.

For people with dementia, the experience of recovery changes over time as the severity of the illness increases. Increased severity directly impacts upon anosognosia (acceptance and awareness of the impact of the illness). Increasing severity and anosognosia reduces the ability of the person with dementia to be able to personally initiate strategies for managing the impact of illness and reinforce their own sense of identity, thus increasing the need for support from others in undertaking these tasks. Participants with mild dementia were able to describe and show an awareness of their illnesses, its impact upon their lives as well as the strategies which they employed to mitigate the impact and to reinforce self-identity. For those with more advanced dementia, participants were less aware of the problems arising from their dementia. Consequently, they took less personal responsibility for the management of the impact of dementia. Carers described gradually taking over this responsibility for the management of the illness, until a point was reached where they perceived themselves to be fully responsible. Where people with advanced dementia were successfully retaining a sense of self, it was apparent that this could only be achieved through support by others, both in terms of managing the impact of the illness as well as reinforcing the identity of the person with dementia. In the case of Mr J and his wife, Mrs J was able to reinforce the self-identity of her husband, as a grandfather, and as a keen gardener. This changing experience of recovery for people with dementia would appear to be distinct to dementia, given its inevitable progression and the associated

increase in anosognosia. This is not the case for functional mental illnesses where the course and outcome of illness cannot be so clearly predicted. This has a direct impact upon the need for carers and to a lesser extent OPMHS to take a role in enabling coping strategies which manage, rather than mitigate the impact of the illness as well as reinforce a sense of personal identity through the later stages of the illness.

For individuals who are married or in long-term relationships, the impact of dementia takes place within the context of that relationship. One of the key roles of spousal carers appears to be enhancing the sense of identity of the person with dementia, by facilitating the use of compensatory techniques such as visual and environmental prompts as well as supporting the continuity of relationships, roles and meaningful activities. This fits with the suggestion that in the later stages of the illness, the 'flame of recovery' might be held by family members (Irving and Lakeman 2010).

Further these findings are consistent with research which makes clear the role of family members in actively maintaining a sense identity for people with dementia (Genoe et al. 2010, MacRae 2011, Phinney 2006). This appears to be a key difference in the experience of recovery for older people compared to adults of working age whereby recovery is more of an individual process, and responsibility for recovery is less likely to be assumed by a spouse or other carer. It is however recognised that the role of other informal carers, such as siblings or children was not fully explored within this research. Also, research aimed at understanding the role of carers in facilitating recovery for adults of working age is under-developed (Scottish Recovery Network 2009). These findings relate to spousal carers predominantly, and may be linked to the reciprocal nature of spousal relationships. There are implications for practice in supporting all carers in the task of facilitating recovery, most notably education about the benefits of enhancing the sense of identity through continuity. There is also a need to help carers to recognise the value of keeping responsibility for mitigating the impact of illness remains with person with dementia for as long as possible. This is not necessarily straightforward, as carer participants within this study described this gradual and unconscious process rather than being a clear decision taken at a specific time.

It is also worth noting that whilst education may be a useful intervention, there is often a significant emotional burden experienced by spousal carers of people with dementia. Within the interviews, many carers reported an increasing sense of loss as they observed the impact of dementia upon their spouse over time, as well as a sense of bereavement for the loss of their own preferred future.

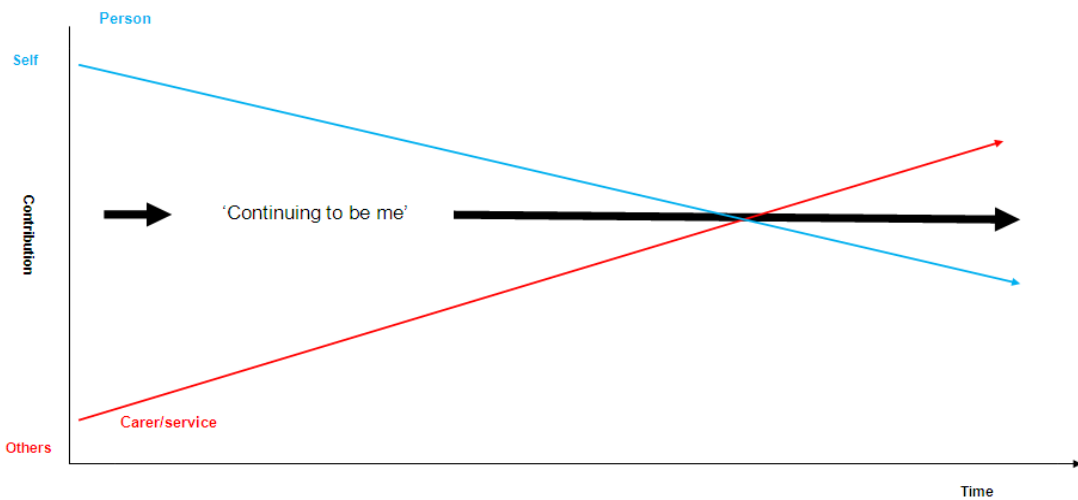
In situations where there are no carers and for those with more advanced dementia, OPMHS and other services may need to take a more active role in supporting a sense of identity of person with dementia, particularly in supporting the continuity of established networks and occupations. The proposed overlap between person-centred care (Kitwood 1997) and recovery was discussed in Section 2.5.2. This research supports some of the areas of overlaps identified, for example:

- i. That identity can be reinforced by having a significant understanding of the person (McKay et al. 2012),
- ii. The importance of engagement in meaningful activities (Sole and Read 2009)
- iii. Providing comfort, by knowing what is important to the person and responding to this (Martin 2009).

In summary, there appear to be two components of recovery which influence the experience of recovery for people with dementia: increased severity over time, and the role of carers in facilitating the experience of recovery. Increased severity of illness leads to reduced awareness and less taking of personal responsibility by the person with dementia. Within the trajectory of dementia, a point will be reached where carers or services will take over more responsibility for the management of the impact of illness. The extent to which continuity and identity can be reinforced by carers and to a lesser extent services for people with advanced dementia can be seen as being crucial to the on-going recovery for people with dementia.

Overall, this study has found that recovery for people the dementia relates to the extent to which the sense of self as held by the person with dementia, and reinforced by significant others, can be maintained. A framework for understanding these additional components for people with dementia was summarised in a peer-reviewed publication (Appendix I) and is shown in Figure 3.4.

Figure 3.4 Framework for recovery and dementia



This research has three main strengths. Firstly, the qualitative interviews provided narrative accounts of the experience of mental illness for older people who use mental health services in order to explore the concept of recovery. Using grounded theory techniques in the analysis of service user and carer narratives enabled revision to the existing concept of recovery. In particular, the use of theoretical sampling added rigour to the analysis and subsequent findings. The second strength is that these findings were generated from range of service users of OPMHS, thus increasing the generalisability of the findings. Finally, the clinical applicability of the findings, derived from the sample of users of OPMHS has potential value in the development of OPMHS to ensure that implementation of recovery-oriented practice fits with the experiences of service users and carers. It also allows OPMHS to be clearer as to where they should deviate from established recovery-oriented practice developed for adults of working age, given the lack of empirical research and a policy agenda which stresses the need to consider differences in recovery across the life-span, but does not provide specific practice guidance (Department of Health 2011).

The main limitation of the research is that the findings predominantly reflect the experience of a life lived for the most part without mental illness. Nineteen of the 28 participants interviewed had their first experience of using mental health services over the age of 65 years, and none of the participants interviewed had used services for adults of working age within the previous two years. The extent to which the experience of recovery for older people with persistent mental health problems who use mental

health services for adults of working age differs from their younger peers has not been tested. This limits the generalisability of this study, as the findings only relate to users of OPMHS, and not older people with mental health problems in general.

In this chapter, a conceptual framework for understanding the experience of recovery in users of OPMHS has been presented, as has a linked framework for understanding the additional components of recovery for people with dementia. In Chapter 4, these conceptual frameworks are used to identify the clinical implications for working practices within OPMHS.

Chapter 4 Clinical Implications of the Conceptual Framework

The aim of this chapter is to present the clinical implications arising from the conceptual framework of recovery for older people, and the linked framework for recovery for people with dementia as described in Chapter 3. This chapter generates an evidential pathway for the translation of the conceptual framework of recovery for older people into the active ingredients required for a recovery intervention for staff, by exploring the working practice implications arising from the framework empirically.

The conceptual framework showed that the experience of recovery from mental illness appeared primarily to be connected to the perceived impact of illness upon the sense of self, and the extent to which a sense of self can be maintained or regained. Additionally, two components: time and the role of carers were identified as being significant in a linked framework for people with dementia. Whilst clinical implications were drawn from the frameworks, these were not explored with service users, carers and staff. Therefore three focus groups with service users, carers and staff were subsequently undertaken to more fully explore the working practice implications arising from the two frameworks.

The overall aim of the focus groups was to inform the development of a model, comprising a recovery intervention for staff and intended effects. The focus groups addressed three research questions:

- 1) Which working practices support the recovery of users of OPMHS?
- 2) To what extent do these working practices differ from those currently delivered within OPMHS?
- 3) What differences exist between the views of service users, carers and staff about the working practice implications generated from the framework of recovery for older people and the linked framework for recovery and people with dementia?

The methods and results of the focus groups are presented, and the potential implications of the findings on the development of the model are discussed, along with the strengths and limitations of this research.

4.1 Methodological Considerations

Focus group discussions were used to investigate service user, carer and staff views about the working practice implications arising from the framework for recovery in older people, and the linked framework for people with dementia. Focus groups were chosen over individual interviews for two reasons:

- 1) Focus groups provide more in-depth insight into the views of participants in a natural social setting as the group discussion allows participants to reflect upon their own views and positions on topic areas in response to hearing the views of others (Berg and Liune 2012).
- 2) In a focus group, participants are more likely to respond to, and be influenced by each other as opposed to the researchers (Finch et al. 2014). This reduces the potential biasing impact of the facilitator on the data collected.

A key issue in the planning of the focus groups was the degree of heterogeneity within each potential group. For the combined service user and carer group, it was decided that heterogeneity was important in order to obtain a range of views. It was recognised that too much heterogeneity can inhibit disclosure (Finch et al. 2014). However, it was decided that an existing group of both service user and carers would provide a range of experiences, but within an environment where participants were familiar with each other and would be comfortable.

For the staff focus group, whilst diversity in opinion was sought, it was decided that greater homogeneity among participating staff members in relation to organisational position would allow for more open discussion. Therefore two staff focus groups took place; one for staff with full-time clinical responsibilities (Band 6) and one for more senior clinical staff, who held additional managerial responsibilities (Bands 7 and 8a). This grouped participants in such a way that their relationship with and knowledge of the research topic (recovery and recovery-oriented practice) would be similar (Finch et al. 2014). For example, more senior clinicians might have been more aware of the policy agenda supporting recovery than more junior clinicians.

Further, the extent to which participants were familiar with each other was also considered. For the service user and carer group, it was decided that an existing involvement group would be used rather than setting up a focus group with participants who were unfamiliar with each other. Using an established group was intended to ensure that participants would feel comfortable meeting together and would be interested in contributing towards a research topic linked to service delivery. However

existing groups have a history of shared understandings which can inhibit exploration of topics in more depth (Flick 2009). In planning the service user and carer focus group, the researchers identified the need for them both to ensure that they (as facilitators, fully explored initial responses from participants (Finch et al. 2014).

As a suitable existing staff group did not exist, it was decided that two focus groups would be set up. Given the size of the OPMHS, it was not possible to identify staff who would not have known each other. Therefore staff from different teams were invited, to try to increase the diversity of experiences and opinions.

4.2 Methods

4.2.1 Sample and setting

Service user participants were over 65 years of age, had a clinical diagnosis of a functional mental illness, and either were, or had been, users of OPMHS in South London. Carer participants had been informal care-givers for people with dementia, who had died. All carers defined themselves as having substantial experience as carers, and had maintained on-going contact with the OPMHS. All service user and carer participants were able to provide informed consent. They were all members of an existing service user and carer advisory group associated with the OPMHS.

Staff participants included nurses working in community mental health teams as well as multi-disciplinary senior clinicians. All staff participants were employed by the OPMHS in South London.

4.2.2 Procedure

NHS Research Ethics (reference: 09/H0722/66) and local service Research & Development approval were granted in December 2009 (Appendix A and B).

The facilitators were the principal investigator, a recovery training facilitator (a nurse employed to deliver the recovery intervention) and a research worker. In each group, the principal investigator led the process, and recovery training facilitator and research worker acted as moderators.

The principal investigator and research worker attended a service user and carer advisory group meeting and asked members of the group to consider involvement in the planned focus group. The researchers gave the service users and carers a study information sheet, which explained what participation would involve, and also provided the date of the planned focus group.

A total of 16 staff were approached by the principal investigator, who emailed the two different groups of staff to invite them to participate in either focus group 1 (community nurses) or 2 (multi-disciplinary senior clinicians), dependent upon their work role. The email enclosed a study information sheet, which explained what participation would involve, and the date and location of their respective focus group.

The three focus groups were carried out in 2010. The combined service user and carer focus group was co-facilitated by the principal investigator and the research worker, and the two staff focus groups were co-facilitated by the principal investigator and the recovery training facilitator.

The service user and carer focus group took place at the team base of a community mental health team (CMHT) which was in easy travelling distance for all of the participants and was also wheelchair accessible. Transportation was arranged for participants with mobility difficulties. No payment was made for participation.

The two staff focus groups took place at a hospital site, and within normal working hours.

Before starting each focus group, information sheets were given, questions about the study were invited, and written consent was obtained from all participants. The user and carer focus group lasted 2 ½ hours, with a 30 minute break for lunch. The staff focus groups lasted 1 ½ hours, and no refreshment breaks were taken.

In each of the focus groups, the principal investigator delivered a 20 minute presentation on the findings from the earlier research which produced the framework of recovery for older people, as well as the linked framework for recovery for people with dementia. At the end of the presentation, the researchers directed the group members back to individual power-point slides for each of the seven themes within the framework as follows: Identity, Impact of Illness, Making Sense of the Experience, Dealing with Illness, Recovery of Self, Working with People with Dementia and (Working with) Carers.

In turn, the researchers asked the group to consider the working practices which they felt would support service users in each theme and how this compared to their experiences of current practice. The researchers worked through the themes in order, progressing onwards as the discussion on each theme ended. The researchers intervened periodically within all focus groups to ensure that reticent group members were asked for their opinion on the theme being discussed, and to ensure that the conversation remained focused. Each focus group was audio-recorded, transcribed verbatim and checked for accuracy by the principal investigator.

4.2.3 Analysis

The transcripts were analysed by the principal investigator, using the seven themes as a coding framework for each of the working practices identified. Each transcript was read repeatedly, and meaningful segments of text were given descriptive codes and assigned to the relevant code. Any segment of text which could not be assigned to one of the seven themes in the coding framework, was grouped separately, and reviewed at the end of the analysis. A computer software package, NVivo 8 (QSR International, 2008) was used in order that the principal investigator could systematically collate data relevant to each theme. The principal investigator met with the independent qualitative researcher (JM) for academic supervision and reflexivity in order to consider how own standpoint during the data collection and analysis, particularly on the impact her own role (as the professional lead for occupational therapy) might have had on the process.

4.3 Results

4.3.1 Participant characteristics

The clinical and socio-demographic characteristics of the user and carer participants are shown in Table 4.1

Table 4.1 Clinical and socio-demographic characteristics of service user (n=4) and carer (n=2) participants

Participant type (Number)	Diagnosis	Age (Years)	Gender
Service user (No.1)	Bipolar disorder	75-84	Female
Service user (No.2)	Depression	65-74	Female
Service user (No.3)	Depression	65-74	Male
Service user (No.4)	Bipolar disorder	65-74	Male
Carer (No.5)	Bereaved spouse	75-84	Female
Carer (No.6)	Bereaved spouse	85-94	Male

The staff participants included 3 nurses in group 1 (community nurses), and 2 occupational therapists, 2 nurses and 1 social worker in group 2 (multi-disciplinary senior clinicians). Pre-existing relationships existed between all staff participants, but none were members of the same clinical team.

4.3.2 Service User and Carer Focus Group Findings

Working practice examples were identified by service user and carer participants for the themes of Identity, Making Sense of the Experience, Dealing with Illness and Carers, although not for the Impact of Illness, Recovery of Self, and Working with People with Dementia. One additional theme of Being Given Time was identified from the analysis. The key working practices identified by theme within the focus group have been summarised in Table 4.2

Table 4.2 Working practices from the service user and carer focus group

Theme	Area of practice identified
Identity	Getting to know the person, their experiences, what they were like before they were unwell
Making sense of the experience	Knowing that you are not on your own/being given hope Finding out what the service user wants, using service user expertise
Dealing with illness	Pro-actively providing information Supporting continuity of meaningful activities
Carers	Being offered help
Being given time	Not feeling rushed/feeling that time is not an issue for clinicians

Identity

Participant views on working practices which supported the theme of Identity included: getting to know the person, their experiences and what they were like before they were unwell.

These practices were identified by both service user and carer participants. Good practice examples included: a) the need for staff to obtain a detailed personal biography of the service user and b) the need for staff to understand how the service user had characterised themselves before they came unwell, including an awareness of the relevant life experiences which defined them as individuals, and significant relationships, roles and activities. Accounts were provided of staff who had previously taken the time to really get to know service users, as well as those who had not.

'He really worked out who he was before he become ill. I thought that was really important and good...' (No. 5, Carer)

'The experiences that you have from your life...It's the where you come from, that's the bit that gets left out.' (No. 1, Service user)

Making sense of the Experience

Participant views on working practices which supported the theme of Making Sense of the Experience included: knowing that you are not on your own, being given hope, finding out what the service user wants and using service user expertise.

Service user and carer participants described situations in which staff had told them about other service users who had similar mental health problems, and how this had helped them to come to terms with the experience, as well as providing re-assurance about the potential for recovery following illness.

‘One approach that I found was really encouraging. Obviously I’d never been so terrified in my life, but for a member of staff to take time and say that this has happened to other people and we recognise this, and these are the possibilities and these maybe the reasons why. You’re not on your own, not initially.’ (No.2, Service user)

Service user participants discussed how important it was to be asked about how they saw the situation and what solutions they had identified themselves. Service user participants reported that this had not been their routine experience of working practice. This practice was not identified by carer participants.

‘If he actually asked me to say where I was coming from first. That would have been helpful, before he actually produced the cognitive behavioural handbook (No.1, Service user)

‘I am entirely with you. Before one is told what is the matter with one it would be very nice to have a chance to say how I think I am (No.1, Service user)

Service user participants also described how it had taken time to develop their confidence to express their own opinions, needs, and personal preferences. Further, they stated that they would have been unlikely to do so without prompting from staff at the earlier stages of their contact with services.

‘Also you have to learn to ask and express your needs and that took me a long time to learn how to do that...This is something you learn with experience of the illness.’ (No.2, Service user)

'That was my main thing ...was to have the confidence back, to ask what I need and also to say no to the things I don't want, and you do, you have to have the confidence to do this.' (No.1, Service user)

Dealing with Illness

Participant views on working practices which supported the theme of Dealing with Illness included pro-actively providing information and supporting continuity of meaningful activities.

Pro-actively providing information was identified by both service user and carer participants as one of the most highly valued aspects of practice which supported them in dealing with the impact of illness. This included being given information about the underlying illness, ways of dealing with the illness, as well as services and support available. This is illustrated in the following example by a carer participant who received wide-ranging information at the point of her husband being diagnosed with dementia.

'When he told us about dementia and that X had it. He gave us lots of good advice. He told us to get our money sorted out, to make a will, to get power of attorney all very practical and sensible stuff. He spelt out how it was going to develop, and he let us know the things need to be done before it would be too late. He then gave us really good advice about services available at the (local) service.' (No.5, Carer)

Service user and carer participants made clear that being given information specific to their needs was extremely helpful, as they perceived themselves as unlikely to be informed as to where gaps in their knowledge existed. However, service user participants indicated that staff could be more pro-active in providing information to service users.

'I would have liked to have things like leaflets and information. We never had anything given to us in writing I had to find those things off my own effort.' (No.1, Service user)

Finally, whilst some service user and carer participants discussed information which was more widely available from organisations such as the Alzheimer's Society, or

books written by other people who had lived experienced of mental illness, information given directly by staff remained most highly valued, as it was more tailored to individual needs.

Supporting continuity of meaningful activities was identified as a practice which enabled service users and their carers to deal with the impact of illness.

He had always been quite keen on drawing and the community mental health team decided that this woman would come and do art with him, he wasn't sure about it at first but soon he gradually enjoyed it, I think this was good for him.'
(No.5, Carer)

Carers

Being offered help was the practice which carer participants valued. This related to the value of being offered help by services, and being encouraged to accept help, even if this had not been something which they had asked for.

'It gave me a great sense of relief, although I had not asked for help.' (No.6, Carer)

'There was a lady who was looking after her mother who has dementia and she wouldn't leave her with anyone, and I said to her it's a mistake that we are all making. We should ask for help and use it. I think it is pretty common, you feel you have got to do everything...In my case they (the community mental health team) slowly built up my confidence, you know, calling, coming up with suggestions.' (No.6, Carer)

Additional theme 1: Being Given Time

Finally, one additional theme of Being Given Time was identified. This was valued by both service user and carer participants. The perception of not feeling rushed appeared to be very significant, particularly in reinforcing a sense of personal value

'Later I had an absolutely excellent therapist, in fact I had two and each of them gave the impression, I'm sure it was against the rules, that they had the all the

time in the world and they behaved as if they had. It made all the difference.'
(No.2, Service user)

'I don't think it needs to be rushed. We were never rushed, they always so generous with their time. We never got the feeling that there were loads of people and you were being rushed. You can't rush someone with dementia, impossible.' (No.5, Carer)

4.3.3 Staff Focus Group Findings

Working practices were identified for the themes of Identity, Impact of Illness, Making Sense of the Experience, Dealing with Illness, Working with People with Dementia, Carers, but not for Recovery of Self. Additional themes of Risk Management, Redefining Staff Roles, and Organisational Commitment were identified from the analysis. Areas of working practice relating to each theme are summarised in Table 4.3

Table 4.3 Working practices from staff focus groups

Theme	Area of practice identified
Identity	Getting to know the person, their experiences and what they were like before they were unwell as part of assessment process, maintaining identity as part of the care planning
Impact of Illness	Understanding the feelings
Making Sense of the Experience of Illness	Providing reassurance to service users that they are not on their own with their mental health problems, providing hope, finding out what the service user wants, using service user expertise, keeping responsibility with the user
Dealing with Illness	Identifying and drawing upon previous coping strategies, using a coaching approach, supporting well-being and using strengths, continuity of meaningful activities and networks
Working with People with Dementia	Tailoring interventions to stage of dementia, life history work at the early stages of dementia, focus on meaningful activities
Carers	Working with carers: coping strategies for carers, problem solving techniques, reducing carer burden so that focus on meaningful activities can be maintained
Risk Management	Overcoming risk avoidance, need for a team approach to positive risk-taking, organisational barriers, lack of support for staff
Redefining Staff Roles	Holding a more realistic view of staff importance in users' lives, actively decreasing dependency on services, sharing the common humanity between staff and service users
Organisational Commitment	Ensuring multi-disciplinary understanding of recovery, developing a more consistent approach to recovery-oriented practice, overcoming organisational barriers, team culture and dynamics

Identity

Staff views on working practices which supported the theme of Identity included: getting to know the person, their experiences and what they were like before they were unwell and maintaining identity as part of the care planning process.

The importance of really getting to know a service user during the assessment process, taking a detailed biography and using this to understand the impact of the illness in the context of the person's life was emphasised. The need to set this as the foundation of recovery support was stressed, as was the need to build a positive relationship with service users. There was a suggestion that this was not routinely undertaken in practice.

'I think make it a big a sort of focus, a focussed part of doing the first assessment and then kind of following on from that using that time we have with the client to explore further those parts of their identities which come up through the assessment process. So their role as a husband or wife, mother, father, and as you say, pick up someone's photograph on a mantelpiece and say 'oh can you tell me about that?' and that brings a lot of information and that is a good way of building up trust with somebody as well and them feeling that they are valued as a human being rather than just as a patient,' (No.1, Nurse, group 1)

'It sounds like we need to relate people to the person more doesn't it, you know, it sounds obvious, but I am not sure that we are doing that, it is almost like you want people to be able to put themselves in those shoes, but they (staff) do need to know enough about the person to do that.' (No. 5, Occupational Therapist, group 2)

Using prompts such as photographs were highly valued by staff in group 1 (community nurses) in helping them to really getting to know the service user.

'I think photographs for me are such a powerful thing, people have showed their photo albums when they were men in their, you know, thirties, and their family holidays and that to me just brings who they were into focus, not just a story, but you can actually just see the person and you know, they did all these things and they had this rich life, and that to me, that's a great way of really bringing it into focus really.' (No.2, Nurse, group 1)

'There is something about photographs isn't there? I have sat down with patients in the community and gone through personal albums with them and they were showing me all their children's weddings and all those things and it is just like you're not just my patient you're a husband, father, a grandfather, you're an immigrant, you know. There is so much more, photographs are fantastic.' (No.1, Nurse, group 1)

The practice of keeping a focus on maintaining identity as an important part of the care planning process was identified with staff reporting that this was not routinely undertaken.

'It is not something we make enough of, we are more focussed on problems and the issues of concern but I do think that it is something that we could realistically make much more focus of someone's care, and incorporate it as part of their care plan in order to help them to maintain their identity.' (No.2, Nurse, group 1)

'The way we do work with service users, from day one, the first thing we start thinking about is day centres and in fact we start trying to reinvent their identities in some way. In some ways, (we should) see that (maintaining identity) as being our focus, and we should be looking at who they are.' (No.5, Occupational Therapist, group 1)

Impact of illness

Understanding the feelings being expressed was identified as the practice which would support the theme of Impact of illness. This involved both exploring the underlying feelings as well as demonstrating empathy.

'To try to show that you understand, you know. You know, empathise with their feelings.' (No.2, Nurse, group 1)

'I was thinking about my lady who has got Parkinson's, and asking her what is it like, you know tapping into that. 'How does that make you feel?' (No.1, Nurse, group 1)

Making Sense of the Experience

Participant views on working practices which would support the theme of Making Sense of the Experience included: providing reassurance to service users that they are not on their own, giving hope, keeping responsibility with the service user and finding out what the service user wants.

The practice of giving hope and providing reassurance to service users that they are not on their own appeared to be particularly pertinent for participants in group 1 (community nurses). This group stressed the value of staff providing hope to service users by being hopeful themselves as to the potential for recovery and also by (confidentially) sharing experiences of other people in similar situations who had recovered. The importance of recognising small progress steps was also noted.

'Many times I have been asked by people, 'Have you seen people like me before.' 'What's the worst person you've ever seen?', and I think that it is good to have proper examples, so "actually I met a lady similar to you and this is what she did, and this person went on to get better" and that does kind of give them hope, not in a forced way, but believing that it is possible, you're not different and you can do the same.' (No.2, Nurse, group 1)

'It is a struggle, you're going in and you're just holding the hope, hoping that you are going to come out of it, you're going to come out of it. So it's just being there and holding that hope and being positive because if you are going in and just reinforcing the negatives, you just think what's the point. It's just going "things will get better."' (No.1, Nurse, group 1)

Participants in both groups stressed the importance of keeping responsibility with the service user and the need for staff to resist the temptation to take this (responsibility) on themselves. Specific techniques such as problem solving and coaching were identified, as were situations where risk was present and the need to jointly manage this with service users, rather than staff taking on full responsibility for the management of potential risks.

'I was also thinking ... it is about working with service users, teaching them how to problem solve, but not actually telling them what to do, so the learning is about the problem solving technique, which can then be applied to every situation, so it is much more about empowering, enabling and something about

giving that sense of responsibility back to the service user... so you know, I am a resource to use if you need me, however I am not going to take over all of these tasks for you.' (No.4, Occupational Therapist, group 2)

'I think that there is something about sharing the responsibility for risk management, and I have had one lady who would often talk about taking overdose and going up to see her, you would have that (feeling), 'Oh my god, what way is she going to do it (take an overdose), she's on antidepressants, is she going to do it with her medication?' But it is having that difficult conversation with her. 'This is what you've done, what was going on around it?' and saying 'Well okay, this is the plan, this is what we agreed to do.' and saying its okay, and being ok to leave it at that. Because I can't take a whole week, I can't give her 24 hours a day and it's walking away and saying okay, I have done everything, we've had a discussion. Discussed it at the multi-disciplinary team clinical meeting and discussed it with the family, the social worker, carers going in.' (No.1, Nurse, group 1)

The importance of finding out what the service user feels is the priority for them, and what is most important to him or her was stressed by staff.

'Finding out what it really is which is important to people, and what they want to do... what is it that people really want to be doing?' (No.4, Occupational Therapist, group 2)

There was a strong suggestion in both groups that this did not routinely happen in practice.

Dealing with Illness

Participant views on working practices which would support the theme of Dealing with Illness included: identifying and drawing upon previous coping strategies, using a coaching approach, supporting well-being by focussing on strengths, and continuity of meaningful activities and networks.

The practice of identifying and drawing upon existing coping strategies was highlighted.

'I think it is about helping our staff to identify service users' coping strategies, or somehow teaching staff how to elicit what service users do to cope.' (No.5, Occupational Therapist, group 2)

'I think we need to look at their (service users) previous coping strategies and if they are applicable to the current situation and finding out whether there have been times when they have shown great strength... I think that when you are a care co-ordinator, you should make it part of your routine, finding out from people what has helped you in the past, what's helped you to move on in difficult times and maybe we can carry on and expand or develop those.' (Nurse, group 1)

Participants made clear the potential for using problem solving and coaching techniques to enable service users to identify their own solutions to problems. Such techniques were linked to finding out what the service user wants, as well as building upon their expertise for self-management. Coaching techniques were perceived to have a dual purpose in also keeping responsibility with the service user.

'I think that it is just listening to the person, hearing their frustrations, their fears and looking to what they see as being the barriers, and looking together at whether there are practical ways that they can be overcome.' (No.3, Nurse, group 1)

Participants in both groups stressed the need for staff to find out what strategies service users had used previously and whether they could be utilised to support their well-being. A focus on identifying and using strengths was also suggested, as was the use of WRAP plans (Copeland 2005) to support the process.

'I was thinking that the staff really have to know what those prompts are, and what those questions should be to get that information out, and staff really have to think about that.' (No.7, nurse, group 2)

The importance of facilitating engagement or re-engagement in meaningful activities and networks was particularly highlighted by staff in group two.

'But when we do the assessment, do we actually go back, and focus on 'What you were doing?' and 'What's stopping you now?' It might just be listening to

the radio, or doing something else, I don't think that we don't do those things'
(No.7, Nurse, group 2)

Working with People with Dementia

For the theme of Working with People with Dementia working practices included: Undertaking life history work with service users early in their illness, and taking a staged approach.

The important of working pro-actively with service users early in their illness was advocated, in particular undertaking a life history at that stage, so that it can be used in the later stages of the illness, when the ability of the person with dementia to give a life history will be more impaired.

'Well I think the thing is with the early diagnosis work that we've been doing, is that if we can get people at that really stage, and get a really good history, at that point, then you have got a really good idea about the person, and you can actually use that, you know in the future.' (No.6. Nurse, group 2)

The need to take a staged approach to working with service users at different points during their illnesses was identified.

'But we need look at the illness over time, and connect different times of contact with different parts of our services. We should be saying at different points, what is it that you need now.' (No.7, Nurse, group 2)

Carers

For the theme of Carers, practices which focussed on working with carers were identified. This included the need to work with carers to identify their personal coping strategies, as well as addressing carer burden as this might limit opportunities for recovery to take place.

'I think when you've got your service users who rely so fundamentally on the carer as the person who is looking after their life, I think that you should be

asking the carer what is your coping strategy as well as the service user.’ (No.7, Nurse, group 2)

Three additional themes of: risk management, redefining staff roles and organisational support were identified through the analysis.

Additional theme 1: Risk management

Risk management emerged as a strong theme within both staff focus groups. The need for positive risk management was stressed, as was the need for a team approach to manage positive risk-taking, contingency planning as well as organisational barriers which hinder positive risk-taking in practice.

‘But isn’t it about the service supporting that? So that staff feel that they are really supported to work in that way? It reminds me of the first day that we discharged from X (ward) with telecare, and everybody said to me ‘you can’t do that’, and I was supported, but it was really terrifying, it reminds me of that, because that person was actually able to return home, and the family, and whole service supported it, so that person was able to continue ‘to be me’ by going back home, and actually stay at home until she died...because it was about supporting somebody to be able to do what they wanted to do.’ (Occupational Therapist, No.5, group 2)

Additional theme 2: Redefining staff roles

A theme of redefining staff roles was identified by staff participants in both focus groups, and in particular the need to challenge the perception of staff that they are centrally important to service users in helping them to manage their illness. Key work tasks for staff were seen as supporting service users to make sense of the experience of illness by providing hope, focussing on wellness (as opposed to being illness oriented) and actively working towards the avoidance of dependence upon services.

‘I am thinking about how often we automatically go in there, and say ‘I will call the social worker on your behalf.’ But what about ‘this is the phone number; you need to contact social services, what about you giving them a call, and talking about what your needs are?’ Things like that would stop that dependency from

developing from the word go. It almost like we should get paid (by commissioners) not to increase dependence.’ (No 4, Occupational Therapist, group 2)

‘There does seem to be something about being a mental health worker that you want to go in and resolve all of the issues.’ (No.2, Nurse, group 1)

Redefining roles related to the perceived benefit of taking a more flexible approach to professional boundaries and being able to share one’s own experience as a staff member. Additionally the need for staff to recognise the common humanity between staff and service users was advocated, and overcoming an ‘us and them’ approach.

‘Professional boundaries, well people like to hide behind that, but I think we should all be human...I think when people hear that, they take you a bit more seriously like you know, yeah, I will shed a tear with you because you know when I have been at my lowest and you just think what’s the point. I wasn’t depressed, I wasn’t prescribed antidepressants but you know it was quite traumatic and quite painful. I think when people hear that they think well yeah, you know you’ve got a story to tell as well. I can take you a bit more seriously than just coming and saying yes take your tablet and things will get better. I think it’s being genuine. It’s being real, that people can see that you mean it. It’s hard to describe it.’ (No.1, Nurse, group 1)

Additional theme 3: Organisational commitment

The need to consider organisational commitment in relation to organisational expectations and team level change for delivering consistency in recovery-oriented practice was stressed. Organisational commitment such as clear recovery standards and targets were suggested.

‘It is having some clear standards how this should be done ...how this is communicated to service users and their families.’ (No.7, Nurse, group 2)

Additionally, the need to overcome barriers to implementing recovery-oriented practice was stressed, for example, the electronic patient record system which was perceived to be deficit-oriented.

'It is about the (electronic patient record system) document, as well, you know it is very deficit oriented, it really is, and I think a lot of people, especially the more inexperienced people rely heavily on it...this is as much as I have to ask, and not how do I get to know this person, but I need to get this form, onto the (electronic patient record system) within the next 24 hours... this is a real obstacle.' (No.5, Occupational Therapist, group 2)

The need to take a team approach to implementing recovery-oriented practice was stressed, as was the key role of team leaders, supervision processes, and the risk that negative team dynamics and team cultures might sabotage new ways of working.

4.3.4 Comparison between service user/carers and staff views

Similarities and differences between service user and carers views and staff views are summarised in Table 4.4

Table 4.4 Similarities and differences between service user/carer and staff views

Theme	Identified by participants in all focus groups	Identified only by service user and carer participants	Identified only by staff participants
Identity	Really getting to know the service user, their experiences and what they were like before they became unwell		Using photographs, maintaining identity as part of the care planning process
Impact of Illness			Understanding the feelings
Making sense of the experience	Providing hope/knowing that the service user/carer is not on his/her own Finding out what the service user wants Using the expertise of service user		Keeping responsibility with the service
Dealing with illness	Continuing with meaningful activities and relationships	Pro-actively providing information	Focus on well-being, use of strengths, previous coping strategies, using coaching
Carers		Being offered help	
Working with People with Dementia			Tailor intervention to stage of dementia, life history work at early stage of dementia, coping strategies for carers, including problem solving
Other themes		Being given time	Positive risk-taking, staff roles, sharing the common humanity, organisational commitment: expectations and team change

4.4 Discussion

This chapter describes data derived from the three focus groups with service users, carers and staff. The findings were produced using thematic analysis, and make clear the working practice implications from the conceptual framework of recovery for older people, and the linked framework for recovery for people with dementia.

There were two main areas of importance for the subsequent development of an overall model of a recovery intervention and its intended effects: a) the identification of the active ingredients of the recovery training components of the intervention and b) implementation considerations. Active ingredients can be defined as the components of an intervention, which directly impact upon the intended outcomes, and without which the intervention would be ineffective (McCleary et al. 2013).

In identifying the active ingredients of the intervention, prominence was given to areas of working practices where the views of service users, carers and staff were shared. Shared views were particularly evident for Identity, Making Sense of the Experience and Dealing with Illness. Four active ingredients for the intervention were identified.

Active ingredient 1 was Recovery and Older People. Some of the findings presented focus more on the implementation of recovery-oriented practice within OPMHS, as opposed to the direct working practice implications. The need for wider understanding about the concept of recovery and recovery-oriented practice across the multi-disciplinary team was identified. The findings indicated that staff would need to be able to understand what recovery means in practice and be able to recognise the benefits for delivering recovery-oriented practice, in order to be sufficiently motivated to implement and communicate the need for change. It was decided that an introductory training module on Recovery and Older People be included as an active ingredient within the intervention, in order to address these points.

Active ingredient 2 was Maintaining Identity. Identity was an over-arching theme within the framework of recovery for older people presented in Chapter 3. There was a high level of shared opinion in all of the focus groups that a key task for staff should be working with service users to maintain identity. It was decided that Maintaining Identity would form a distinct training module. As discussed in Section 2.5.2, the significance of identity is the cornerstone of person-centred care for people with moderate to severe dementia (Kitwood 1997). It was evident from this research, that a focus on maintaining identity was highly valued by service users and carers, including those with functional mental health problems. Furthermore, there was a shared view by all participants that

staff in the local OPMHS did not focus sufficiently on maintaining identity within routine practice. This is in keeping with concerns about the mixed level of implementation of person-centred care in practice (Martin 2009, McKay et al. 2012). A training module on Maintaining Identity would represent a component of recovery training which would be distinct to OPMHS.

Active ingredient 3 was Enhancing Resilience. The findings suggested that helping service users to make sense of the experience of mental illness and to develop their own mechanisms to deal with their illness should be actively facilitated by staff. It was decided that these two themes should be consolidated into one training module, Enhancing Resilience to form a third active ingredient of the intervention. In this context, resilience was defined at an individual level, as moderating the impact of illness, and enabling positive adaptation and the achievement of personally meaningful outcomes (Friedli 2009). Whilst the content of such a module might need to be tailored to working with older people, for example the use of language or working with carers, this module was consistent with the content of recovery training programmes delivered within mental health services for adults of working age (Basset et al. 2003, Bird et al. 2011, NHS Education for Scotland and Scottish Recovery Network 2008, Roberts and Boardman 2014).

Active ingredient 4 was Team-level ownership. Concern was expressed by staff about the factors which might hinder implementation of the intervention, such as the impact of negative team dynamics and culture. This meant that a number of strategies would be needed to support the implementation of recovery-oriented practice within OPMHS. It was decided that an active ingredient of the intervention would be team-level ownership. This would be achieved in two ways, first by delivering the intervention as a team based intervention, and second the facilitation of team level ownership at point of delivery so that issues pertaining to team-level organisational culture and practice could be addressed. Organisational culture can be defined as the shared attitudes, beliefs and assumptions which influence behaviour and how tasks are undertaken (Deal and Kennedy 2000). Additionally, it was decided that organisational commitment would be addressed within the supporting implementation strategy for the intervention

Finally, it was evident from the focus groups, that some views expressed by service users and carers were not fully agreed with by staff. Pro-actively providing information was stressed by service users and carers, and identified as a practice which did not routinely take place, however staff in the two focus groups did not identify this as an area of practice which needed to change. Service user and carers views on the

provision of information is consistent with research which suggests that the method and timing of provision is a significant factor to its use generally and as a self-management resource (Protheroe et al. 2008). Whilst this point could be included within the training module on Enhancing Resilience, the dissonance between service user, carer and staff views in this area makes clear the need for more direct dialogue between service users, carers, and staff about the experience of using services. As discussed previously, meaningful service user and carer involvement has not, for the most part, been routinely embedded within OPMHS (Bowers et al. 2005). Whilst the development of a systematic approach to service user and carer involvement falls outside of the scope of this thesis, it is recognised that it forms part of the foundation of achieving recovery-oriented system transformation (Allott et al. 2002, Farkas et al. 2006) and should be addressed by the local OPMHS.

The focus groups had two main strengths. First, the service user and carer focus group was designed to take place with a group of participants who were used to meeting as a group. They were at ease with one another and therefore would have been more likely to be open about disclosing their own experiences through their involvement in the service user and carer advisory group. They were interested in mental health service delivery, were willing to express their opinions and provide broader perspective to their responses, and were motivated to improve services more generally. Second, the proportion of nurse participants (62%) was similar to the overall nursing workforce (61%) within the local OPMHS. Therefore the generalisability of the findings is strengthened. There are three main limitations to the focus groups. First was the lack of service users with dementia, and second was the relatively small number of participants. Third was that having a combined service user and carer group may have inhibited more frank discussion, although the participants were un-connected in their respective roles.

The findings from this research identified four active ingredients which informed the development of a model, comprising of a recovery intervention and intended effects for use within OPMHS. The model will be presented in Chapter 5.

Chapter 5 Development of the OAR Model

The aim of this chapter is to describe the development of the OAR model. The model comprises the OAR intervention; a team-based recovery intervention for staff working in OPMHS and a description of the intended effects of the intervention. The term OAR was identified by the principal investigator, made up of the following elements OA: Older Adults, and R: Recovery. This model underpins both the evaluation and supporting implementation strategies. The OAR model was developed from evidence from three sources:

1. A literature review on recovery, as well as recovery and older people (Chapter 2)
2. The framework of recovery for older people which was produced from qualitative interviews with service users and carers (Chapter 3)
3. The practice implications for staff arising from the framework of recovery for older people identified through focus groups with service users, carers and staff (Chapter 4)

A preliminary OAR model and proposed evaluation strategy was developed and was piloted with two clinical teams. The final OAR model was then generated based on the pilot findings.

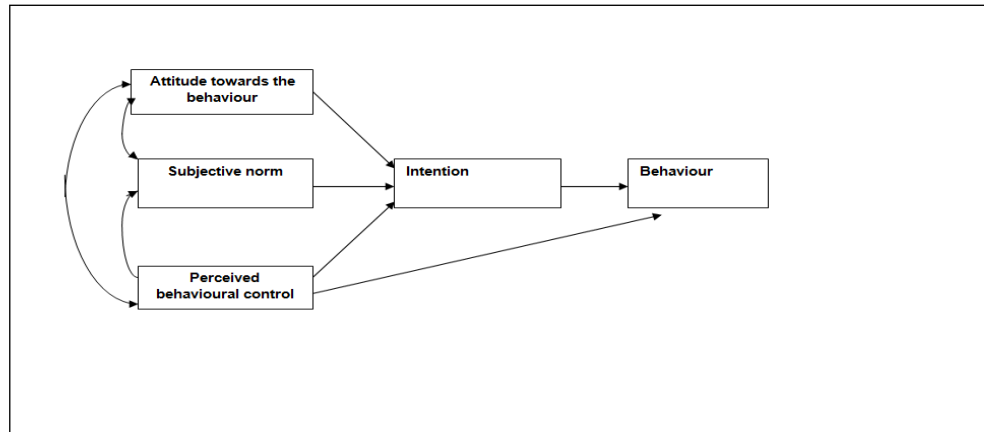
In this chapter, the draft OAR model is presented, as well as the findings from the pilot and resulting amendments which produced the final OAR model. The associated evaluation and implementation strategies are also described.

5.1 Development of preliminary OAR Intervention

The purpose of the preliminary OAR intervention was to support the recovery of users of OPMHS. As identified in Chapter 4, the key contribution from staff towards this outcome was identified as supporting the maintenance or regaining of a sense of identity and by enhancing resilience. The preliminary OAR intervention was intended to increase identity-supporting and resilience-enhancing behaviours by staff. To meet this aim, it was intended that the OAR intervention would impact upon staff attitudes, subjective (and team) norms and perceived behavioural control. These are known to influence behavioural intention, which influences behaviour as described in the theory of Planned Behaviour (Ajzen 1991) and supported through a subsequent meta-analysis

(Armitage and Conner 2001). The theory of planned behaviour is illustrated in Figure 5.1.

Figure 5.1 Theory of planned behaviour



In developing the content of the intervention, the principal investigator reviewed the findings from the three focus groups undertaken with service users, carers and staff (Chapter 4). The focus groups identified four active ingredients required for the OAR intervention. These comprised: Recovery and Older People, Maintaining Identity, Enhancing Resilience and Team Level Ownership. Material for the content of the intervention was also drawn from good practice examples provided in the focus groups

The literature on recovery-oriented working practices as described in Section 2.3.1 and material from existing recovery training programmes was reviewed (Basset et al. 2003, NHS Education for Scotland and Scottish Recovery Network 2008, Perkins 2008). Additionally, the principal investigator, service user trainer and recovery training facilitator also attended a 5 day recovery programme run by another NHS trust with a pro-recovery culture.

Finally, a Training Advisory Group (TAG) was set up. The TAG group was a time-limited working group established to develop and review the content of the intervention. The TAG group comprised 2 service users, 3 trainers (1 staff trainer and 2 service user trainers), 3 senior clinicians and the principal investigator and research worker. The group met once to review the proposed content of the intervention, and twice after delivery of the preliminary intervention as part of the pilot study. Group members were invited by email to join the TAG group by the principal investigator, and dates were set and given in advance for the three meetings. A meeting structure was used, with

agenda items set in advance, with presentations from the principal investigator and the research worker on the two conceptual frameworks for recovery (Chapter 3) and findings from the focus groups (Chapter 4), and the proposed content of the intervention. The principal investigator chaired the meeting, and minutes were taken by an administrator and checked by group members for accuracy. Summary of key themes were used to support the development of the intervention, and subsequent amendment following the pilot study.

5.2 Content of the preliminary OAR intervention

The OAR intervention was developed as a team-based recovery training package with three training modules and an action planning day provided in addition to standard care. The OAR intervention was designed to be delivered to staff working in community mental health teams (CMHTs), memory services and acute in-patient units within OPMHS. The first three active ingredients (Recovery and Older People, Maintaining Identity, Enhancing Resilience) each formed a training module in the team recovery training component of the intervention. Team Level Ownership was an active ingredient which underpinned delivery of the overall intervention, and also included an action planning day module. Team level ownership was further addressed in the implementation strategy.

The content of each active ingredient is now discussed.

5.2.1 Active Ingredient 1: Recovery and Older People Training Module

The Recovery and Older People training module was provided first. The purpose of the module was to enable staff to understand what recovery means for older people and to understand the key practice implications. The module included an introduction to the concept of recovery, modified from the narratives of adults of working age with lived experience. Additionally, the framework of recovery for older people, and the linked framework for people with dementia (Chapter 3) were presented. The three elements of recovery-oriented practice discussed in Section 2.3.1 were explored: promoting citizenship, supporting personally defined recovery and the nature of the working relationship (Le Boutillier et al. 2011). The aim of the module was to challenge the perception that staff are 'doing recovery already' (Davidson et al. 2006). This perception is widely held by many mental health professionals in services for working

age adults, and it was considered that such a view would also exist in OPMHS. Through this challenge, it was intended that staff would be able to more accurately assess the gap between current ways of working and recovery-oriented practice at an individual and team level.

The learning objectives of the Recovery and Older People module were:

- Staff will understand what is meant by the concept of recovery
- Staff will understand how the concept of recovery applies to older people, including those with dementia
- Staff will understand what is meant by recovery-oriented practice with older people, including those with dementia

5.2.2 Active Ingredient 2: Maintaining Identity Training Module

The Maintaining Identity training module was provided second. The module was focused on increasing staff recognition of the significance of maintaining or regaining a sense of identity in the process of recovery for users of OPMHS. The purpose of the module was to build both awareness and skills in the practice tasks related to supporting the maintenance of identity. Skills-based workshops included focusing on identity within assessment and care planning processes, working with families and significant others, and facilitating the continuity of meaningful activities and relationships. Additionally, the life history tool was introduced, and its use explored in depth. A life history is a written record of an individuals' life history, giving details of significant life events, key biographical information, likes, dislikes and preferences for future care delivery. The aim of the module was recognition of the need to make maintaining or regaining a sense of identity a key focus of clinical work with all service users.

The learning objectives of the Maintaining Identity module were:

- Staff will recognise the significance of maintaining or regaining a sense of identity for users of OPMHS
- Staff will be able to identify ways in which they can support the maintenance of identity in their work with service users

- Staff will be able to identify ways in which they can support the continuity of meaningful activities and relationships in their work with service users
- Staff will recognise the need to undertake life history work, and be willing and able to undertake this task

5.2.3 Active Ingredient 3: Enhancing Resilience Training Module

The Enhancing Resilience training module was the final training module. The purpose of the module was to encourage staff to work pro-actively with service users to enhance their resilience. The module introduced the concept of resilience, and explored partnership working. An overview of coaching adapted from a coaching programme for clinicians (Grey and Bailey 2010) was included, and skills based workshops on using powerful questions, goal setting, holding responsibility, managing set-backs and having difficult conversations were facilitated. A Well-being plan developed by service users and carers from the local OPMHS, based on the WRAP plan (Copeland 2005) was also introduced, and its use was explored in depth. Positive risk taking was also included. The aim of the module was building self-autonomy and resilience for service users.

The key learning objectives of module three were:

- Staff will recognise the importance of keeping responsibility with service users, and will be able to identify ways in which their own practice supports or hinders this objective
- Staff will develop skills so that they are able to pro-actively support the resilience and enhance the personal responsibility of service users
- Staff will be able to support service users to identify and set goals
- Staff will be able to co-produce well-being plans with service users

5.2.4 Active Ingredient 4: Action planning day and team level ownership

An action-planning day was facilitated after completion of the three training modules in order to develop a team (recovery) action plan. The team (recovery) action plan was intended to support team-level recovery practices and team culture. Each team was

expected to develop a team (recovery) action plan which detailed three areas of pro-recovery practice change, agreed by the team with objectives and timescales by the end of each action planning day.

Additionally, maximising team level ownership was facilitated in the delivery of the intervention in three ways. First, the preliminary OAR intervention was delivered as a team based intervention to maximise the extent to which supporting recovery was understood to be a team responsibility, rather than relying on specific individuals, in order to change the subjective norms of the team (Ajzen 1991). This was intended to address the issue of recovery support being seen as an activity to be undertaken only when time and resources allow, rather than being a central task of practice (Davidson et al. 2006).

Second, team level ownership was enhanced at two points during the training modules. First, during the first training module, the team were asked to reflect upon, and to rate the extent to which team's practice and processes were recovery-oriented. On completion of the three training modules, the team was asked to identify three areas of practice that they wanted to develop further (within the action planning day) to become more recovery-oriented.

Third, the trainers adopted a process consultancy approach (Schein 1999) in their facilitation of the three training modules and action planning day. Process consultancy is an approach to supporting organisational change, based on two underpinning principles about change. These are that successful change is more likely to occur when the individuals who need to make the change can:

- a. identify what the underlying problem might be and what needs to change, in this case working practices which do not support recovery
- b. actively create the proposed solution to the problem, in this case, new ways of working which support recovery.

It was intended that the trainers would refrain from giving their opinions about team practice at any point throughout delivery of the intervention, and instead support reflection and self-appraisal by team members. The role of the trainers was to promote the view that it was the team who knew most about their own strengths and weaknesses, and therefore would be able to (a) accurately self-assess the extent to which current service delivery was recovery-oriented, and (b) identify the specific individual and team practices which would work within their respective services. This

approach was intended to increase ownership by teams, rather than dictating change externally. Additionally, this approach sought to reinforce one of the key messages within the training modules, namely the belief that using the 'lived experience' of staff to identify problems and solutions would be beneficial and that reliance upon 'expert' (trainer) advice was unlikely to support sustained change. A similar approach has been taken within the ImROC programme which was discussed in Section 2.3.1, which involves mental health services undertaking self-assessments, planning and monitoring their own changes towards recovery system transformation.

Within the preliminary OAR intervention, the training modules were delivered sequentially, and the content included a mixture of didactic teaching, information provision and skills based workshops, in addition to the introduction of a number of practice support tools. Each individual training module, and action planning day took a full day (4 days in total).

5.3 Intended Effects of the preliminary OAR intervention

The OAR intervention was intended to lead to positive change in staff knowledge and attitude, staff practice, service user experience and service user outcomes.

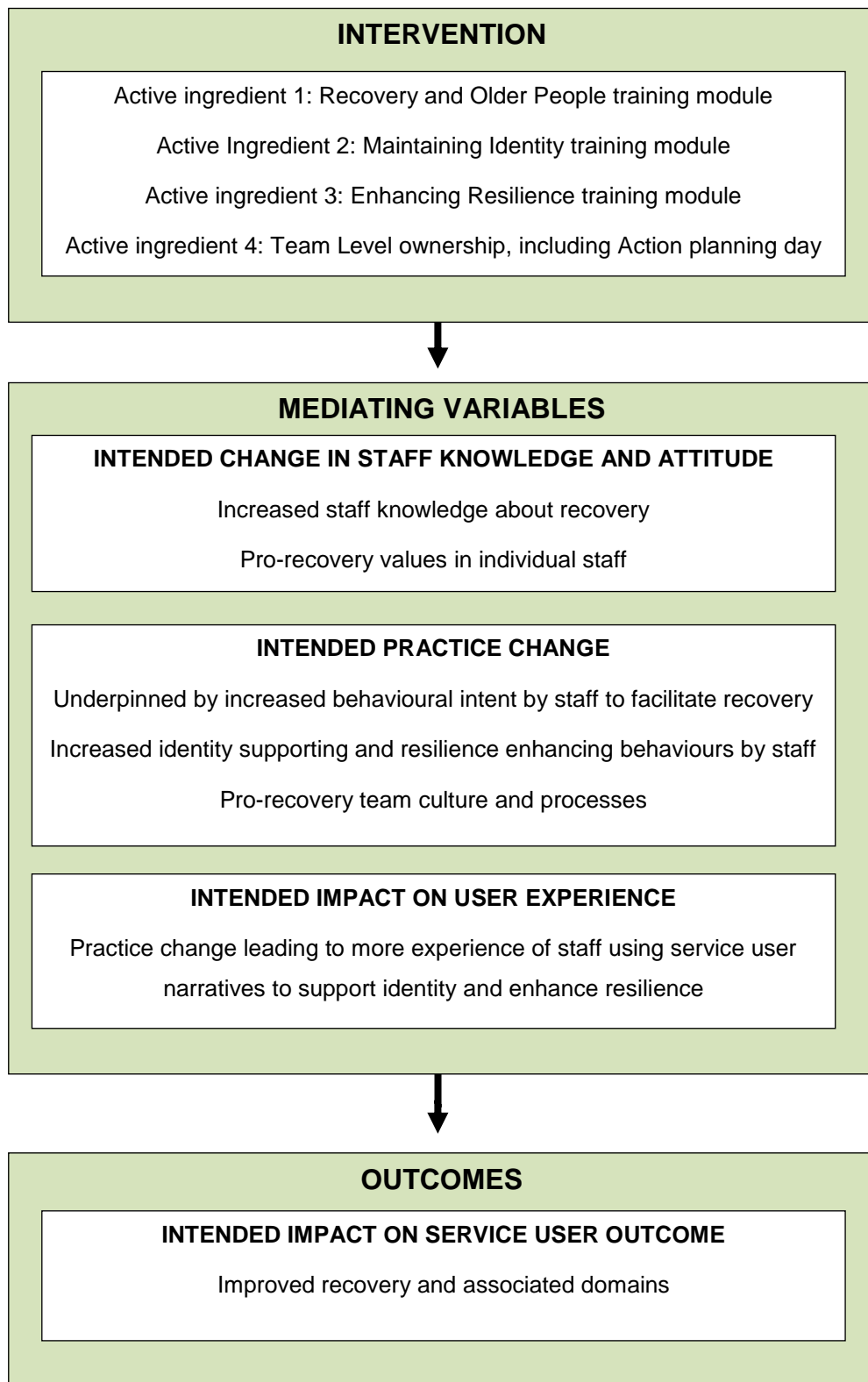
For staff receiving the OAR intervention, the intended outcome in knowledge and attitude was change in the values of staff at an individual level. Staff would hold increased beliefs that recovery is possible, and view the role of staff as facilitating recovery. An improvement in staff knowledge about recovery following delivery of the intervention was also expected.

Practice change after receiving the OAR intervention would be underpinned by a change in the behavioural intent of staff to work more collaboratively with service users. It was expected that the focus of staff in their work with service users would be maintaining identity, and enhancing resilience and self-management. Increased collaboration between staff and service users was expected in order to maintain identity, and enhance resilience and self-management. Finally, it was intended that sustained change would be evident in the culture of teams through an increased number of team processes and projects promoting a shared team value about the importance of supporting recovery.

As a result of staff receiving the OAR intervention, the intended effect on service user experience was a change in the way in which service users perceived that staff work with them. It was expected that service users would perceive that staff would take time to know 'who they are' through obtaining a detailed biography, and using this information to work together to maintain/regain identity and promote self-management.

It was expected that the intervention would lead to improvement in recovery and associated domains. The preliminary OAR model made clear the mediating variables of increased staff knowledge about recovery, positive attitudes towards recovery, subsequent change in the behaviour intent and practice of staff and improved service user experience, leading to change in service user outcomes. The preliminary OAR model is summarised in Figure 5.2.

Figure 5.2 Preliminary OAR Model



5.4 Preliminary Evaluation Strategy

The preliminary evaluation strategy was developed to measure the impact of the OAR intervention and its intended effects. The strategy was derived from the preliminary model presented in Figure 5.2, and had three components: fidelity assessment, process evaluation and outcome evaluation.

5.4.1 Fidelity Assessment

Fidelity assessment involved measuring whether the intervention was delivered as planned. For the preliminary OAR intervention, this meant assessing whether the training was delivered as a team based intervention, whether all three training modules were delivered as intended and whether staff attended training sessions. A fidelity checklist was developed, comprising attendance, delivery of the intervention and subsequent implementation strategy.

5.4.2 Process Evaluation

The purpose of the process evaluation was to identify whether the mediating variables had operated as expected and to identify the factors which had contributed to the success or failure of the intervention (Hulscher et al. 2003). There were five proposed components to the process evaluation: acceptability of the intervention, reach of the intervention, change in the mediating variables as shown in Figure 5.2, fidelity assessment and the identification of (context) factors influencing implementation of the intervention. An overview and rationale for each intended component is now provided, and the method for each component will be discussed in Chapter 6.

Acceptability of the intervention was assessed by qualitative interviews with staff and trainers directly following the delivery of the action planning day. The aim of the interviews was to investigate participant views on the acceptability of the intervention, including the degree to which learning objectives were met, and to identify key themes which may have helped or hindered the effectiveness of the intervention.

Measurement of mediating variables was undertaken in five ways. First, change in staff attitude and knowledge was assessed through the completion of staff recovery measures prior to training module 1 and upon completion of training module 3, in order to provide pre-post comparison data. The choice of measures will be discussed in

Section 6.5 however the criteria used for the selection of measures were a) measures which were widely used, b) measures with robust psychometric properties and c) measures with face validity. The two selected measures were:

1. The Recovery Attitudes Questionnaire (RAQ-7) (Borkin et al. 2000) which seeks to measure attitudes and values about recovery.
2. The Recovery Knowledge Inventory (RKI) (Bedregal et al. 2006) which assesses mental health staff knowledge and attitudes about recovery. The tool was designed to measure staff knowledge before and after training as well as being a tool to assess and respond to staff training needs.

Second, it was intended that measurement of change in the behavioural intent of staff would be assessed through review of longitudinal routine data. It was decided that an anonymised audit of care plans would be undertaken to assess whether there was change in the care planning practice of staff through their written intentions to work collaboratively with users to maintain identity, enhance resilience and self-management. Care plan audits have been shown to be useful in measuring the impact of recovery training as a measure of staff behavioural intent, and therefore as a proxy of staff working practices (Slade et al. 2009, Gilbert et al. 2013). The care plan audit assesses change in two domains: topic and responsibility.

- a) For topic, the assumption was that more recovery-oriented care planning would lead to a higher proportion of topics focused on recovery goals such as enhancing resilience, self-management and maintaining identity, for example, the development of well-being / WRAP plans, maintaining social networks or activities, as opposed to clinician goals such as 'monitor mental state.'
- b) For responsibility, the assumption was that more recovery-oriented care planning would lead to a higher proportion of action being taken by the service user as opposed to being taken by staff. For example a shift from 'care coordinator will monitor mental state' to 'care coordinator and service user will together review how 'X' is feeling.'

Third, qualitative interviews with staff, six months after delivery of first training module, to assess whether change had taken place. The qualitative interviews investigated

whether there had been change in practice at individual or team level, and also the context factors which had helped or hindered practice change. The topic guide is provided in Appendix J

Fourth, an audit of team (recovery) action plans. This assessed the number of team (recovery) action plans which been implemented in order to assess to the extent to which sustained change in team practice had taken place.

The final component of process evaluation was a change in service user experience. This was assessed by investigating service users' perceptions of the degree to which staff were working with them to actively focus on maintaining or regaining identity and in promoting self-management, and whether this changed over time. Existing measures which rate the degree to which service delivery is recovery-oriented such as the Recovery Self-Assessment (O'Connell et al. 2005) were reviewed. However, whilst this measure rated highly in terms of psychometric properties, it emphasises components of recovery-oriented practice which did not appear to be highly valued by older people with mental health problems (Chapter 4) such as peer support, cultural diversity of the workforce, and service user rights. Specific measures within OPMHS do not exist. Therefore it was therefore decided that this aspect of the process evaluation would be assessed using a questions based on the conceptual framework for recovery for older people (Chapter 3). This will be discussed in Chapter 6.

5.4.3 Outcome Evaluation

Outcome evaluation involved measuring whether the anticipated improvements in service user outcomes arising from the OAR intervention (shown in the bottom box in Figure 5.2) had taken place.

This involved the completion of self-rated recovery measures by service users. The original criteria for the selection of candidate measures were measures which:

1. Had been successfully used with older people
2. Assessed at least one outcome domains identified in the preliminary model (e.g. maintenance of identity, or increased self-management)
3. Were widely used

4. Had adequate psychometric properties

A review of available recovery measures identified the lack of specific measures for older people (Burgess et al. 2011). Therefore it was necessary to delete criterion 1 and choose measures of recovery developed for adults of working age. Four measures were identified as candidate measures for use within the pilot of the OAR intervention, as listed below:

1. The Developing Recovery Enhancing Environment Measure (DREEM) (Ridgway and Press 2004)
2. The Illness Management and Recovery (IMR) Scales (Mueser et al. 2004)
3. The Mental Health Recovery Star (MHRS) (MacKeith and Burns 2008)
4. Goal Attainment Scale (GAS) technology (Kiresuk and Sherman 1968)

All four measures were tested in the pilot of the OAR intervention, which is now described.

5.5 Pilot of the OAR intervention

The preliminary OAR intervention and supporting evaluation strategy was piloted in 2010. There are varying definitions of what constitutes either a pilot or a feasibility study and a lack of an overall agreed definition. Additionally, concern exists about the reporting of such studies, for example, re-classifying studies as pilot studies if there are unfavourable results (Lancaster et al. 2004, Arain et al. 2010). Pilot studies can be seen as a smaller version of a larger study, which are used to test study processes and measures (Arain et al. 2010). A distinction is made between an external pilot study which are stand-alone separate studies, and internal pilot studies where findings will be incorporated into a future main study (Lancaster et al. 2004) In comparison, feasibility studies can be used to define important parameters for a future larger trial, for example to estimate likely effectiveness, and from this to calculate a sample size for a future RCT (Arain et al. 2010).

The testing of the preliminary OAR model and supporting evaluation strategy was categorised as an internal pilot study, and the more comprehensive evaluation of the OAR intervention presented in Chapter 6 and 7 was categorised as a feasibility study.

5.5.1 Aims

The aims of the pilot study were:

1. To assess the experience of the preliminary OAR intervention and to modify the intervention as necessary (Optimise the intervention)
2. To test the data collection and analysis issues involved in the staff measures and care plan audit (Data collection and analysis)
3. To select appropriate measures for the outcome evaluation (Measure selection)
4. To inform the development of an implementation strategy (Implementation)

5.5.2 Method

NHS Research Ethics (reference: 09/H0722/66) and local service Research & Development approval were granted in December 2009 (Appendix A and B).

Measures

The Recovery Attitudes Questionnaire (RAQ-7) (Borkin et al. 2000) is designed to measure attitudes reflecting beliefs about recovery from mental illness. It is a 7-item measure, with a 5-point Likert scale which ranges from 1, strongly disagree, to 5, strongly agree. The tool has two sub-scales: sub-scale 1: Recovery is possible and requires faith and sub-scale 2: Recovery is difficult and will differ amongst people.

The Recovery Knowledge Inventory (RKI) (Bedregal et al. 2006) is a 20 item instrument that assesses mental health staff knowledge and attitudes about recovery. A 5-point Likert scale is used with ranges from 1, strongly disagree, to 5, strongly agree. There are four sub-scales which cover the following dimensions of recovery: sub-scale 1: Roles and responsibilities in recovery, sub-scale 2: Non-linearity of the recovery process, sub-scale 3: The roles of self-definition and peers in recovery and sub-scale 4: Expectations regarding recovery.

The Developing Recovery Enhancing Environments Measure (DREEM) (Ridgway and Press 2004) is a 79-item self-report instrument which assesses where people are in the

process of recovery and what markers of recovery they may be currently experiencing. Service users rate the performance of their mental health services on activities related to recovery and on promoting resilience. It is intended to be completed by users of mental health services for adults of working age. The schedule can either be completed as a questionnaire or as a personal interview, and covers seven sections: demographic data, stage of recovery, elements of recovery (rated on a 5-point Likert scale), staff or service performance, specific needs, organisational climate and recovery markers.

The Illness Management and Recovery (IMR) Scales (Mueser et al. 2004) does not measure specific components of recovery, but instead assesses aspects of illness management and recovery. It is a service user self-report measure and has 15 items, including progress towards goals, social relationships and roles, management of symptoms, self-management and coping mechanisms. It uses a 5-point Likert scale.

The Mental Health Recovery Star (MacKeith and Burns 2008) is a tool for supporting change and measuring progress towards recovery within everyday working practice. It covers ten domains of recovery, and the service user is asked to rate their progress in each of these on a 10 point scale. Service users are asked to identify specific domains which they may wish to work upon, and when the measure is repeated, change over time in these areas can be measured. The domains are: Managing mental health, Self-care, Living skills, Social networks, Work, Relationships, Addictive behaviour, Responsibilities, Identity & self-esteem and Trust & hope.

The Goal Attainment Scale (GAS) (Kiresuk and Sherman 1968) is a method of measuring goals which are personally meaningful for service users. Service users are asked about the main problems related to their mental health problems, as well as their priority goals, up to a maximum of three. Service users are asked to identify what the expected outcome for each goal would be, if it were achieved, and also the outcome if it was partially achieved or considerably more or less than expected. Each outcome is transposed onto a 5-point measure. Attention is paid to obtaining detailed information about the outcomes for each goal, and the articulation of SMART (specific, measurable, achievable, realistic, time-specific) goals is encouraged. GAS technology was designed for people with mental health problems as a mechanism to identify progress towards personally meaningful goals. GAS technology is a method of scoring the extent to which a service user's goals are met in the course of treatment or service

contact, which means that service users set their own outcome measures. GAS technology has been used in a range of clinical settings, including mental health, elderly care, chronic pain and rehabilitation (Turner-Strokes 2009), as well for people with dementia (Rockwood et al. 2002, Rockwood et al. 1997).

A non-standardised training evaluation feedback sheet was developed for the pilot study which related to the experience of the training modules. Staff participants were asked to provide ratings (using a 10-point Likert scale, ranging from very poor to excellent) to six questions, as below:

1. Quality of the training modules as a whole
2. Course administration
3. Training location, venue, facilities and food
4. Training design, training methods and exercises
5. Recovery training facilitators and style of delivery
6. Overall confidence as a recovery-oriented practitioner following the training

Procedure

It was agreed with the service director of the local OPMHS that the pilot would take place with two clinical teams in one local authority borough. This was based on perceived organisational readiness for intervention, assessed as the absence of any substantial service delivery difficulties or senior managerial vacancies. A meeting took place with the two team leaders to give them information about the intervention.

The researchers jointly attended the team meeting in each of the two teams prior to the delivery of the intervention to describe the intervention and wider programme of work, and to present the four aims of the pilot study. Staff were asked to approach current service users about involvement in the pilot study. Staff were given a study information sheet, explaining what participation would involve, which they were encouraged to pass to service users.

At the beginning of the first training module, all staff present were approached directly by the research worker and asked to complete the two quantitative recovery measures immediately before delivery of the training module. A study information sheet for staff was provided and written consent obtained. Each staff member was given a code marked on their individual measures, which were given out by hand by the research worker to allow for data linkage.

The OAR intervention was delivered in 2010 to two community mental health teams. The intervention (three training modules and action planning day) was delivered as planned. The intervention was delivered by a recovery training facilitator (a mental health nurse with over 15 years of experience working with older people with mental health problems) and an experienced service user trainer. The intervention was delivered over a four week period, with each team receiving each training module in the first three consecutive weeks, followed by the action planning day in the fourth week.

Staff who completed all three training modules were approached by the research worker and asked to repeat the measures and complete the training evaluation feedback sheet at the end of the last training module (day 3).

Following attendance at the two team meetings, contact details of service users who expressed an interest in involvement in the pilot study were given by staff to the research worker. The researchers then contacted individual service users to explain the study and discuss involvement in more detail. An appointment interview was made with those expressing an interest in participation. Service user interviews were carried out in 2010 by the researchers. The majority of interviews were carried out in participants' own homes. Before starting interviews, the information sheets were given, questions about the pilot and wider study were invited, and written consent was obtained.

The use of DREEM and GAS were piloted in the first 12 interviews with service user participants and the use of IMR and the MHRS in the final 13 interviews. The researchers maintained reflective diaries to note down their observations during the administration of the measures. For DREEM and IMR, the researchers explained how each measure would be administered and scored, and participants were asked if they felt able to complete the measure independently. Participants who felt able to complete the measures did so, without involvement from the researchers. For participants who felt unable to complete the measures, the researchers read each question to service user participants and supported them to identify their rating. For the MHRS and GAS technology, the interviews took the form of a guided interview. At the end of each

interview, participants were asked a series of questions relating to their experience of each measure, such as the clarity of questions, whether questions were helpful and/or distressing to answer. The interviews lasted between 60 and 120 minutes. Service user participant responses to questions about the measures and fieldwork notes were combined and summarised by the principal investigator.

Three qualitative interviews with staff took place after delivery of the intervention. These were carried out by the principal investigator in order to understand how staff experienced the intervention and to identify the factors which influence implementation (Appendix J). The three staff members from different professional groups were approached by the principal investigator, who emailed the participants a month after delivery of the action planning day, and invited them to participate in a qualitative interview. The email enclosed a study information sheet, which explained what participation would involve. All three gave a positive response to the request and from this a date and location for the interview was agreed. The qualitative interviews were audio-recorded, transcribed verbatim and checked for accuracy by the principal investigator.

The findings from qualitative interviews and the training evaluation sheet were presented to a Training Advisory Group (TAG), which was discussed in section 5.1. The TAG group met twice after delivery of the intervention to review trainer reflections, staff participant training evaluation feedback data, staff qualitative interview findings, and the results from the pilot of staff measures.

Finally, a care plan audit was undertaken by the research worker, using the Case Register Interactive Search (CRIS) system. The CRIS system is a database of the electronic patient journey system used by the local NHS Foundation Trust, which can be fully searched, but whereby identifiable service user details are disguised (Stewart et al. 2009). An initial review of the total number of care plans available across the pilot area (two CMHTs) was undertaken which showed 503 completed care-plans (out of a total caseload of 680 service users), and from this, it was possible on the CRIS system to request a random sample of care plans from 40 service user records. These data were exported from the CRIS system. Care plans contain several action points, here called entries. The corresponding care plan entries were audited. A coding framework was developed using the most frequent topic areas, such as monitoring mental state, and linking between services, as well as topic areas expected following the intervention, for example, maintaining relationships. Each care plan was reviewed and each entry, on average 3-4 per care plan, was coded in two ways. First, the entry was

allocated to the relevant topic area from the coding framework. An overall calculation of the total number of entries per topic was made. Second, the entry was allocated to a code for responsibility for action, indicating whether the action was to be carried out by the staff member, the service user, the carer, or jointly. The proportion of entries for each code was calculated. The research worker kept a record of the time taken to complete the audit.

Analysis

The transcripts from the qualitative interviews were analysed by the principal investigator, using thematic analysis in order to identify factors influencing acceptability and implementation. Analysis involved three stages: familiarisation with the data, development of two coding frameworks (for each of the research aims), and indexing and sorting the data (Spencer et al. 2014). Familiarisation involved the principal investigator re-reading the three transcripts in order to become familiar with their content. Development of the two coding frameworks (one for optimise the intervention and one for implementation) involved the principal investigator labelling meaningful sections of narrative with descriptive codes, and identifying prominent themes in the data to use as a coding framework. Indexing and sorting the data involved allocating sections of relevant text within all of the transcripts to the relevant codes within each framework. Due to the small number of transcripts, the analysis was undertaken manually.

The mean scores and the standard deviation were calculated from the ratings given in the training evaluation feedback sheets.

The raw scores from the RAQ-7 and the RKI were entered onto Microsoft Excel and transferred to SPSS Version 18 for analysis. Mean scores and standard deviation were calculated however inferential statistics could not be undertaken due to the low sample size.

5.6 Results

5.6.1 Participants

From an eligible group of 32 staff, 22 staff received the entire intervention, 1 staff member received part of the intervention (1-2 training modules), and 9 staff did not receive any of the intervention.

22 staff completed pre and post training staff recovery measures. A summary of the staff participants who received the entire intervention is summarised in Table 5.1.

Table 5.1 Pilot study staff participants (n=22)

Profession	Team 1	Team 2
Nursing	5	5
Occupational Therapist	1	
Psychiatrists	1	2
Psychologists	1	1
Social workers	1	3
Support workers	2	
Total	11	11

The recovery measures were piloted with 25 service users. 13 service users had functional mental health problems, and 12 had dementia.

Three qualitative interviews were carried out with a nurse, a team leader, and a consultant psychiatrist.

5.6.2 Qualitative interviews

Themes for Aim 1 (Optimise the intervention) and Aim 4 (Implementation) were identified.

Aim 1 (Optimise the intervention)

In relation to the training experience, the structure was positively received, and training was perceived to have increased staff knowledge of recovery.

'I think it was well designed in the way, you know the structure of it and starting with more general things, figuring out what this actually means before applying it before talking about what we as a team need to do.' (No.1, team leader)

Whole team training was valued. The opportunity provided by the training for the team to have time together to reflect upon the team's work and approach to clinical care, and agree new ways of working (within the action planning day) was highly rated by all participants.

'I think people value the time away so having that time away to have team discussion because there isn't anywhere else to have that, with the challenges we face with time and workload, so it gave us the opportunity to focus on something that we can actually, you know do, to improve on our practice...That was the best day for me because it brought it all together and actually there's absolutely no way there would have been any real change, if we hadn't sat down and committed ourselves to having a series of actions so I was really pleased that was done because I could see what would happen without that and it just would have back to the same situation because you forget.'(No.2, nurse)

Additionally, the involvement of a service user trainer was perceived to be beneficial to the learning objectives.

The practical exercises were particularly valued. It was however suggested that there could have been more focus on the working practice implications for people with dementia.

'We didn't really explore recovery process in dementia which I would have hoped to touch upon and I know there is not much research on it, (but) for us that is like 50% of who we see. It was only touched on and instilled general principles that we could apply.' (No.3, psychiatrist)

The length of the training (four days in total) was raised as a potential concern given other workload demands, however it was not seen as impossible to achieve.

Aim 4 (Implementation)

Three key themes relating to the transfer of learning into practice were identified: fit with other service demands, wider organisational commitment and implementation support.

Fit with other service demands related both to teams trying to respond to a number of competing priorities as well as the potential clash in expectations between the (recovery training) intervention and other initiatives, such as the locally implemented Productive Community Services programme (NHS Institute for Innovation 2006)

'Like there's a question in one of their audit questions (Productive Community Services) which asks can you evidence that the service user has participated in the care planning or something like that. But it doesn't talk about language at all, and very much what we talked about in the recovery training was language.'
(No.1, team leader)

There was a desire for initiatives to complement each other, and where possible, avoid the need for duplication.

The need for wider organisational commitment from senior managers was also identified.

'And I think the other thing that needs to be questioned is that, I don't think, I've heard the word 'recovery' mentioned in other places recently i.e. in the (local) service, I haven't heard it from my service manager in quite a long time, I haven't heard it at executive level, and that's really interesting. It's not just about us continuing to talk about it; it is also about higher management continuing to talk about it.' (No.1, team leader)

The need for implementation support from the recovery training facilitator following delivery of the training was identified by all of the participants to a) help participants to implement changes to their practice and b) ensure an on-going focus on recovery within the team. Implementation support with the whole team was seen as most helpful, although the potential for individual supervision was also identified as a mechanism for practice change.

'Maybe if X (recovery training facilitator) attended our business meeting or team meeting for the last twenty minutes once a month to keep us focused really, to see how we are getting on with this, give us any guidance or

information. Something ongoing, you don't need to take us all away again, maybe ad hoc or a brief visits once in a while to keep us on track.' (No.3, psychiatrist)

5.6.3 Training evaluation feedback

Feedback from the staff (n=22) who completed training evaluation feedback questionnaires after delivery of the final training modules was summarised. Ratings for each question were out of 10, with good = 7, very good = 8 and excellent = 9, as shown in Table 5.2

Table 5.2 Pilot study staff participant training feedback (n=22)

Evaluation Feedback	Team 1 (n=11)	Team 2 (n=12)
	Mean (s.d.)	Mean (s.d.)
Training modules	9.18 (0.98)	8.21 (0.89)
Training design, methods and exercises	8.82 (0.98)	8.00 (1.11)
Content and hand-outs	9.36 (0.81)	8.50 (1.22)
Recovery training facilitators and delivery style	9.36 (1.03)	8.64 (0.63)
Confidence as a recovery-oriented practitioner	8.00 (1.18)	7.93 (1.21)
Course administration	7.90 (2.47)	7.86 (2.51)
Training location, venue, facilities and food	7.80 (1.40)	7.71 (1.59)

All of the participant feedback was rated as good (over 7), very good (over 8) or excellent (over 9).

5.6.4 Staff measures

In considering the feasibility of the measures, all 22 staff who attended all three training modules completed both measures, and all items were completed. Completion of both measures took between 5 and 10 minutes. Research worker time involved in the administration and collation of the measures did not exceed 90 minutes at each completion point.

Participants commented very little on either measure, apart from expressing some confusion relating to question 2 in the RAQ-7, which asks participants to agree or disagree with the statement 'recovery requires faith', and whether the word 'faith' related to religious belief or to hope (about recovery). Scores for the RAQ-7 are shown in Table 5.3

Table 5.3 Pilot study RAQ-7 ratings (n=22)

Sub-scale	Pre-training Mean (s.d.)	Post –training Mean (s.d.)
Factor one Recovery is possible & requires faith	16.00 (2.05)	16.59 (2.02)
Factor two Recovery is difficult & differs among people	13.59 (1.22)	13.50 (1.22)

Scores for the Recovery Knowledge Inventory (RKI) are shown in Table 5.4.

Table 5.4 Pilot study RKI ratings (n=22)

Sub-scale	Pre-training Mean (s.d.)	Post-training Mean (s.d.)
Sub-scale 1 Roles & responsibilities	3.59 (0.83)	3.90 (0.74)
Sub-scale 2 Non-linearity of the recovery process,	2.63 (0.83)	2.98 (0.92)
Sub-scale 3 Role of self-definition and peers in recovery	4.07 (0.34)	4.29 (0.37)
Sub-scale 4 Expectations regarding recovery	2.93 (0.88)	3.14 (0.97)

The sample size (n=22) for both measures was too small for a paired sample t-test.

5.6.5 Care Plan Audit

Care plans from 40 service users in the two clinical teams were audited. A total of 160 different care plan entries were found. Care plan entries could be coded to against more than one different topic, so 226 entries were recorded against different care plan topics. Research worker time involved in the collation and auditing of the data took approximately 6 minutes per care plan.

Topics addressed in care plans are shown in Table 5.5.

Table 5.5 Pilot study care plan audit of topics (n=160)

Care plan topic	Number of Entries (%)
Monitor mental state	70 (44)
Symptom/relapse prevention/ behaviour management	25 (16)
Monitor medication	31 (19)
Functional/ADL	10 (6)
Emotional support	16 (10)
Linking between services	17 (11)
Accommodation	6 (4)
Finance support	1 (1)
Physical Health	8 (5)
Social Needs	13 (8)
Work or volunteering	1 (1)
Learning/education	0
Carer/support work	14 (9)
Practical support	14 (19)
Meaningful activity/ engaging in activity	0
Maintaining relationships	0

The care plan audit for responsibility for action is shown in Table 5.6.

Table 5.6 Pilot study care plan audit of responsibility for action (n=160)

Responsibility for action	Number of entries	Proportion of overall entries (%)
Staff	141	88%
Service User	3	1.8%
Carer	2	1.2%
Staff and Service User	4	2.4%
Staff and Carer	1	0.6%
Service User and Carer	0	-
Staff, Service User & Carer	0	-
Not identified	9	6%

5.6.6 Service user measures

Service users commented on each measure.

The DREEM was useful in encouraging participants to reflect upon progress. Overall, it was considered to be too time consuming and having the potential to lead to participant fatigue. With over 75 questions, most service user participants requested that the researchers read out the questions. Reading the questions aloud appeared to reduce the potential for misinterpretation, and participant feedback focussed on the value (to them) of talking about their concerns and aspirations. However, the measure took on average 90 minutes to administer and 50% of the participants required an additional meeting to complete the measure. It was not possible with any of the participants to complete an additional measure in the same session.

GAS technology was useful in encouraging participants to articulate goals, and in supporting the standardisation of metrics of progress towards goals across different respondents. However it was not possible for the researchers to know whether the goals set were realistic, as some goals appeared to the researchers to be much less likely to be attainable than others, for example 'I want to get rid of my epilepsy.' This uncertainty limited the reliability of GAS technology as a research end-point measure.

The MHRS was found to be useful in promoting progress, and positive feedback was received on the visual aspect of the tool (a ladder graphic) which plotted current stage and future aspirations. Recording progress was also perceived to be beneficial. It was found that several of the ten domains were not meaningful for older people, for example, the work category. Additionally, participants reported difficulties with the rating system, in particular, the ten point scale was perceived as confusing and at times not helpful. Participants with dementia found completion of the MHRS difficult; the concept of a ladder was hard to understand, and many were unable to identify their current stage and future aspirations.

Finally, the IMR was relatively straight forward to complete, and easy to understand. Two items required further explanation, namely personal goals and self-help, as the language was less familiar to older people. The researchers found the measure quick to administer, taking on average between 5-10 minutes, leaving adequate time for the completion of further measures within the same session.

5.7 Discussion

The implications of the results for each of the four pilot aims are now discussed.

5.7.1 Aim 1 (Optimise the intervention)

The qualitative interviews and the training evaluation feedback indicated that the intervention was acceptable to staff. It was however apparent that minor amendments to the content of intervention were required, which will be discussed in section 5.8.

5.7.2 Aim 2 (Data collection and analysis)

For aim 2 (Data collection and analysis), staff measures and the care plan audit were reviewed.

For the staff measures, feasibility and consistency with other similar studies was considered. It was not possible to assess sensitivity to change due to the small sample size (n=22)

On the basis of the overall completion rate, ease of completion and administration, it is concluded that RAQ-7 and RKI measures were feasible. The RAQ-7 author was contacted regarding confusion about question 2, which asks participants to agree or disagree with the statement 'recovery requires faith'. The author confirmed that it meant hope about recovery. A minor amendment (of adding brackets to question 2) was made to the questionnaire.

In considering whether the measures provided results which were consistent with other similar studies, comparison was made to two other studies using normative data for staff working within mental health services for adults of working age. First, the pilot study results for the RKI were compared to the findings of an Irish study which used the RKI to ascertain attitudes and knowledge towards the concept of recovery in 129 randomly selected mental health professionals, including nurses, psychiatrists, occupational therapists and social workers (Cleary and Dowling 2009). Results from the pre-training RKI scores are compared to the results in the Irish study in Table 5.7.

Table 5.7 Comparison of RKI between pilot baseline (n=22) and Irish study (n=129)

RKI Sub-scales	Pilot baseline	Irish study
	Mean (s.d.)	
Sub-scale 1	3.59 (0.83)	3.79 (0.68)
Roles & responsibilities		
Sub-scale 2	2.63 (0.83)	2.80 (0.69)
Non-linearity of the recovery process,		
Sub-scale 3	4.07 (0.34)	4.03 (0.65)
Role of self-definition and peers in recovery		
Sub-scale 4	2.93 (0.88)	3.08 (1.01)
Expectations regarding recovery		

It was concluded that the pilot results for the RKI were broadly consistent with the scores for other similar groups of staff. Additionally, the results were consistent with the

data generated as part of the development of the RKI (Bedregal et al. 2006). This indicated that there was a hierarchy to the highest scores obtained, with higher mean scores for sub-scale 3 (self-definition) followed by sub-scale 1 (roles and responsibilities, and then subscales 4 (expectations) and 2 (non-linearity).

The pilot findings for the RAQ-7 were compared to a study which used the RAQ-7 to measure the effectiveness of a two-day Collaborative recovery training programme (Crowe et al. 2006). The results from the pilot study were compared to the results for mental health professionals (n=147) in the Collaborative recovery training programme as shown in Table 5.8.

Table 5.8 Comparison of RAQ-7 ratings between pilot (n=22) and the Collaborative recovery training study (n=147)

Sub-scale	Pilot study		Collaborative recovery training	
	Baseline	Mean (s.d.)	Post-training	
Sub-scale 1 Recovery is possible	16.00 (2.05)	16.01 (2.26)	16.59 (2.02)	17.05 (2.19)
Sub-scale 1 Recovery is difficult and differs among people	13.59 (1.22)	13.02 (1.50)	13.50 (1.22)	13.32 (1.51)

It was concluded that the pilot findings for the RAQ-7 were broadly consistent with the scores for other similar groups of staff.

Both measures appeared to be feasible, and were broadly consistent with the scores for other similar groups of staff, therefore it was decided that the RKI and RAQ-7 would be used in the process evaluation within the overall evaluation strategy.

For the care plan audit, two aspects were considered: feasibility and whether the results appeared to provide a realistic indication of staff behavioural intent in their work with service users. In considering the feasibility, it was quick to administer, and it was possible to collate information for a high number of service users in a fairly shortly period of time (6 minutes per care plan).

In considering whether the care plan audit provided a realistic indication of staff behavioural intent, the care plan audit did provide an overview of the care plan topics within the two clinical teams but it was not clear whether these represented a clinical or a service user-led focus. For example, it was not possible to tell whether topics such as monitoring mental state (44%) or linking between services addressed a clinician or service user goal (Table 5.5). The broad nature of the topics made conclusions difficult to confirm.

For responsibility for action, the results showed that in 88% of the care plans audited staff were taking action in relation to care plan topics compared to less than 3% involving service users taking action, either alone or with others (Table 5.6). This appeared to indicate working practices which focused upon 'doing to' as opposed to 'doing with' and as such did not appear to support self-management. It was concluded that this element of the care plan audit was more reliable than the audit of topics in assessing orientation towards recovery, as well as being an indication of behavioural intent.

The care plan findings appear to be broadly representative of working practices evident in the OPMHS, which followed a model of traditional mental health care service delivery at the point of delivery of the training. Overall it was concluded that the care plan audit was feasible, and that responsibility for action appeared to provide an overview of staff intended behavioural intent of their work with service user. It was decided that it could be used as a proxy of working practices as part of the process evaluation, however it was decided that the care plan topic component of the audit would be discontinued.

5.7.3 Aim 3 (Measure selection)

Neither the DREEM nor GAS technology were appropriate. The MHRS also had difficulties identified, which is consistent with a recent study seeking to test the psychometric properties of the MHRS (Killaspy et al. 2012). This study found inter-rater reliability to be poor. The authors concluded that the measure appeared to be rating social functioning rather than recovery.

Feedback from participants relating to the IMR scale was positive. It was therefore concluded that the IMR scale was feasible, and would be included within the evaluation strategy.

5.7.4 Aim 4 (Implementation)

The need for implementation support and organisational commitment was identified. Implementation support was incorporated into the amendments of the OAR intervention and will be discussed in section 5.8. Organisational commitment was included within the implementation strategy which is presented in section 5.11.

5.8 Amendments based on pilot

The pilot study was carried out in order to a) optimise the intervention and b) to test components of the proposed evaluation strategy including measures and c) support the development of an implementation strategy. Findings from the pilot study were also presented to the TAG group, where amendments to the OAR intervention was discussed and agreed.

The findings from the pilot study found that the preliminary OAR intervention was acceptable to staff working in OPMHS. The pilot study identified the need for a small number of changes to be made to the content of the intervention. These included:

- Reducing the time spent providing an overview of recovery principles and the literature relating to adults of working age and on social inclusion in module 1: Recovery and older people
- Increasing the content and time spent on maintaining/adapting meaningful occupation, maintaining valued social roles in module 2: Maintaining identity

- Increasing the content and time spent on supporting self-management, particularly for people with dementia in module 3: Enhancing resilience
- The provision of implementation support as part of the intervention

A summary of the final structure and content of the OAR intervention is shown in Appendix K.

The components of the process evaluation intended to measure change in staff knowledge, attitude, and practice supporting recovery were satisfactory. It was agreed that the action responsibility component of the care plan audit to assess change in the behavioural intent of staff following delivery of the OAR intervention would continue, but the care plan topic component would be withdrawn. A small edit was made to question 2 of the RAQ-7 to reduce confusion.

For the outcome evaluation, the pilot concluded that the IMR was the only measure which was satisfactory. Due to the difficulty in finding suitable recovery measures for older people which were both feasible and captured the components of recovery which appear relevant for older people, it was decided that health-related quality of life (QoL) measures would be used. Two measures were identified dependent upon diagnosis, the DEMQOL (Smith et al. 2007) for people with dementia or the Short Form Health Survey (SF-12) (Ware et al. 1996) for older people with functional mental health problems.

The DEMQOL is a dementia specific health-related QoL measure. The measure is a 28-item interviewer-administrated questionnaire which asks people with dementia to rate their QoL. It is appropriate for use at all stages of dementia. The DEMQOL measures five domains of health-related QoL which was developed from a conceptual framework for QoL in dementia, including Daily activities and looking after yourself, Health and well-being, Cognitive functioning, Social relationships and Self-concept (Smith et al. 2005). It was intended that the measure would be used solely with people with dementia within the evaluation strategy.

The Short-Form Health Survey 12 (SF-12) is a generic health-related QoL measure suitable for use within the general population. The measure was developed in the USA and is recognised as being a standard measure of health across a number of populations and different conditions (Jenkinson et al. 1997). It is a brief, 12-item measure which considers the impact of physical and emotional difficulties on overall

health, daily activities, social activities and mood. It uses a 5-point Likert scale. The SF-12 has been developed from the Short-Form Health Survey 36 (SF-36) (Ware 2000) which has been shown to demonstrate good validity for older people (Lyons et al. 1994).

It was decided that these measures would not need to be piloted, as the psychometric properties of both measures have been widely tested and both address components of recovery identified within the framework of recovery for older people, namely coping strategies and social networks.

The amendments made to the OAR intervention and evaluation strategy are summarised in Table 5.9

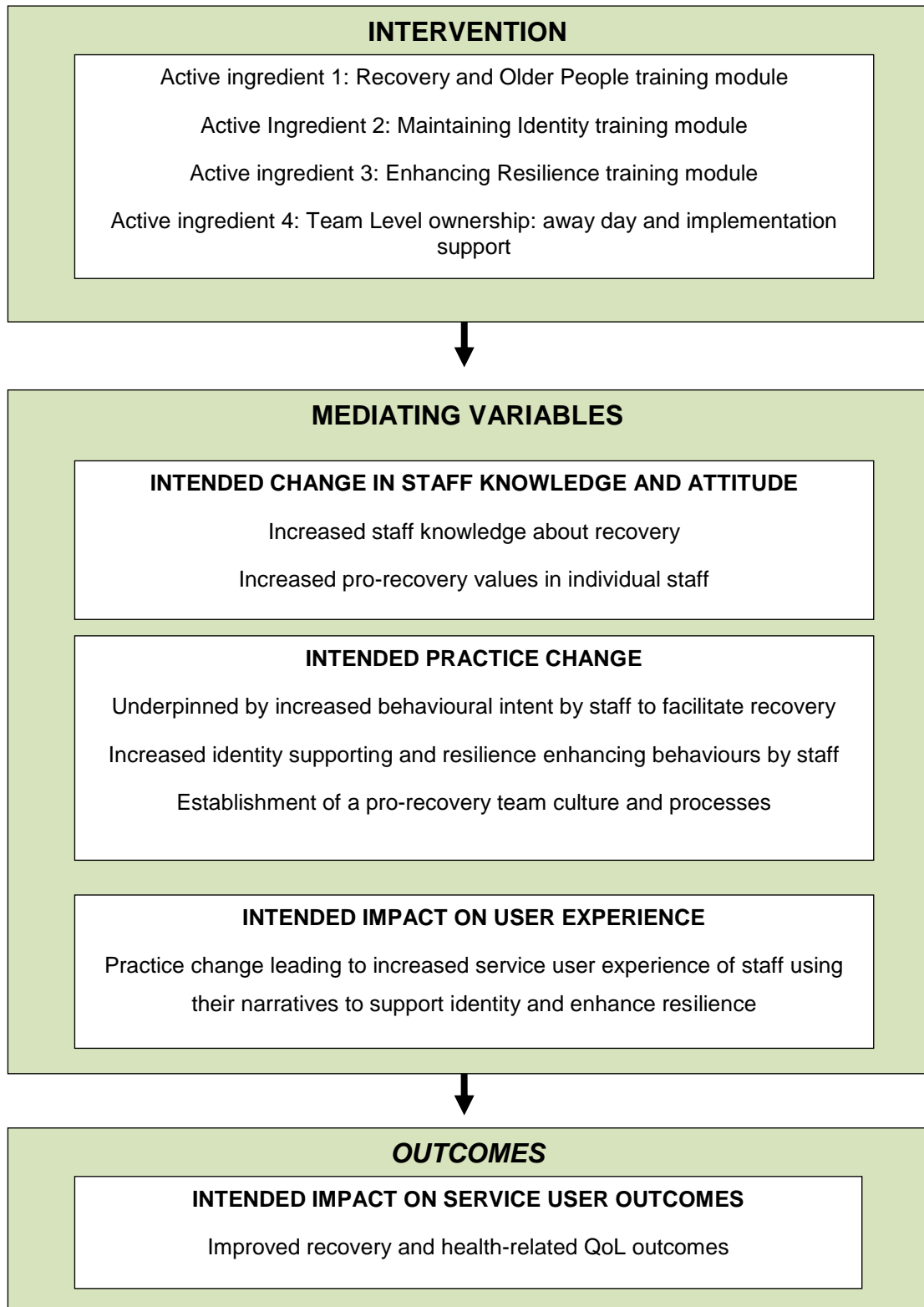
Table 5.9 Amendments to the OAR intervention and evaluation strategy

Aim	Pilot study findings	Amendments made to the OAR intervention
Acceptability	More emphasis on practical implications, especially for work with people with dementia.	Reduction in the time spent providing an overview of recovery principles and the literature relating to adults of working age (module 1: Recovery and older people). Increased time on practical ways to maintaining/adapting meaningful occupation, maintain valued social roles (module 2: Maintaining identity) and supporting self-management (module 3: Enhancing resilience). Use more examples for people with dementia. Withdrawal of the use of the MHRS as a recovery supporting tool within module 3 given pilot findings for aim 3 (measure selection)
Data Collection & Analysis	Minor misunderstanding with one item on the RAQ-7. Difficulties identified with topic component of care plan audit	A small edit made in brackets to the question two on the RAQ-7 to ensure that the question is properly understood. Removal of the care plan topic component of the care plan audit
Selection of measures	Three of the four measures, DREEM, GAS Technology and MHRS were not feasible	Discontinue use of DREEM, GAS technology and MHRS. Use health-related quality of life measures to support the outcome evaluation.
Implementation	Identified need for implementation support. Need for early building of a relationship with managers and clarity re: expectations and practical arrangements for training.	Development of an implementation strategy, to include: Agreeing a contract for delivery of the intervention with service managers and team leaders and building of relationship with team leader prior to training Delivery of implementation support tailored to each clinical team

5.9 Final OAR model and intended effects

The changes to the outcomes were incorporated into the overall model. The final OAR model and intended effects is provided in Figure 5.3

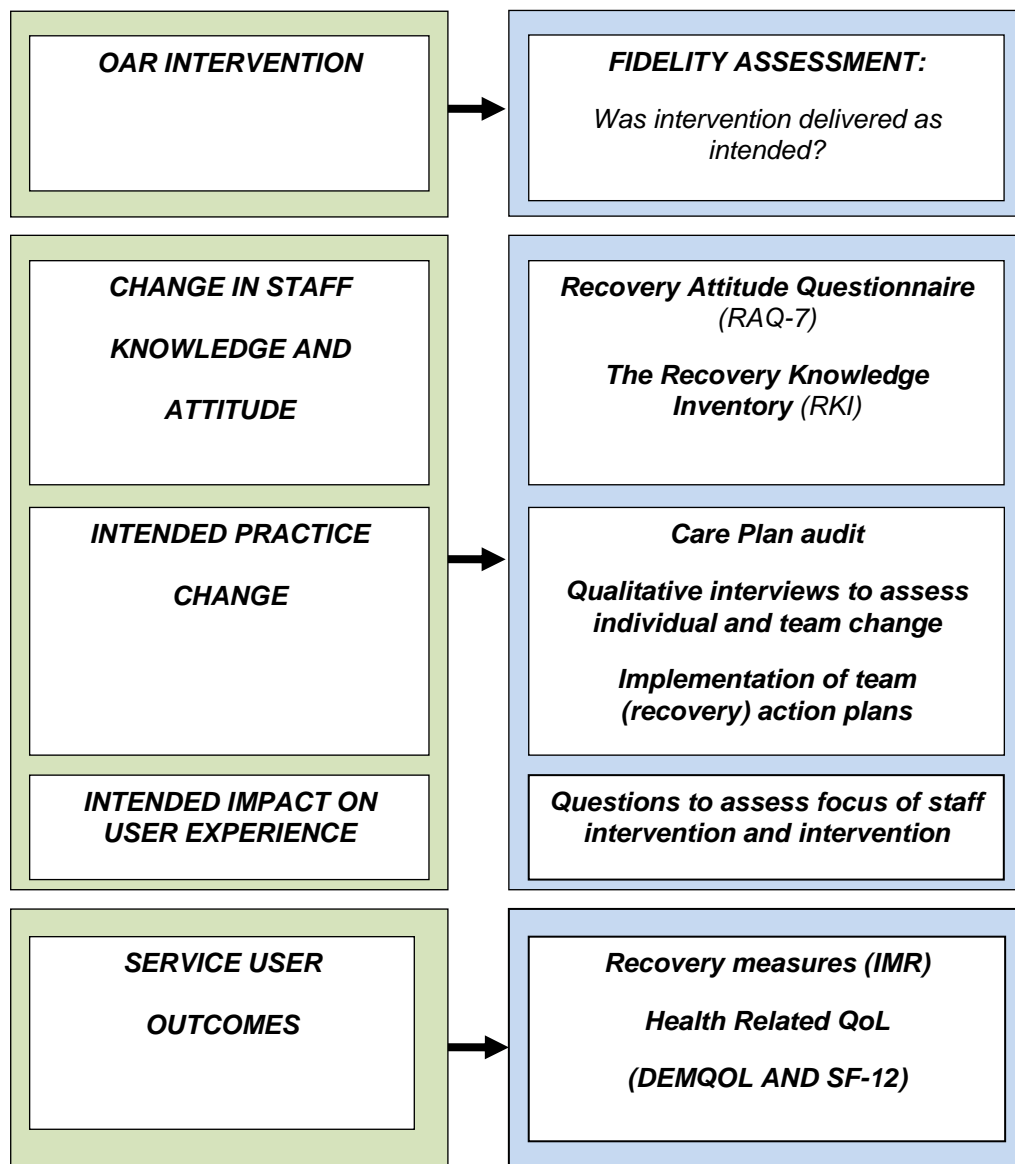
Figure 5.3 Final OAR Model



5.10 Evaluation Strategy

The key components of the overall evaluation strategy were unchanged, and are as described in section 5.4, although changes have been made to the care plan audit and some of the measures. A summary of the evaluation components related to the OAR model are summarised in Figure 5.4.

Figure 5.4 Evaluation components related to the OAR model



5.11 Implementation Strategy

The implementation strategy was developed in order to support the transfer of learning. The strategy was informed by the pilot findings, the qualitative study in Chapter 4 and was also underpinned by three Organisational Development (OD) theories. These theories and their use within the implementation strategy have been summarised in Table 5.10.

Table 5.10 OD theories embedded within the implementation strategy

Theory	Key components of the theory	How utilised within the implementation strategy and active ingredient 4 (Team level ownership)
Theory of Planned Behaviour (Ajzen 1991)	Significance of attitudes, subjective norms and perceived behavioural control in behaviour change	<p>Implementation strategy: Co-facilitation by service user trainer, to challenge existing attitudes towards people with lived experience</p> <p>Team level ownership: Whole team training and team assessment/reflection of areas of team practice which do not support recovery/agreeing on areas which need to change/agreeing on a team (recovery) action plan</p>
Adoption Model (Fraser and Plsek 2003)	<p>Creating tension & awareness of the need to change. Observing ideas that generate interest/fit with the reality of experience of the adopter. Seeing a way to solve the problem/significance of peers in this process. Approach to change: 're-invent' new ways of doing things/trial and error learning</p>	<p>Implementation strategy: Co-facilitation by service user trainer and experienced nurse trainer to enhance credibility, and create tension/recognition of the need to change. Provision of implementation support to support 'trial and error' approach to implementing change</p> <p>Team level ownership: Team deciding on need/areas to change, using team relationships to influence/agree change/team develop and agree their own team (recovery) action plan</p>
Process consultancy (Schein 1999)	Assumption that change will only be successful if those changing see the underlying problems, and identify their own solutions	<p>Implementation strategy: Team will identify implementation support requirements</p> <p>Team Level ownership: Process consultancy facilitation approach, avoidance of an 'expert' role, encouragement of team identifying areas which require change and developing their own team (recovery) action plan</p>

The proposed implementation strategy for the OAR intervention had three components, comprising a) organisational support and commitment, b) acceptability and feasibility and c) team level implementation support.

Obtaining organisational support and commitment referred to both strategic and operational levels. At the strategic level, this involved obtaining approval by the executive management team of the OPMHS, and agreement with service managers. At the operational level, there was an expectation of meetings which allowed for contracting between service managers, team leaders and the recovery training facilitator. The purpose of these meeting was to brief service managers and team leaders about the OAR intervention, and also to make clear the expectations of teams receiving the intervention, specifically whole team attendance and commitment to the development of a team (recovery) action plan. Service manager attendance at the end of the action planning day was expected. It was intended that a written contract following the meeting would be circulated to confirm agreements made and responsibilities of the service manager, team leader and recovery training facilitator. Finally, a team briefing session prior to delivery to explain the aims and expectations of the intervention was planned.

The intervention needs to be acceptable to staff participants. The recovery team training and action planning day components of the intervention would be jointly facilitated by a recovery training facilitator (a nurse with experience of working with older people with mental health problems) and a service user trainer, both competent in delivering training to mental health professionals, in order to promote the credibility of the intervention to staff participants. The trainers were expected to role-model collaborative working between an expert (by qualification) and expert (by experience).

To support the feasibility of the intervention for the clinical teams, it was intended that the training modules and team action planning day would be delivered one day per week over four consecutive weeks, to reduce pressure upon the clinical team and enhance whole team attendance. To maximise the feasibility of the intervention for in-patient units, it was decided that the training would be undertaken in three consecutive days in groups of two to three cohorts (due to the size of the teams), with the action planning day being undertaken with as many ward team staff as possible, in order to reduce pressure upon the clinical team and enhance whole team engagement.

For all teams, it was intended that the training modules and action planning days would take place at a venue separate from but geographically close to the team base, to enhance attention to the learning.

It was decided that following the action planning day a programme of team level implementation support would be agreed between the team and the recovery training facilitator. This was not expected to exceed 3 days in total, and it was intended to be facilitated by the recovery training facilitator for a period of up to three months following the action planning day. The purpose of the implementation support was to facilitate delivery of the team (recovery) action plan. Implementation support could include advice on developing new team processes, educational supervision at a team or individual level, or co-working with staff with individual users. As it was intended that it would be negotiated and agreed with the team, dependent upon the team (recovery) action plan, the implementation support could not be prescribed in advance.

There are four main strengths of the pilot study. First, it allowed 'real life' testing of the preliminary OAR intervention, through delivery to two community mental health teams. Second, delivery of the preliminary OAR intervention was evaluated through three separate methods: staff quantitative measures of knowledge and attitude, staff training evaluation feedback and staff qualitative interviews. Third, changes to the OAR intervention were agreed by members of the TAG group, and were therefore open to more independent scrutiny. Finally, the proposed measures for the outcome evaluation were tested with 25 service user participants, which allowed for problems with the measures to be identified and alternative measures to be found.

The main limitation of the pilot study was that due to time pressures, it was not possible to pilot the service user experience questionnaires, nor was it possible to evaluate the implementation support component of the OAR intervention.

A preliminary OAR model was developed, piloted with two clinical teams and subsequently modified. In Chapter 6, the OAR model will be evaluated in the OAR study to establish the parameters for a future trial. The research objectives and hypotheses, overall research design, measures, procedures and analysis strategy will be presented.

Chapter 6 Methods for the OAR Study

The purpose of this chapter is to describe the methods used for the OAR study, which evaluated the OAR intervention. The OAR study was a feasibility study which was made up of two sub-studies. In Sub-study 1 (Staff outcomes), the OAR intervention was provided to 15 teams, and outcomes for staff were assessed. Sub-study 2 (Comprehensive evaluation) was nested in Sub-study 1, and involved a more detailed mixed-method evaluation of process and outcome for service users and staff in six of the 15 teams.

This chapter describes the research objectives and hypotheses, overall research design, measures, procedures and analysis strategy.

6.1 Aims, Objectives and Hypotheses

The aim of the OAR study was to carry out a feasibility study based upon the MRC Framework (Campbell et al. 2000), as discussed in Section 1.2.1 and further discussed in section 6.2. There were three objectives:

Objective 1 (Optimise the intervention) was to pilot and if necessary modify the OAR intervention, in order to maximise its feasibility and effectiveness. Data from both sub-studies was used to assess:

- Acceptability of the OAR intervention for staff (Objective 1.1: Acceptability)
- Whether the OAR intervention reached its target population (Objective 1.2: Reach)
- Whether the OAR intervention was delivered as intended (Objective 1.3: Fidelity)
- Impact on staff attitude, knowledge and practice (Objective 1.4: Mediating Variables)
- Factors which influenced the implementation of the intervention (Objective 1.5: Context)

Objective 2 (Optimise the evaluation) was to pilot and if necessary modify the evaluation strategy. Data from both Sub-studies was used to assess:

- Feasibility of the measures (Objective 2.1: Measures)

- Evaluation strategy (Objective 2.2: Evaluation)

Objective 3 (Establish trial parameters) was to inform a future definitive trial. Sub-study 2 (Comprehensive evaluation) tested the two hypotheses (Objective 3.1: Hypotheses):

- Hypothesis 1 (Recovery): the OAR intervention would lead to improved recovery for users of OPMHS
- Hypothesis 2 (QoL): the OAR intervention would lead to improved QoL for users of OPMHS

Sub-study 2 also assessed:

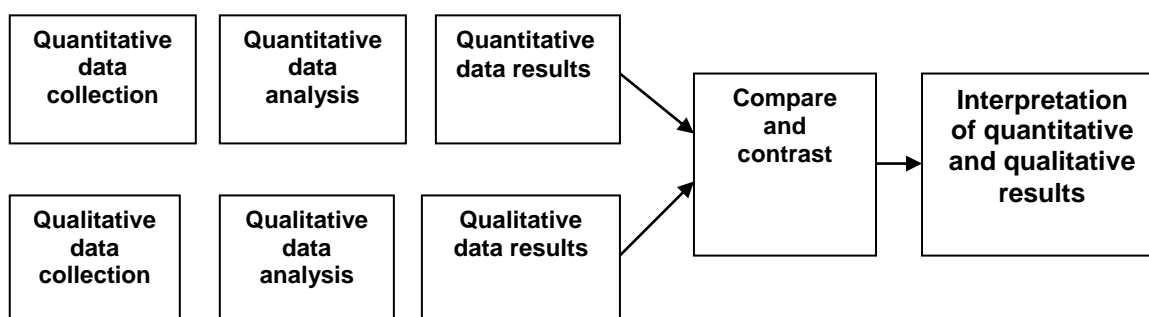
- Data for sample size calculation for a future definitive trial (Objective 3.2: Sample size)
- Factors required for an optimal recruitment strategy (Objective 3.3: Recruitment)
- Factors required for an optimal retention strategy (Objective 3.4: Retention).

6.2 Research design

As discussed in Sections 1.2.1 and 1.2.5, the scientific framework for the OAR study was the Medical Research Council (MRC) Framework for the evaluation of complex interventions (Campbell et al. 2000), along with the updated guidance (Craig et al. 2008). As the literature review on recovery and older people (Section 2.5) made clear, research is only beginning to emerge on recovery and older people, and the full implications for working practice and service delivery are not yet known. The development of a conceptual framework for recovery and older people (Chapter 3) contributed to the evidence base and development of theory (phase I) of the MRC Framework. The development of working practice implications (Chapter 4) and the development of the model and piloting of the intervention (Chapter 5) contributed to the MRC Framework modelling phase (phase II). Sub-study 1 (Staff outcomes) and Sub-study 2 (Comprehensive evaluation) were designed to address questions to the MRC Framework modelling phase (phase II). Sub-study 2 also addressed questions applicable to the exploratory trial phase (phase III) of the MRC Framework, in order to inform a future definitive RCT (phase IV).

As discussed in Section 5.5, as definitions of pilot and feasibility studies are inconsistent, the OAR study was categorised as a feasibility study, as it specifically sought to address the parameters required for a future definitive trial (Arain et al. 2010). The overall research design for the OAR study was mixed-method. There are a number of approaches which can be used to underpin a mixed-method design, and in deciding upon the model, three factors were considered: timing (of data collection), weighting of each approach and the stage at which the findings would be combined (Cresswell and Plano Clark 2011). A convergence model was used (Cresswell and Plano Clark 2011). This involved collecting and analysing the quantitative and qualitative data separately followed by convergence during interpretation. Within the convergence model qualitative findings are used to fully understand and corroborate quantitative findings, which are given prominence. The convergence model is shown in Figure 6.1.

Figure 6.1 Convergence model (mixed-method design)



For Objective 1 (Optimise the intervention), a number of different designs were used to address the sub-objectives. For Objective 1.3 (Mediating Variables) two quasi-experimental designs were used. First a pre-post design was used to measure staff attitudes and knowledge about recovery directly before and after delivery of the team recovery training component of the OAR intervention. Second, an interrupted time-series (ITS) design was used for the care plan audit in order to strengthen the findings from the pre-post measures (Ramsay et al. 2003). Within an ITS design, data are collected on multiple occasions before and after delivery of the intervention (interruption) in order to assess whether the intervention has an effect greater than the underlying trend. Such observations allow for the investigation of potential biases upon the outcome, such as secular trends (where the outcome may increase or decrease over time and not relate to the intervention), seasonal and random effects, as well as differences in the duration of effect following the intervention (Ramsay et al. 2003). An ITS design cannot fully attribute positive change in outcome to the intervention, as

there may be other cofounders influencing the outcome (Gilbody and Whitty 2002). For the OAR study, it was decided that care plan data would be collected on five occasions, with a minimum of two observations prior to delivery of the intervention.

Thematic analysis was chosen to address Objectives 1.1 (Acceptability) and 1.5 (Context). This was a pragmatic decision suited to health services research, made on the basis of the weighting given to the quantitative findings within the OAR study, and because thematic analysis was a more appropriate level of complexity than other more theoretically driven approaches.

For Objective 3 (Establish the trial parameters), in line with the MRC Framework, undertaking a definitive randomised controlled trial was not indicated given the current state of knowledge. As an alternative to a RCT, a quasi-experimental approach was used to evaluate the effects of the intervention without randomisation, using a 'controlled before and after' design (CBA) (Gilbody and Whitty 2002). Specifically, this involved delaying delivery of the OAR intervention to a number of (non-randomised) teams to create a comparison group to replace randomisation. This allowed for outcomes to be compared between teams who had received the intervention to those who had not. This design was chosen for two reasons. First, funding for the wider programme of work carried an expectation of delivery of the intervention to all teams within the local OPMHS. Second, staged delivery of the OAR intervention allowed for targeting of project resources in order to fully support implementation of the intervention into practice. Such designs are suitable to healthcare practice interventions in 'real world' settings, where RCT designs are not suitable (Handley et al. 2011). Indicators of the applicability of this approach include compatibility between teams and a likelihood that similar trends would be experienced throughout the study (Gilbody and Whitty 2002). As all of the participating teams were community services within a similar geographical area, under the same overall service structure, it was decided that these factors were present.

The OAR intervention was provided at a cluster (team) rather than individual staff level. Delivery at individual staff level was not feasible as a) the OAR intervention was designed as a team level intervention with change towards a pro-recovery culture at team level as an intended outcome, and b) it was unrealistic to ask staff to provide recovery-oriented practice to some service users and not to others. It was recognised that the cluster design would impacted upon the analysis strategy (Campbell et al. 2004, Barbui and Cipriani 2011), and this is discussed in more detail in section 6.7.2.

An overall summary of the key research design decisions made for Objective 1 (Optimise the intervention) and Objective 3 (Establish the trial parameters) is shown in Table 6.1.

Table 6.1 Design for each research objective

Objective	Sub-Objective	Design	Methods
1) Optimise the intervention	Acceptability	Thematic analysis	Individual qualitative interviews
	Mediating Variables	Pre-post design	Measurement of staff recovery knowledge and attitude
	Mediating Variables	Interrupted time series (ITS)	Care plan audit
	Context	Thematic analysis	Individual qualitative interviews
3) Establish trial parameters	Hypothesis	Controlled before and after (CBA)	Outcome evaluation

6.3 Sample and setting

The study took place in an OPMHS which was part of an NHS Foundation Trust in South London. The OPMHS covered four local authority boroughs, and provided secondary mental health services to people over the age of 65 years with a mental health diagnosis. The service was made up of community mental health teams (n=10), acute in-patient units (n=4), memory services (n=1), specialist care units (n=5) and liaison services (n=4). Service users who had used working age adult mental health services within the last two years were not placed under the care of the service, remaining instead with their existing service.

In November 2011, the local OPMHS employed 514 staff, with nursing forming the majority (61%) of the workforce. Psychiatrists (11%), occupational therapists (8%),

psychologists (4%) and support workers (4%) were also employed. Social workers were employed directly by the respective local authority to work in community mental health teams (CMHTs).

Fifteen teams participated in Sub-study 1 (Staff outcomes). They comprised MHTs (n=10), acute in-patient units (n=4) and memory service (n=1).

Six teams from Sub-study 1 also participated in Sub-study 2 (Comprehensive evaluation) comprising five CMHTs and one memory service across two local authority boroughs.

In November 2011, the OPMHS had an overall caseload of 3,500 service users, which was 3% of an overall population of 115,874 people over the age of 65 years (Office for National Statistics 2011). The combined service user population of the six teams within Sub-study 2 (Comprehensive evaluation) was 2,150 service users.

Inclusion criteria for service users Sub-study 2 (Comprehensive evaluation) was being over the age of 65 years, being able to give informed consent and having any mental illness diagnosis. Exclusion criteria was care co-ordinator concern about the personal safety of researchers, or the service user being assessed by the care-co-ordinator as being in crisis and therefore too unwell to participate.

6.4 Interventions

All teams provided treatment as usual throughout the OAR study.

6.4.1 Treatment as usual

Treatment as usual consisted of the provision of either in-patient or out-patient and domiciliary (for service users residing in the community) assessment and treatment. All services were multi-disciplinary, typically containing nurses, occupational therapists, psychiatrists, psychologists, social workers and support workers.

Within acute in-patient units, 24 hour care was provided to service users with both organic and functional mental health problems in crisis. This involved assessment, pharmacological, psychological and rehabilitative treatments and discharge back to the community (own home) or to residential care.

Within CMHTs, care was provided to service users with both organic and functional mental health problems, using the framework of the Care Programme Approach (CPA) (Department of Health 1999). This involved assessment of the health and social care needs of each service user, development and review of a care plan intended to address these needs, an allocated care co-ordinator to provide face to face contact and delivery mental health care interventions to the service user, and liaison as necessary with carers and other agencies. Frequency of contact ranged from weekly to three-monthly visits.

Care in the memory service was not under the CPA framework and the care pathway was one of assessment of memory problems, diagnosis of dementia as appropriate, medication initiation and review on a six monthly basis for service users with mild to moderate dementia living within their own homes.

6.4.2 The OAR intervention

The development and piloting of the OAR intervention was described in Chapter 5. In summary, the OAR intervention was developed for delivery to staff over a four month period to promote pro-recovery practice. The intervention had three components: team recovery training (three modules), an action planning day and implementation support. The team recovery training comprised three full training days made up from three training modules, Recovery and Older People, Maintaining Identity and Enhancing Resilience. Team level ownership involved an action planning day and implementation support, and underpinned the OAR intervention and the supporting implementation strategy (Section 5.11). The intended impact of the OAR intervention upon normal care included increased staff focus on maintaining the identity of service users, and the enhancement of resilience and self-management in service users. The intended impact of the OAR intervention is described in Section 5.9.

Delivery of the three modules in the team recovery training component of the intervention was intended to take place sequentially, using a trainers manual, staff participant folder and pre-prepared Microsoft power-point presentations. The content of the OAR intervention is described in further detail in Appendix K.

On the final day of the team recovery training, the team were asked to identify three areas of team practice/processes which they wished to work on in the subsequent action planning day, in order to support a move towards pro-recovery culture within their team. The action planning day addressed the three identified areas, leading to an

agreed team (recovery) action plan with objectives and timescales. The relevant service manager was invited to the last part of the action planning day to receive feedback about the team (recovery) action plan and to provide managerial approval or support as required. During each action planning day, the training dyad agreed the implementation support required to support achievement of the action plan with the team leader. Implementation support included advice on developing new pro-recovery team processes, educational supervision at a team or individual level, and co-working with staff with individual service users. The implementation support was delivered for a period of up to three months after the action planning, up to a maximum of three days input.

Delivery of the team recovery training and action planning day components of OAR intervention was provided by an experienced healthcare professional and a service user, both with experience of delivering training. The recovery training facilitator employed to deliver the OAR intervention was a nurse with 15 years of experience working in OPMHS. The recovery training facilitator delivered the implementation support to each team. Additionally, two mental health professionals working for the local OPMHS (a senior nurse and a social worker) were recruited to deliver the team recovery training. Service user trainers were also recruited. However it was not possible to recruit service user trainers from the local OPMHS, therefore all of the service user trainers (n=3) were users of mental health services for adults of working age.

All of the training delivered to individual teams was facilitated by the same staff and service user trainer dyad. The principal investigator, senior nurse, recovery training facilitator and the most experienced service user trainer attended a 5-day recovery training course run by a neighbouring NHS Trust, with a pro-recovery culture and working practices (Perkins 2008). All of the trainers undertook a 3-day OAR 'train the trainers' programme, which was developed and facilitated for the OAR intervention by the principal investigator and the most experienced service user trainer.

6.5 Measures

Two staff-rated measures were used. The Recovery Attitudes Questionnaire (RAQ-7) is a 7-item staff-rated measure of pro-recovery attitudes (Borkin et al. 2000). The RAQ-7 has two sub-scales: recovery is possible and needs faith (Recovery is possible) which has 4 items and recovery is difficult and differs among people (Recovery is

difficult) which has 3 items. Each item is scored on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The sub-scale scores are the total of the item scores, ranging from 4 to 20 for Recovery is possible and 3 to 15 for Recovery is difficult, with higher scores indicating higher levels of pro-recovery attitude. This measure has acceptable internal consistency for the two subscales Recovery is possible ($\alpha = 0.66$) and Recovery is difficult ($\alpha = 0.64$), and adequate test-retest reliability (0.67) (Borkin et al. 2000).

The Recovery Knowledge Inventory (RKI) is a 20-item measure of recovery knowledge (Bedregal et al. 2006). There are four sub-scales: roles and responsibilities in recovery (Roles), non-linearity of the recovery process (Non-linearity), the roles of self-definition and peers in recovery (Self-definition), and expectations regarding recovery (Expectations). Each sub-scale has 4 items, and each item is scored on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The total sub-scale scores are the mean of the total item scores within that sub-scale, ranging from 1 to 5, with higher scores indicating higher levels of recovery knowledge. This measure has adequate internal consistency for three of the four subscales: Roles ($\alpha = 0.81$), Non-linearity ($\alpha = 0.70$) and Self-definition ($\alpha = 0.63$). The Expectations subscale ($\alpha = 0.47$) is recognised as having poor internal consistency (Bedregal et al. 2006).

Three service user-rated measures were used. The Illness Management and Recovery Scales (IMR) is a 15-item service user rated measure which assesses aspects of illness management and recovery (Mueser et al. 2004). The recovery domains include: illness knowledge, interaction with others, engagement in roles/activities, symptom distress, relapse prevention, and coping. Each item is scored on a five-point Likert scale, ranging from 1 (minimal illness management) to 5 (significant illness management). The total score ranges from 15 (worst level of illness management) to 75 and can be seen as an aggregate measure of illness self-management. Whilst the IMR was not designed for people with dementia, review of the items and correspondence with the author (May and October 2011) concluded that there were no reasons as to why the measure would not be suitable. The measure has adequate internal consistency ($\alpha = 0.68$) and good test-retest reliability (0.81) (Salyers et al. 2007). This measure was used with all service user participants.

The DEMQOL is a 29-item service user-rated measure of dementia specific health related QoL (Smith et al. 2007). The measure has three domains: feelings (13 items), memory (6 items) and everyday life (9 items), as well as one item on overall QoL. Each

item is scored on a four-point Likert scale, ranging from 1 (a lot) to 4 (not at all). The total score for the three domains ranges from 28 (lowest QoL) to 112. This measure has good internal consistency ($\alpha = 0.87$) and test-retest reliability (ICC= 0.76). Performance for people with advanced dementia was identified as requiring further testing (Smith et al. 2007). This measure was used with service user participants with dementia.

The Short-Form 12 (SF-12) is a 12-item service user-rated measure of generic health-related QoL (Ware et al, 1996). The measure has two composite scores, one for Physical health (PCS) and one for Mental health (MCS). The two composite scores are made up from sub-domains of physical functioning, role limitation, physical pain, general health, vitality, role limitation (emotional), social functioning and mental health. 10 of the items on the measure are scored on a five-point Likert scale, ranging from 1 (all of the time) to 5 (none of the time), and two of the items are scored on a three-point Likert scale. The Physical and Mental health composite scores (PCS and MCS) are computed using different weighting from the scores of the 12 items, ranging from 0 to 100, with higher scores indicating the highest levels of health. The SF-12 was developed from the Short-Form 36 (SF-36) where the same eight domains are addressed, due to concerns about the length of the SF-36. There is good evidence of reliability, validity and responsiveness for the SF-36 (Haywood et al. 2005), and initial construction of the SF-12 was tested against the SF-36 (Ware et al. 1996). The measure has good internal consistency: Physical health (PCS) ($\alpha = 0.84$) and Mental health (MCS) ($\alpha = 0.81$) (Lim and Fisher 1999). This measure was used with service user participants with functional mental health problems.

6.6 Procedure

NHS Research Ethics (reference: 09/H0722/66) and local service Research & Development approval were granted in December 2009 (Appendix A and B).

6.6.1 Sub-study 1 (Staff outcomes)

It was agreed with the service director and clinical director of the local OPMHS that all clinical teams would receive the full OAR intervention, apart from specialist care and liaison services. The planned timetable of the OAR intervention was agreed sequentially by local authority borough to encourage a joined up approach to care

delivery between CMHTs and acute in-patient units within each borough. Additionally, the order of the delivery was decided by the service director, on the basis of perceived organisational readiness for the OAR intervention, assessed as the absence of any substantial service delivery difficulties or senior managerial vacancies. The overall timetable for delivery was in keeping with the overall timescales of the wider programme of work and funding requirements. The service director advised relevant service managers that their clinical teams would receive the OAR intervention.

The principal investigator discussed the OAR intervention at three leadership events for team leaders and four profession specific events for nursing, psychiatrists, psychologists and support workers.

Preparatory work was started four months before each team received the OAR intervention. Meetings were set up by the recovery training facilitator with each team leader and their respective service manager to provide more information about the OAR intervention, to identify suitable local training venues, to make clear mutual expectations and to set dates for delivery of the team recovery training and action planning day components of the intervention in accordance with the overall timetable of delivery. Additionally, it was agreed with the in-patient service manager that a financial contribution towards replacement costs to support staff attendance could be made. An email was sent to team leaders and service managers following the meeting confirming the details agreed. This made clear that team leaders were responsible for advising their team members of the training dates. Additionally, the team leaders were asked to provide the names of team members to allow for preparation of the staff measures. The recovery training facilitator, principal investigator and research worker also delivered presentation to individual teams about the OAR intervention.

The OAR intervention was delivered to fifteen teams between March 2010 and November 2011. The first two teams to receive the intervention served as the pilot for the OAR intervention discussed in Chapter 5.

Delivery of the team recovery training component of the intervention to community teams took place one day per week over three consecutive weeks, and over three consecutive days for in-patient units. All of the team recovery training and action planning days were held off-site. The recovery training facilitator delivered team recovery training to 12 teams, and the senior nurse and social worker, delivered the training to the remaining three teams.

The research worker attended the beginning of the team recovery training, and asked staff to complete the RAQ-7 and the RKI. Measures for each participant were marked with an individual identification number to allow for data linkage. Staff participants who completed all three days of training were asked to re-rate the RAQ-7 and RKI at the end of the team recovery training.

The action planning day took place within 1 week of completion of the team recovery training component of the intervention. The recovery training facilitator was involved in the facilitation of all of the away days, and provided all of the implementation support to teams in the three months following the action planning day.

Data from completed staff measures were entered onto a Microsoft Excel spreadsheet. Transcription errors from paper to electronic databases were estimated by double entry of 20% of all the data by the principal investigator. A concordance rate of 94% between the research worker and principal investigator was found, which was deemed acceptable.

Advice was sought from the authors of the two measures as to how to handle missing data. One replied with general advice, the other did not reply. In the absence of a known consistent approach to this issue, a decision for both measures was made to impute missing items using the mean average score on completed items.

The fidelity assessment was completed by the principal investigator from training records and following discussion with the recovery training facilitator and team leaders.

6.6.2 Sub-study 2 (Comprehensive evaluation)

It was agreed with the service director and clinical director of the local OPMHS that Sub-study 2 would take place in the six teams within the final two boroughs to receive the OAR intervention.

In November 2010, the researchers held meetings with the six team leaders and the respective service manager to advise them about Sub-study 2, including staff involvement in the OAR intervention and service user involvement in the outcome evaluation. A letter was sent to all to consultant psychiatrists informing them that Sub-study 2 would take place with a random group of service users from each team across

the two boroughs. Additionally, presentations were made at each multi-disciplinary team meetings to provide information about Sub-study 2.

An initial recruitment target was set of 150 service users, 25 service users per team. This was based on feasibility of recruitment within the available time and financial resource envelope. This generated a maximum number of service users who could be seen.

Service users from each team's caseload were randomly selected. The caseload from each participating team was alphabetically listed by the research worker, with each service user allocated a sequential number based on their position in the list. An electronically generated random number sequence was then used to randomly re-order the list. The first 100 service users in the list for each team were considered for eligibility and invitation into the study. 100 service users were identified, as it was not known how prior to commencement of the recruitment process how many participants a) would be eligible and b) would consent to being involved in the study.

From December 2010 onwards, the researchers spent time with all of the teams in Sub-study 2 and met with care coordinators to ascertain whether there were reasons why the service users selected for invitation should not be approached for invitation into the study. No approach was made to service users without discussion with the relevant care coordinator and receipt of their approval.

If care coordinators agreed that potential service user participants could be approached for invitation into the study, a letter was sent out (Appendix L) with a study information sheet and a stamped addressed envelope asking the service user to return a slip to the research team if they did not wish to be contacted by the researchers.

Participants who did not return a slip to the research team within ten days were telephoned by one of the researchers and asked if they would be interested in meeting to find out more about involvement in the study. A meeting was organised with those expressing an interest in participation.

Meetings involved either the research worker or the principal investigator, and most of the meetings took place in participants' own homes. The study information sheet was discussed, questions about the Sub-study were invited, and written consent was obtained. The researchers then administered the IMR for all participants and either the DEMQOL for participants with dementia or the SF-12 for participants with functional

mental health problems. To assess service user experience, participants were then asked about their experience of the OPMHS (Appendix M). Meetings lasted between 60 and 120 minutes. Baseline assessment took place in January and February 2011, by the principal investigator and the research worker.

Following baseline assessment, service user participants were contacted on two further occasions at six months in July 2011 (T1) and at twelve months in January 2012 (T2). At each contact, participants were asked whether they were willing to remain in the Sub-study. For those who were, meetings were arranged, and measures were re-administered. Both researchers maintained fieldwork diaries throughout the data collection period.

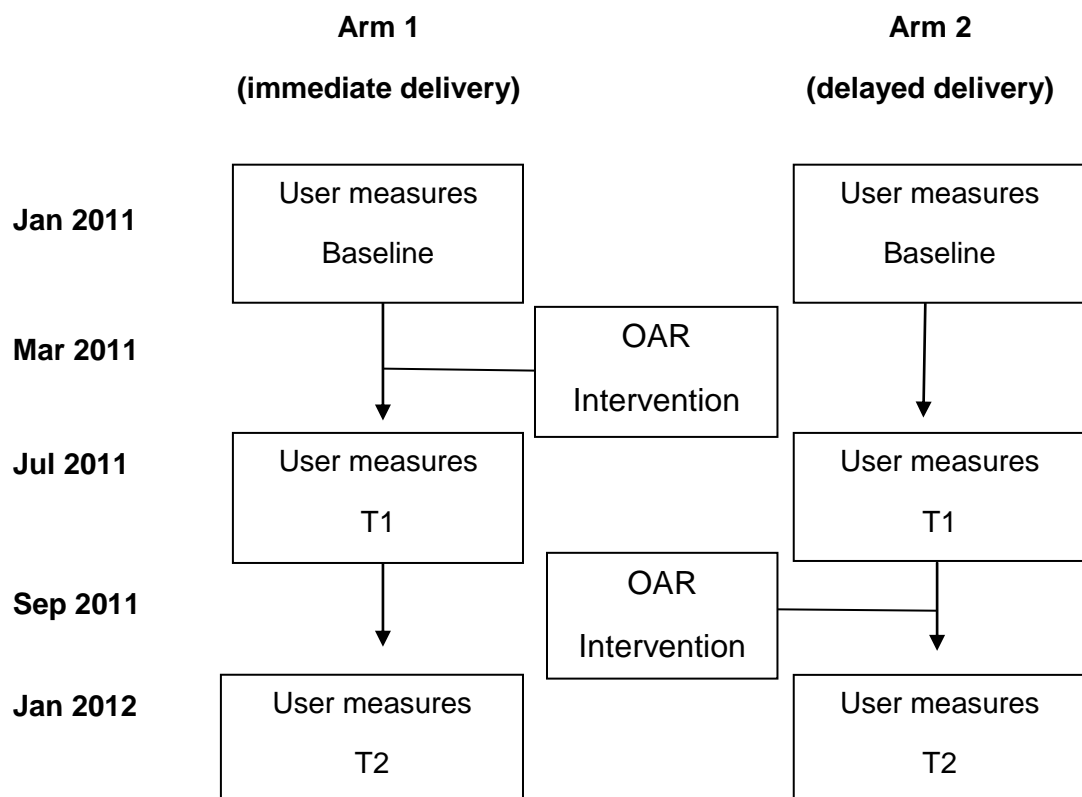
Data from service user measures were entered onto a Microsoft Excel spreadsheet. Advice was sought from the authors of each measure as how to deal with missing data. The IMR author indicated that average values should be imputed for missing data. The DEMQOL authors provide a substitution algorithm for missing data which imputes a mean score for items with missing data. No direct response was obtained from the SF-12 authors, and no standard imputation rule was identified. This was problematic due to the complex formula for the calculation of the two composite scores (MCS and PCS), as each score is a sum of different weights from each of the twelve items. The literature on imputation for the SF-12 is mixed, with some authors suggesting an imputation algorithm using US-derived general population mean weights for three or less missing items (Perneger and Burnand 2005), whereas others have suggested using zero values (Lacson et al. 2010). A decision to use zero values was made due to the very low level of missing data (n=5), less than 1% of the dataset, and because use of US-derived population means may be unrepresentative of the UK older adult mental health service user population.

10% of the service user data were hand-checked by the principal investigator, including allowable age ranges, and the appropriate quality of life measures for the diagnosis. Transcription errors from paper to electronic databases were estimated by double entry of 10% of all baseline data by the principal investigator and research worker. For the baseline assessment, a concordance rate of 92% was found. Double entry of 15% of the data for T1 and T2 was undertaken, and the concordance rates for T1 and T2 were 90% and 98% respectively, which were deemed acceptable

The OAR intervention was delivered to the six teams involved in Sub-study 2 between March and December 2011, following the same procedure described for Sub-study 1.

Teams were non-randomly allocated to two arms, based on operational reasons. Arm 1 involved immediate delivery of the OAR intervention (March 2011) and Arm 2 involved delayed delivery of the OAR intervention by 6 months (September 2011). The two arms were formed by borough (two teams in one borough, and four in the other). Teams in Arm 1 (immediate delivery) received the OAR intervention between March and June 2011, and teams (in Arm 2 (delayed delivery) received the OAR intervention between September 2011 to December 2012. The sequence of intervention and outcome evaluation for Sub-study 2 is summarised in Figure 6.2.

Figure 6.2 Evaluation and intervention sequencing for Sub-study 2



A month after delivery of the team recovery training and action planning day, April 2011 for study arm 1 (immediate start) and October 2011 for study arm 2 (delayed start), a staff member from each team was approached by the principal investigator, and asked to take part in a qualitative interview about their experience of these two components of the OAR intervention. Potential participants were purposively sampled, following discussion with the trainers, in order to involve staff members who were judged by trainers either to have actively participated or to have disengaged from the experience. The principal investigator emailed the potential participants, and provided a study

information sheet, which explained what participation would involve. Interviews were arranged with those who consented, at the participant's work location during work hours. The study information sheet was discussed, questions invited and written consent obtained. The topic guide (Appendix J) was used to investigate the experience of the team recovery training and action planning day. Interviews lasted between 30-60 minutes.

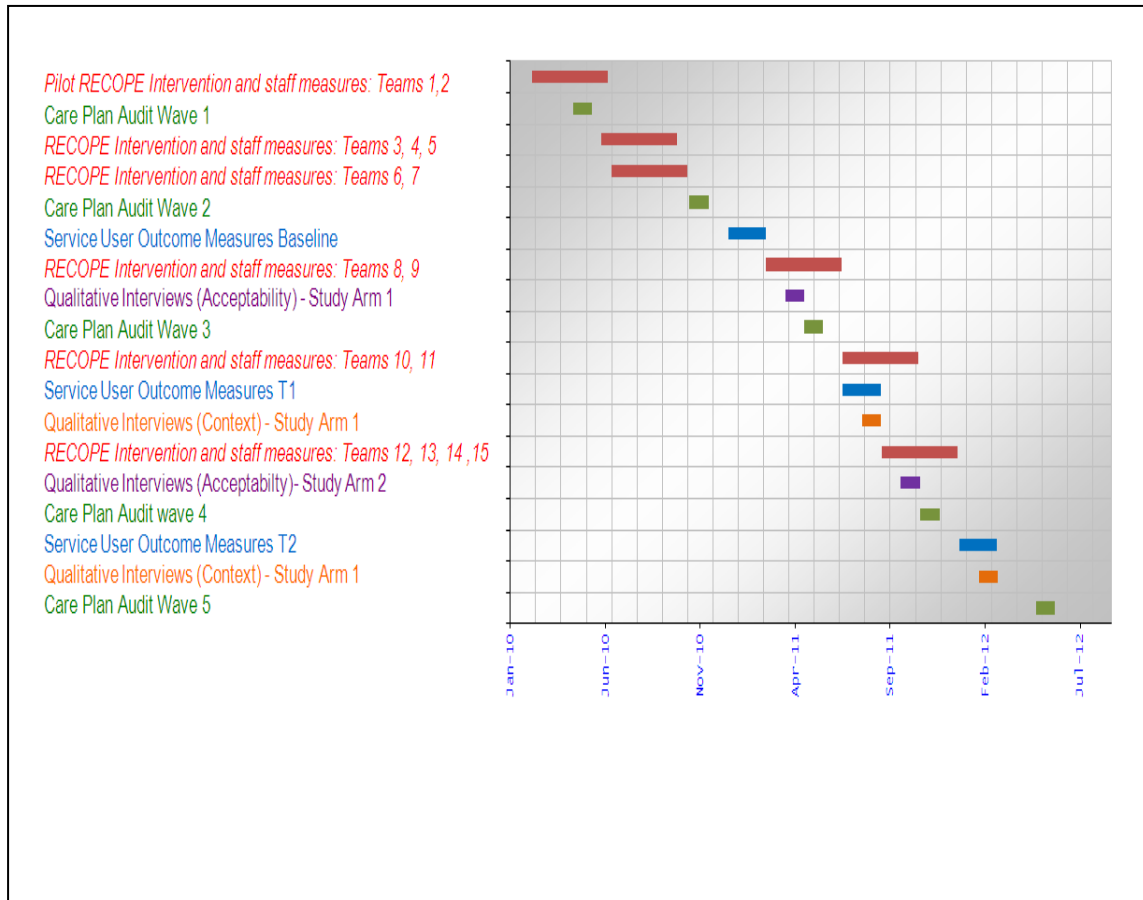
Interviews also took place with the staff and service user trainers one month after the action planning day to investigate their experience of the team recovery training and action planning day (Appendix N).

Two months after the end of the OAR intervention, August 2011 for Arm 1 (immediate delivery) and February 2012 for Arm 2 (delayed delivery) different staff members from each team were approached to take part in qualitative interviews, using the criteria discussed above. The interview sought to assess whether pro-recovery change in their own or team practice had taken place, and what factors had affected change or lack of change. The research worker undertook one of the six interviews and the principal investigator undertook the remaining five interviews.

A care plan audit was undertaken by the research worker, using the Case Register Interactive Search (CRIS) system discussed in Section 5.5.2. An audit of the care plans from the two study arms commenced in May 2010 from a total caseload of 2,150 service users. A random sample of care plans from 15% of the caseload was requested, extracted, and collated by study arm. Data were exported from the CRIS system, and each action point in the care plans was identified and coded for responsibility for action, with categories of Staff (where the action was to be carried out by the staff member alone), Service user, Staff & Service user, Carer and Carer & Staff. An overall total of the number of care plan entries under each area of responsibility for action was collated for each audit. The audit was undertaken on five occasions and repeated on a six-monthly basis. Data were audited in May 2010, November 2010, May 2011, November 2011 and May 2012. The audit was undertaken twice (May 2010 and November 2010) prior to delivery of the OAR intervention to Arm 1 (immediate delivery). The same service user records were used for each repeated care plan audit.

A summary of the overall OAR intervention and evaluation is shown in Figure 6.3.

Figure 6.3 Summary of intervention and evaluation activity



A summary of research activity by Sub-study is shown in Table 6.2.

Table 6.2 Summary of research activity by Sub-study

Research Objective/activity	Sub-Objective	Sub-study 1 (Staff outcomes)	Sub-study 2 (Comprehensive evaluation)
Objective 1 (Optimise the intervention)			
Qualitative interviews	1.1 Acceptability	No	Yes
Review of attendance and attrition	1.2 Reach	Yes	Yes
Fidelity assessment	1.3 Fidelity	Yes	Yes
Staff measures	1.4 Mediating Variables	Yes	Yes
Care plan audit	1.4 Mediating Variables	No	Yes
Survey of service user experience	1.4 Mediating Variables	No	Yes
Qualitative interviews	1.5 Context	No	Yes
Staff measures (Linear regression)	1.5 Context	Yes	Yes
Objective 2 (Optimise evaluation)			
Review of measures	1.1 Measures	Yes	Yes
Review of evaluation strategy	1.2 Evaluation	No	Yes
Objective 3 (Establish trial parameters)			
Service user outcomes (hypotheses)	3.1 Hypothesis	No	Yes
Service user outcomes (sample size)	3.2 Sample size	No	Yes
Review of recruitment data	3.3 Recruitment	No	Yes
Review of retention data and attrition	3.4 Retention	No	Yes

6.7 Analysis

All quantitative data were entered onto Microsoft Excel and then transferred to SPSS Version 18 for analysis. STATA 11 was used for the sample size calculation.

6.7.1 Objective 1 (Optimise the intervention)

Objective 1 (Optimise the intervention) was met through completion of a process evaluation to identify which components of the OAR intervention had been effective, for whom, and the contextual factors which had influenced success (Steckler et al. 2002) . The process evaluation included data from both sub-studies and used both quantitative and qualitative methods. The research question, methods and data source for each component are summarised using a process evaluation framework (Grant et al. 2013) in Table 6.3.

Table 6.3 Research question and methods for each process

Sub-Objective	Research questions	Research methods	Collection stage
1.1 Acceptability	Was the intervention acceptable to participants? Which factors influenced acceptability?	Qualitative interviews with staff and trainers	Post team recovery training and action planning day
1.2 Reach	Did the OAR intervention reach its target population?	Assessment of fidelity and receipt by profession	Post team recovery training
1.3 Fidelity	Was the OAR intervention delivered as planned?	Fidelity assessment	Post OAR intervention
1.4 Mediating Variables	Did the OAR intervention change staff knowledge, attitude and practice?	Measurement of staff knowledge and attitude pre-post training	Pre/post team recovery training
		Care plan audit	Pre-post OAR intervention
		Team (recovery) action plans	Post OAR intervention
1.5 Context	Did the intervention lead to change at an individual and team level? Which factors appeared to influence implementation?	Survey of service user experience	Pre-post OAR intervention
		Qualitative interviews with staff	Two months post OAR intervention
		Influence of team and profession on knowledge and attitude change	Pre-post team recovery training

Two rounds of qualitative interviews were used to assess acceptability and context. Interviews were audio-recorded and were transcribed verbatim, followed by review of accuracy by the principal investigator. The analysis strategy was agreed with the independent qualitative researcher. The transcripts were analysed by the principal investigator, using thematic analysis to identify pertinent topics within the data. Analysis involved four stages: familiarisation with the data, development of a thematic (coding) framework, indexing and sorting the data and reviewing of data extracts (Spencer et al. 2014). First the principal investigator re-read the transcripts to familiarise herself with the content. Second, the principal investigator reviewed the first two transcripts of each round of interviews and identified meaningful segments of text within each transcript which she labelled with descriptive codes. The codes identified within the first two transcripts were used to develop an initial coding framework for acceptability (Appendix O) and context (Appendix P) To support rigour in the process, in light of the principal investigator's dual role in both conducting the research and within the local OPMHS, two transcripts in each round of interviews were also coded by an independent researcher, who met with the principal researcher to review and agree the two coding frameworks. The frameworks were then used to code the remaining transcripts. A computer software package, NVivo 8 (QSR International, 2008) was used from this phase onwards to allow the principal investigator to systematically collate and review data grouped within each code. Finally, data extracts were reviewed in order to identify whether codes require subdivision (Spencer et al. 2014). Data collated under more than one code were reviewed at this stage, and relationships between codes were identified.

Reach was assessed by calculating differences in receipt between professions. This was undertaken by assessing completion of the RKI and RAQ-7, and comparing those who received at least one training module to those who received all three training modules of the team recovery training, using the Chi-square test.

Mediating variables were assessed. First overall improvement in attitude (RAQ-7) and knowledge (RKI) following delivery of the training component of the OAR intervention was tested using a paired sample t-test. No adjustment for multiple testing was made, as each sub-scale was of interest, and the implications for each were different. (Cook and Farewell 1996, Perneger 1999). Linear regression was then used to test the impact of individual team and profession and upon RAQ-7 and RKI scores. The change score for each sub-scale was used as the dependent variable and baseline score, and team and professional group of the paired staff measures were the independent variables.

In light of these results, baseline measures were reviewed by professional group to ascertain if ceiling effects were present and the intraclass correlation (ICC) was calculated using a one-way variance of analysis (ANOVA) for the baseline scores and professional group.

Second, care plan audit results were reviewed. At the point of analysis, it became apparent that due to the methodology used for the care plan audit, inferential statistical analyses were not possible. This was because, the same service user records had been used in each plan audit, but only the overall total number of entries made for each area of responsibility had been recorded, and a record of each individual care plan entry had not been coded against the individual service user. Most service users had more than one care plan, and different entries in these could be coded in a number of areas for responsibility for action. This meant that inferential statistical could not be used because the service user (records) studied were not independent of each other over time, and nor were the individual care plan entries. Therefore a narrative summary of the results was undertaken.

Third, the preliminary results from the survey of service user experience were reviewed using informal thematic analysis

6.7.2 Objective 3 (Establish trial parameters)

Hypothesis-testing of the two hypotheses were met by undertaking a preliminary estimate of effectiveness of the OAR intervention on service user outcomes with data from Sub-study 2 (Comprehensive evaluation). The expected pattern of change was improved outcomes in arm 1 between baseline and T1, and in arm 2 between T1 and T2, as shown in Figure 6.4

Figure 6.4 Expected pattern of change

Comparison	Baseline to T1	T1 to T2
Arm1	Improved outcomes	Sustained change
Arm 2	No change	Improved outcomes

The analyses focused on comparison between baseline and change between time points. The design of the study as a cluster design was considered as part of the analysis strategy. This was because the unit of intervention was at team level and the unit of assessment was service user level. The CONSORT reporting guidelines on cluster RCT designs were reviewed, as concern is often expressed about the conduct and poor reporting of cluster RCTs (Campbell et al. 2004). Specifically, concern relates to lack of consideration given to clustering in the planning, recruitment of participants, analysis and reporting of trials. Clustering was incorporated in the analysis, but flow of recruitment and retention through clusters and impact of clustering on sample size was not assessed. Multi-level modelling was considered to account for clustering but the sample size and non-randomised design meant that this level of precision was not possible. The primary unit of analysis for service user and staff data remained at the individual level due to the size of the sample although cluster differences were explored as part of the primary analysis.

The hypotheses were assessed by calculating change between the two time points (baseline to T1, and T1 to T2) for the total IMR and DEMQOL scores, and for the two composite scores (PCS and MCS) of the SF-12. Differences in the pattern of change were assessed by applying a linear regression model, using the change score for each measure between time point, as the dependent variable and study arm and team as independent variables to assess the impact of each upon the outcome. To investigate the impact of clustering on the outcome, a one-way variance of analysis (ANOVA) was carried out for the overall pooled change score for each measure and used to calculate the intraclass correlation (ICC) for each.

In response to the results from the testing of the hypotheses, three post-hoc exploratory analyses were undertaken in order to generate new hypotheses. First, to test whether there was overall change in recovery and QoL outcomes for service user participants during the study period, change scores from baseline to T2 were calculated and tested using a paired samples t-test. Second, to test whether diagnosis impact upon outcome, change scores between baseline and T2 were calculated for participants with dementia and for those with functional mental health problems for the IMR which was the only measure used for all participants, and between-group differences were tested using an independent t-test. Finally, to investigate the impact of the training 'dose', care co-ordinators were categorised into Complete (received all three modules), Partial (received 1-2 modules) or None. This was included as an

independent variable in a linear regression on the change score from baseline to T2 for each measure.

The sample size was calculated as a post-hoc calculation using STATA 11. The IMR were used, as this included service users with both dementia and functional mental health problems. The Cohen's *d* was calculated using the results from Sub-study 2 (see Section 7.4.1) using the pooled mean change for the IMR from the paired samples t-test and dividing this by the standard deviation in order to obtain a standardised effect. The input parameters were the standardised effect size, significance level ($p < 0.05$), the power for a future definitive trial (90%), and an equal ratio between study arms (as opposed to the actual ratio between study arms achieved in Sub-study 2) in order to maximise efficiency using the `sampsi` command. The calculations were adjusted for the intraclass correlation (ICC) using the `sampclus` command.

Although statistical analyses does not have to be undertaken within a feasibility study, the use of inferential statistics allows for preliminary testing of the effectiveness of the intervention on service users (Objective 3.1 Hypothesis) and staff (Objective 1.4 Mediating variables). Given the lack of evidence about recovery interventions for staff working within OPMHS, it was decided that such data would enhance the optimisation of the intervention and as well as helping to establish future trial parameters. The decision to undertake statistical analysis was also justified given the numbers of staff who received part of the intervention ($n=204$) and service user participants recruited at baseline ($n=103$).

The results for the two sub-studies, Sub-study 1 (Staff outcomes) and Sub-study 2 (Comprehensive evaluation) will be presented in Chapter 7.

Chapter 7 Results from the OAR study

This chapter presents the findings from Sub-study 1 (Staff outcomes) and Sub-study 2 (Comprehensive evaluation).

7.1 Descriptives

7.1.1 Staff participants in Sub-study 1 (Staff outcomes)

The OAR intervention was delivered to 15 clinical teams in Sub-study 1 (Staff outcomes). Six of these teams were also involved in Sub-study 2 (Comprehensive evaluation). The total workforce of the 15 teams was 249 staff. Table 7.1 gives a description of participating team ordered by receipt of the OAR intervention.

Table 7.1 Team type, sub study, staff and receipt of intervention by team (n=15)

Team	Team type	Sub-study	Staff (n)	Team recovery training received by staff in each team		
				Complete (3 modules)	Partial (1-2 modules)	None
1	CMHT	1	16	11	1	4
2	CMHT	1	16	11	0	5
3	CMHT	1	14	4	1	9
4	CMHT	1	13	9	4	0
5	CMHT	1	13	5	3	5
6	In-patient	1	22	19	2	2
7	In-patient	1	22	18	2	2
8	CMHT	1 and 2	22	18	1	3
9	CMHT	1 and 2	15	6	5	4
10	In-patient	1	22	21	0	1
11	In-patient	1	23	23	0	0
12	CMHT	1 and 2	13	7	3	3
13	CMHT	1 and 2	13	8	2	3
14	CMHT	1 and 2	13	9	2	2
15	Memory	1 and 2	12	8	2	2
Total			249	177 (71%)	27 (11%)	45 (18%)

From an overall target group of 249 staff, 204 (82%) received all or part of the team recovery training component of the OAR intervention.

Receipt of the team recovery training component of the intervention by profession for the 204 staff participants is shown in Table 7.2.

Table 7.2 Receipt of training by profession

Profession	Received all/part of the training (%)	Received all of the training (%)	Received part of the training (%)
Art Therapy	1 (0)	1 (0)	0
Healthcare assistant	29 (14)	28 (16)	1 (3)
Nurse	91 (45)	80 (45)	11 (12)
Occupational therapist	21 (10)	18 (10)	3 (14)
Psychiatrist	13 (6)	8 (5)	5 (38)
Psychologist	10 (5)	8 (5)	2 (20)
Social Worker	16 (8)	14 (8)	2 (12)
Support worker	23 (11)	20 (11)	3 (13)
Total	204	177	27 (13)

Of the 204 staff who received all or part of the team recovery training, 177 (71%) staff received all of the training. 27 (13%) staff received part of the training (1-2 modules). The percentage of psychiatrists and psychologists receiving part of the training was higher than the rate for other professional groups, but this did not achieve statistical significance ($X^2= 9.05$, 6 df, $p= 0.17$).

Art therapy was removed from the subsequent analysis as there was only one staff member and anonymity could not be maintained. This reduced the number of staff participants analysed to 203, and the number of paired measures to 176.

7.1.2 Outcome in Sub-study 1 (Staff outcomes)

The mean scores for staff attitude (RAQ-7) and knowledge (RKI) before and after the team recovery training component of the OAR intervention are shown in Sub-study 1 are shown in Table 7.3

Table 7.3 RAQ-7 and RKI scores for Sub-study 1 (n=176)

Sub-scale	Pre-training (n=176)		Post-training (n=176)	
	mean (s.d.)	range	mean (s.d.)	range
RAQ-7 sub-scales				
1. Recovery is possible	15.78 (2.06)	9.00 – 20.00	16.27 (2.31)	7.00 – 20.00
2. Recovery is difficult	13.22 (1.41)	7.00 – 15.00	13.33 (1.39)	8.00 – 15.00
RKI sub-scales				
1. Roles	3.63 (0.67)	1.57 – 5.00	3.93 (0.65)	1.86 – 5.00
2. Non-linearity	2.70 (0.69)	1.17 – 4.67	2.92 (0.76)	1.33 – 5.00
3. Self-definition	3.89 (0.55)	1.80 – 5.00	4.15 (0.51)	2.20 – 5.00
4. Expectations	2.92 (0.88)	1.00 – 5.00	3.00 (0.95)	1.00 – 5.00

7.1.3 Staff participants for Sub-study 2 (Comprehensive evaluation)

Qualitative interviews were conducted with 12 staff participants in Sub-study 2, comprising six staff from arm 1 (immediate delivery) and six from arm 2 (delayed delivery).

Characteristics of the staff participants are shown in Table 7.4.

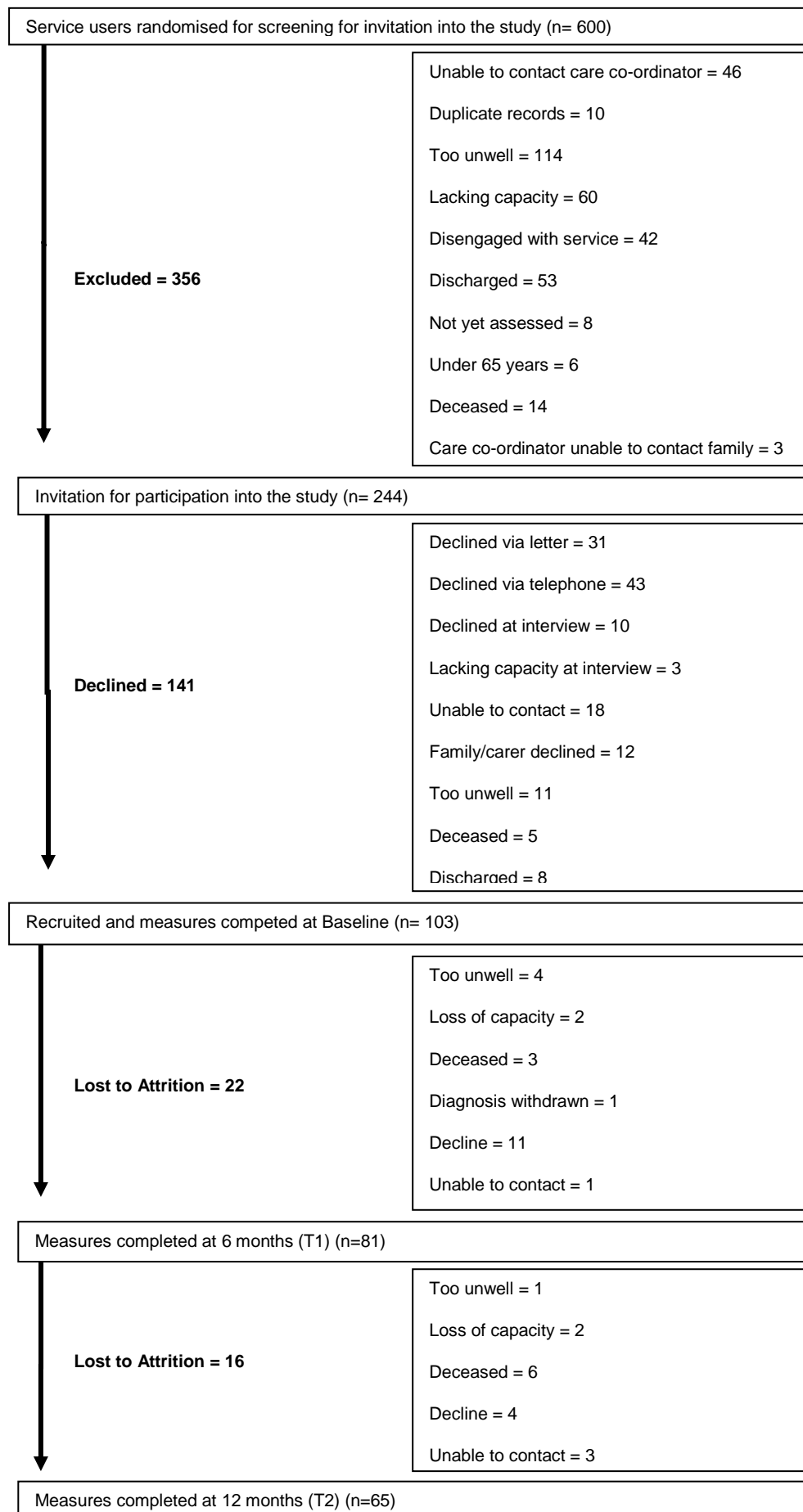
Table 7.4 Characteristics of Sub-study 2 staff participants (n=12)

	Type	n (%)
Professional group	Nurse	5 (41)
	Occupational therapist	3 (24)
	Psychiatrist	1 (9)
	Psychologist	1 (9)
	Social Worker	2 (17)
Gender	Female	8 (67)
	Male	4 (33)
Ethnicity	White – British	11 (91)
	White - Other	1 (9)

7.1.4 Service user participants in Sub-study 2 (Comprehensive evaluation)

600 service user participants were screened and 103 participants were recruited into Sub-study 2. The flow diagram for service user recruitment and retention is shown in Figure 7.1.

Figure 7.1 Flow diagram for service user participants in Sub-study 2



The overall retention rate at T2 was 65 (63%) of the 103 participants who completed baseline assessments.

Socio-demographic and clinical characteristics of service user participants are shown in Table 7.5.

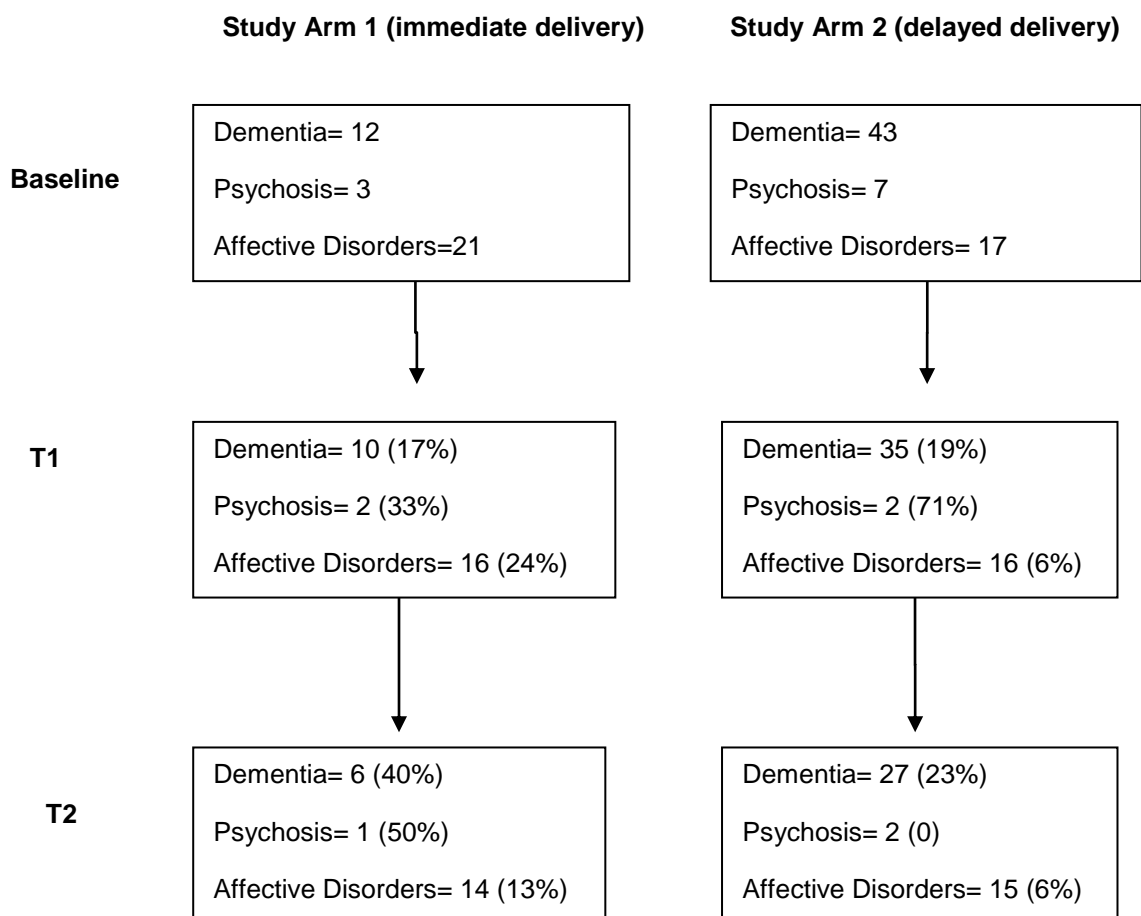
Table 7.5 Characteristics of Sub-study 2 service user participants (n=103)

Characteristic	Type	Number (%)
Gender	Female	67 (65)
	Male	36 (35)
Age	65 - 75 years	28 (27)
	76 - 85 years	54 (53)
	86 years +	21(20)
Ethnicity	White British	77 (75)
	White other	8 (8)
	Afro-Caribbean	12 (12)
	Asian	6 (6)
Marital Status	Married or co-habiting	45 (44)
	Divorced/separated	14 (14)
	Single	12 (12)
	Widowed	32 (31)
Living Situation	Own property	56 (54)
	Rented/social housing	16 (2)
	Sheltered housing	2 (2)
	Living with family/friends	8 (8)
	Residential care	14 (14)
	Other	7 (7)
Diagnosis	Dementia	55 (53)
	Psychosis	10 (10)
	Affective Disorders	38 (37)
Length of contact with mental health services	Less than 1 year	13 (13)
	1-5 Years	60 (58)
	6-10 Years	24 (23)
	10 Years +	6 (6)

7.1.5 Diagnostic spread of service users in Sub-study 2

Of the 103 service users recruited at baseline, the three diagnostic groups were dementia (n=55), affective disorders (n=38) and psychosis (n=10). A breakdown of attrition by each diagnostic group for each study arm is shown in Figure 7.2

Figure 7.2 Attrition by diagnostic group



Differences in attrition from baseline to T2 between study arms were not found to be significant ($X^2= 0.30$, 1 df, $p= 0.58$), and nor were differences in attrition between diagnostic group ($X^2= 4.34$, 2 df, $p= 0.11$).

7.1.6 Service user outcomes in Sub-study 2

The mean service user outcome scores for the IMR, DEMQOL and SF-12 for each study arm are shown in Table 7.6

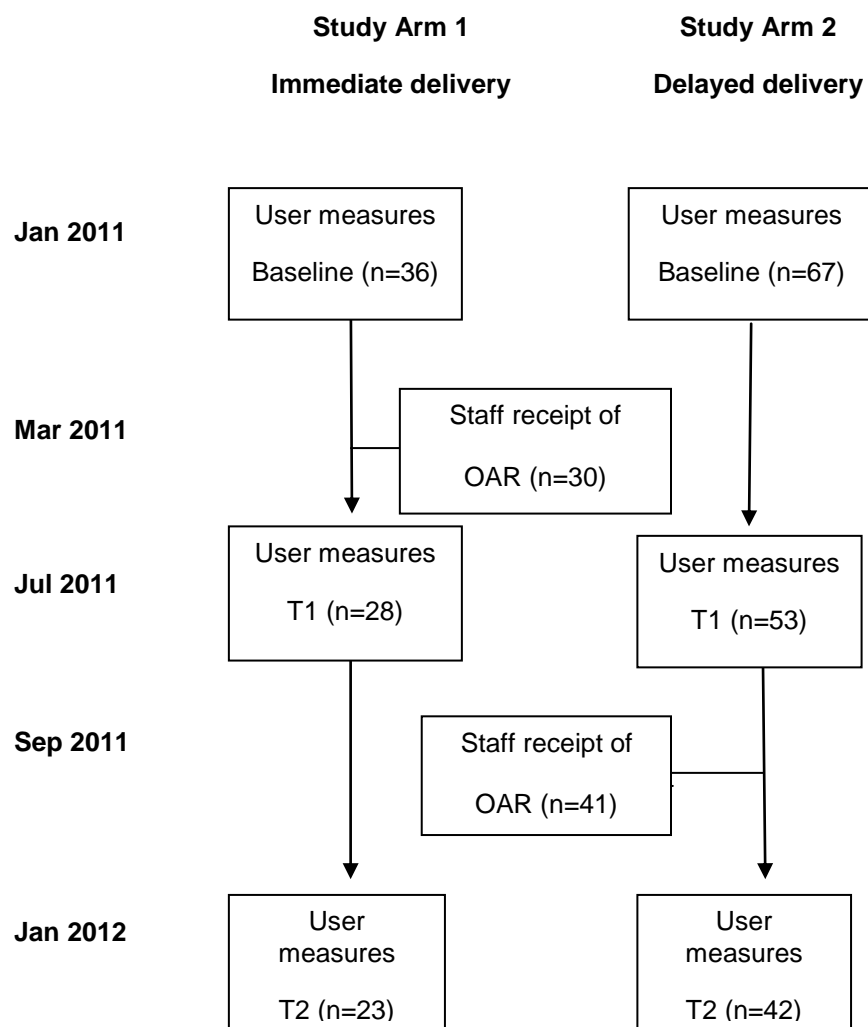
Table 7.6: Service user outcomes in Sub-study 2

Measure	Study Arm 1 (immediate delivery)			Mean (s.d) (n)	Study Arm 2 (delayed delivery)		
	Baseline	T1	T2		Baseline	T1	T2
IMR	45.30 (6.95) (n=36)	48.39 (6.21) (n=28)	49.35 (8.19) (n=23)		45.97 (5.69) (n=67)	46.65 (5.09) (n=53)	47.86 (6.59) (n=42)
DEMQOL	86.68 (7.13) (n=12)	84.95 (6.74) (n=10)	84.67 (19.10) (n=6)		93.27 (6.71) (n=42)	92.52 (11.17) (n=36)	97.11 (11.74) (n=27)
SF12: PCS	41.21 (9.61) (n=24)	41.72 (12.86) (n=18)	42.08 (12.54) (n=17)		41.63 (11.56) (n=25)	42.54 (12.60) (n=17)	39.01 (12.16) (n=15)
SF12: MCS	40.00 (13.95) (n=24)	47.37 (12.96) (n=18)	46.97 (10.99) (n=17)		40.46 (12.54) (n=25)	42.63 (17.97) (n=17)	44.78 (16.13) (n=15)

7.1.7 Participation in Sub-study 2

After 103 service users completed baseline measures, the OAR intervention was delivered to 30 staff in arm 1 (immediate delivery). Service user measures were completed at T1 (six months after baseline) by 81 service users across both study arms. The OAR intervention was then delivered to 41 staff in arm 2 (delayed delivery) and service user measures were completed at T2 (12 months after baseline) by 65 service users across both arms. The breakdown of measure completion rates by study arm is shown in Figure 7.3.

Figure 7.3 Completion rates by Study Arm



7.1.8 Sub-study 2: Care plan audit

The baseline care plan audit comprised 96 service user records in arm 1 (immediate delivery) and 232 in arm 2 (delayed delivery) in Sub-study 2 (Comprehensive evaluation). A breakdown of the number of service users and number of action points in total audited at each time point is provided in Table 7.7

Table 7.7 Number of service users and care plans entries in Sub-study 2

Audit number	Date	Arm 1 (immediate delivery)		Arm 2 (delayed delivery)	
		Number of service users	Number of action points	Number of service users	Number of action points
Wave 1	May 2010	96	419	232	748
Wave 2	Nov 2011	93	433	232	787
Wave 3	Mar 2011	OAR intervention			
	May 2011	96	484	232	860
Wave 4	Sep 2011			OAR intervention	
	Nov 2011	96	509	225	870
Wave 5	May 2012	95	524	177	762
Total			2369		4027

7.2 Objective 1 (Optimise the intervention)

7.2.1 Results for Objective 1.1 (Acceptability)

Five over-arching themes influencing acceptability were identified from the analysis of the qualitative interviews with staff and trainers, with a number of sub-themes identified only from the staff transcripts. An overview of the sub-themes and data sources is shown in Table 7.8.

Table 7.8 Overview of sub-themes influencing acceptability

Theme	Identified by staff and trainers	Identified by staff
Training dyad	Value of having a skilled service user trainer	High skill level of the trainers
	Fit between trainers and team	
Content	Challenge of training to a mixed group of professionals	Mixed opinion about the content
	Flexibility in delivery valued*	*Flexibility not achieved
		Length of the training and action planning day
Challenging assumptions	'We are doing recovery already'	Team culture
Team factors	Team culture	Pro-recovery team members
	Key individuals	
	Shifting the model of traditional mental healthcare	
	Lack of a team approach	
External influences/Timing	Change fatigue	
	Uncertainty about the future of the team	
	Job insecurity**	

*Mixed opinion between staff and trainers

**Only reported by trainers

Each theme is now described.

Theme 1: Training dyad

Both staff and staff trainers identified the **value of having a skilled service user trainer** co-facilitate the training. This increased both the perceived effectiveness and acceptability of the intervention. The sharing of personal experience of the service user, in relation to risk and risk management, was particularly beneficial. This consisted of more than simply retelling the experience, it involved the planned use of the specific experience in a targeted way to encourage reflection on current ways of working, and by doing so, invited recipients to identify implications for their own practice.

'What I found really useful on a personal level was thinking about risk and how we manage risk, and I think that worked really well in the training because we have X's (service user trainer) personal experience which was really powerful...because as a manager I've done serious incident reviews and it's always about we didn't do enough, and hearing X's experience of when she's been suicidal and how she was never, telling the service, telling clinicians is the last things she would do, which is quite powerful thing to hear because we always feel that we've sort of not done enough, not asked the right questions at the right time.' (No.1, Staff, Arm 1)

The **fit between trainers and team** was identified by both staff and trainers as having either a positive or negative impact upon acceptability. In two of the six teams, the relationship between the trainers and the team became strained. In these teams, both staff and trainers described a tense relationship, which became heightened on both sides when there were specific differences of opinion. This dynamic appeared to be linked with the themes of **challenging assumptions** and **team culture** and influenced the acceptability of the team recovery training for staff in these teams. Furthermore, detailed team (recovery) action plans and implementation support were not agreed by either team at the action planning day, reducing the potential for transfer of learning into practice.

'And that became more magnified as the days progressed so by the third day it did feel somewhat adversarial and I think there was a degree of detachment from the day...we never got past that disagreement' (No.3, Staff, Arm 1)

The **high skill level of trainers** was also made clear by staff participants, which included the ability to train, facilitate and resolve conflict, particularly in dealing constructively with issues when differences of opinion arose between the views of the trainers and those of, and between, team members.

'I think the trainers were both, very, very good, I've got a lot of respect for them both really.... There was nothing novice and unskilled about the way they were giving the training, they trained remarkably well. I think they both handled it both really, really well and really calmly and managed to kind of contain and be very open and respond quite well.' (No.4, Staff)

Theme 2: Content

Staff expressed **mixed opinion about the content** of the training component of the OAR intervention, principally due to the range of preferred learning styles within the staff group. For the majority of staff participants, the intervention was acceptable. For many, the components which were most highly valued were those which had some element of skill development and practice, in particular the exercises connected with risk management, coaching and life history work.

'And the life story work, I really enjoyed hearing about that, particularly thinking about where we are with the memory service, this is something that we can give people (service users) they could do work with their family, it's a really useful thing to learn about.' (No.1, Staff, Arm 1)

Conversely several staff participants stated that there should have been a stronger evidence or research base within the content of the training. In particular, it was also suggested that there could have been more linkage between the findings from the earlier qualitative studies within the local OPMHS (Chapters 4 and 5) and the content of the training to teams.

'I think it was clear what recovery meant as a concept and I think people began to feel frustrated when there was direct questions asked what was the evidence base and where had the models that were going to be used been developed from and those questions couldn't be answered... some people became somewhat overtly critical of the model that was being depicted because there wasn't evidence base for it and I think X (the trainers) could have got around that by talking about the wider recovery project.' (No.3, Staff, Arm 2)

The **length of the training and action planning day** (4 days) was identified as a concern by half of the staff participants. One participant queried whether it was necessary for all of the team to undertake the same amount of training.

'I can understand the reasons for it being team oriented. I take that on board but I have to weigh that against whether or not all of the team members needed to do such an extensive amount of training... there's the pressure of lots of other things.' (No, 2, Staff, Arm 1)

The theme of **flexibility in the delivery** of the content of the training arose with both staff and trainers, but there was disagreement as to whether this had taken place. Half of the staff participants suggested that there could have been more flexibility in the delivery of the content, rather than the trainers adhering to the trainers manual. This included the suggestion that the trainers should have spent more time on skill development when this was required, tailoring the training to the team context as well as ascertaining the experience in the room and previous training undertaken.

'There was lots of good stuff in the training, I think some of it could probably have been developed a little bit more, in some ways, for example, the bit about coaching...I think after we had that session people felt very confused about it still, kind of when they would use coaching and should they be using it all the time? Am I expected to go out and do this now? Would I do it all the time or when would I use it and when wouldn't I?' (No.6, Staff, Arm 2)

Conversely, the trainers considered that there had been sufficient flexibility in delivery of the training, and in particular, they perceived that they had tailored the training to individual teams as necessary.

'By the first half of the second day I felt 'they're not getting it.' So we changed it around a bit even though we did a live coaching session.... the package was just perfect, you just need to tailor it to the audience.' (No.3, Staff trainer, Arm 2)

The **challenge of training a mixed group of professions**, all at different grades and abilities was identified by both staff and trainers, and this appeared to be linked to the dissatisfaction about the context expressed by some staff. Staff participants expressed a concern that there was a tendency to pitch the training at a lower level, making it less attractive to certain staff groups, particularly psychiatrists.

'But it's very difficult when you've got a mixture of disciplines and grades and you know, you have got to be careful where you pitch it, you can't pitch it for the

consultant... I mean I really, I think a lot of the exercises we did on communication, I think are too basic. ' (No.3, Staff)

Whilst recognising the challenge of training a mixed group of professions, the trainers held a different outlook on this issue. They reported that more junior staff were generally more willing to learn and were more receptive to the training than senior staff.

'I've noticed that people like support workers were the ones that really, are wanting to learn whereas the further up (the hierarchy) it became harder to teach people.' (No 5, Service user trainer, Arm 2)

Theme 3: Challenging assumptions

The need for the trainers to challenge existing staff assumptions that **'We are doing recovery already'** was seen as an essential component of the training by both providers and recipients. The challenge of doing so without increasing defensiveness was identified by both staff and trainers. It was suggested by both staff and trainers that many staff commenced the training with a perception that they were already delivering recovery-oriented practice and that they did not need to undertake the training. In some teams, challenging existing assumptions did not appear to be problematic, although the need for trainers to recognise and explore existing good practice was suggested.

'I think there were a lot of people saying 'I already do that and I do this better than what you're telling me to do.' ...One of the social workers started saying 'oh this is our social work philosophy and this is where we come from and we're always doing this' and couldn't quite see where X (the trainer) was coming from and I think if we'd actually been able to spend more time expanding that, I think that would have helped.' (No.6, Staff, Arm 2)

In the two teams where the relationship between the trainers and the team had become strained, challenging of existing assumptions appeared to be experienced by some staff participants as a direct criticism of the team and/or of individuals.

'The other thing is I suppose about the recovery model is that I don't really think it is that different to the way that I already work, in lots of ways and I think that were assumptions that the trainers started with (that staff weren't recovery-oriented) which I found quite patronising. And I thought that's wrong.' (No.5, Staff, Arm 1)

An alternative view by several staff was that the perception of being criticised by the trainers was linked to a more general resistance to change evident in the culture of those individual teams, and that it was the team culture which enabled or hindered the opportunity for change to take place.

'The resistance was absolutely enormous and it was like 'this is best practice, this is what we do, why are you suggesting that there's a better way of doing it' and I thought 'just think about it...there is no harm in just exploring it' but we never got to that stage really... The fact is I don't think that, our team takes very well to being told how to change or it gets quite defensive about kind of thinking about ways they can change practice really.' (No.4, Staff, Arm 2)

Theme 4: Team factors

As mentioned, **team culture** (both positive and negative) was perceived as being influential in both the acceptance of the intervention, and also in terms of willingness to consider different ways of working.

'I think this is an innovative team, I think I have clinicians that are very keen on research, they're very keen on moving forward, they like challenging norms, they're very creative and they can see the benefits and things, they're not rigid in their thinking.' (No.2, Staff, Arm1)

'The over-riding group dynamic was negative and so you end up feeling very negative and exhausted like we did and drained.' (No.2, Service user trainer, Arm 1)

The wider implications of supporting recovery, and the challenge of **shifting the model of traditional mental healthcare** within teams, was identified by staff and trainers.

'But it is, it's like changing the whole ethos of the team in some ways because we work from a very medical model.' (No.6, Staff)

In all interviews, **key individuals** within the team were identified as being influential, both positively and negatively, in both enhancing acceptance of the intervention, and also in terms of willingness to consider different ways of working.

'But I do think X was very resistant to it. I think the problem is, is that the team groups with him. They don't like to part with him and so there's that pull, and if X says no, then they'll all go 'no'... so I think it felt that even people who were interested and wanted to, it didn't feel that they could, could embrace it because of that, all the negative influence.' (No.4, Staff, Arm 2)

Building on the theme of positive key individuals, the potential role of **pro-recovery team members** who had influenced attitudes and change beyond the training was identified by staff.

For me a real shift came, it was interesting, not in the training but something that X (a team colleague) said and I think it's probably because I respect X's views but when she joined the team she spoke about recovery and I said to her 'we do it already' and she said 'you'll be surprise how much we don't do' and then she talked about her own experiences at X (another NHS Trust with a pro-recovery culture) where service users are on interview panels. I thought yeah she's right...so I really do think there's something about champions within the teams rather than someone coming in and saying 'I'm your facilitator, how can we take this forward' because it's never owned by the team.' (No.1, Staff, Arm 1)

In arm 2 (delayed delivery), due to a team leader vacancy, a decision was made by the service manager for three of the teams to receive the first two components of the intervention (team recovery training and action planning day) as two mixed cohorts, rather than by individual team. Additionally, psychiatrists in these three teams did not attend the training or the action planning day. The **lack of a team approach** to the intervention was identified by staff and trainers as an issue affecting acceptability, and was perceived to have undermined the effectiveness of the intervention.

'I think I would have preferred it was just our team...it would have been better if it was just our team looking at more a team approach and what we do because there's quite different practices (across the three teams)... and the thing is that it's difficult to move a lot of things along when the doctors aren't on board isn't it, you know because they're such a you know a large group as well when they don't do stuff it does have an impact, and we do notice it in the team.' (No.6, Staff, Arm 2)

Theme 5: External influences/timing

A number of **external influences** were identified, which were perceived to influence the team and the response of the team to the training component of the OAR intervention. These all related to the **timing** of the intervention. Three participating teams were also involved in the locally implemented Productive Community Services programme (NHS Institute for Innovation 2006) which appeared to have led to **change fatigue**. The Productive Community Services programme was delivered to 10 of the 15 teams in Sub-study 1 (staff outcomes) and was identified within the pilot of the OAR intervention as a concern for staff, due to the need to respond to a number of competing priorities as well as the need for initiatives to be joined up as described in Section 5.6.2. However, for the three teams in Sub-study 2 who received the Productive Community programme, the impact appeared to be significant burden. Resentment was very clearly expressed in one of these teams prior to the OAR intervention, about having to engage in another change initiative. The challenge of making the Productive Community Services programme meaningful, which was a top-down initiative, was also identified. Concern was expressed that the OAR intervention would ultimately be experienced in the same way, namely as time consuming and not meaningful.

'I think you know for the team having gone through productives; I think we can't take that out of the mix. We were one of the pilot sites for productives. It made the team felt imposed upon rather than empowered. So I think then bringing in recovery as another thing on the back of it, was like hello again here's something else that we don't have any control over.' (No.1, Staff, Arm 1)

'I think it was just the way that the recovery training was set up, it came out at a really bad time for the team with the productives and people really hated the productives... There quite a lot of resentment (beforehand) you know. It wasn't just 'oh this is a bit of irritating... You know, I think that there was a tension brewing.' (No.5, Staff, Arm 1)

Apart from the pilot feedback from the one team who had received the Community Productive programme, it is not known whether staff from the teams in Sub-study 1 (staff outcomes) had a similar experience, or whether the concerns raised were specific to the three teams in Sub-study 2 (comprehensive evaluation).

For two teams, there was uncertainty about the **future of the team**, due to an imminent service change and to the departure of an established team leader. For these teams, the timing of OAR intervention was not acceptable.

'I also did try to express to X (the trainer) that this was a difficult time and an unfortunate time that giving the team had such concern regarding its own future. It felt, I think it felt that this wasn't the best time. The team didn't feel it was the best time.' (No.3, Staff, Arm 2)

At the time of the OAR intervention, three teams in arm 2 (delayed delivery) were involved in a service-wide consultation process affecting the way in which community services were delivered, as well as a reduction in the number of clinical roles for staff, which led to **job insecurity**. In these teams, the trainers perceived that this led to both cynicism about the underlying purpose of the OAR intervention and reluctance to actively engage. This theme was not identified in the staff interviews.

'(Staff believe that) if you work with people pro-actively in a recovery agenda and that actually you'll be doing yourself out of a job you know. 'If I reduce my caseload by doing what you're telling me to do' and that's the hidden agenda behind it (the team recovery training).' (No.5, Service user trainer, Arm 2)

Overall, opinion about the acceptability of the intervention was mixed. Components of the intervention which appeared to enhance acceptability included involvement of a service user trainer, the specific fit between trainers and team, and the skill level of the trainers. Components which appeared to decrease acceptability included the expectation of a team approach to delivery of the intervention (due to the perception of varying training needs of different professions) as well as a perception that the intervention was too lengthy and not sufficiently tailored to the needs of individual team. Additionally, the trainers not being able to challenge existing assumptions (about the degree to which team practice was recovery-oriented) was also identified as a barrier. Contextual factors influencing acceptability included team culture, the role of key individuals (positive and negative) within the team, and wider external influences impacting upon the timing of the intervention (change fatigue, and uncertainty about the future).

7.2.2 Results for Objective 1.2 (Reach)

Data for this objective came from Sub-study 1 (Staff outcomes). Out of 248 eligible staff, 176 (71%) received all three modules of the team recovery training component of the OAR intervention, and a further 27 (11%) received part of the team recovery training. Receipt of the team recovery training component of the OAR intervention by professional group was compared to overall workforce profile of eligible staff in Table 7.9.

Table 7.9 Receipt of team recovery training in Sub-Study 1 (n=203)

Profession	Staff who received training component of intervention (%)	Professional group of staff eligible for the intervention (%)	Reach for each professional group %
Nursing	120 (59)	138 (57)	87%
Occupational Therapist	21 (10)	25 (10)	84%
Psychiatrist	13 (6)	27 (10)	48%
Psychologist	10 (5)	14 (5)	71%
Social Worker	16 (8)	20 (8)	80%
Support Worker	23 (11)	24 (10)	96%
TOTAL	203	248	82%

With the exception of psychiatrists, receipt of the full team recovery training component of the OAR intervention was 70% or over for eligible staff, with four professional groups achieving over 80%. It is considered that the reach of the training component was adequate for all professional groups apart from psychiatrists.

7.2.3 Results for Objective 1.3 (Fidelity)

Data were collected in Sub-study 1 (Staff outcomes). Four aspects of fidelity were assessed: attendance, delivery of the intervention, obtaining team ownership, and delivery of the implementation strategy. A summary of the findings for each is shown in Table 7.10. A more detailed breakdown by team is shown in Appendix Q.

Table 7.10 Fidelity Assessment

Fidelity domain	Achieved	If no, proportion delivered / implemented
Attendance		
90% of the team to receive at least one training module	No	90% of staff in 5 teams (33%) received at least one training module
75% of the team to receive all of the training modules	No	75% of staff in 5 teams (33%) received all training modules
Delivery of the intervention		
All staff to receive training modules 1, 2, 3	No	93% of teams (n=14) received modules 1-3
All staff to receive training modules 1, 2 3 as a team	No	Only 53% of teams (n=8) received modules as a team
All training modules to be delivered as per manualised package	Yes	
All training to be delivered by a dyad of staff/service user trainer	Yes	
Obtaining Team Level Ownership:		
Team to identify three areas of practice	Yes	
Team to develop an action plan with objectives and timescales	No	60% of teams (n=9) developed a recovery action-plan
All teams to receive implementation support	No	60% of teams (n=9) received implementation support
Delivery of the implementation strategy		
Contracting meeting to take place with all team/ service managers and all teams to have briefing session	No	Contracting meeting with team and service in 93% of teams (n=14). All teams received briefing session
	Yes	
Service manager to attend the last part of the action planning day	No	Service manager attended day in 93% of teams (n=14)

The fidelity standards for attendance for the team recovery training were not met, with only 33% of teams achieving the standards set for receiving full and partial receipt of the team recovery training. However, there was variation in attendance levels with partial attendance ranging from 35% to 100%, and full attendance ranging from 28% to 100%. In-patient units obtained higher levels of attendance.

For delivery of the intervention, the majority (93%) of teams received all three modules of the training component of the OAR intervention, and all (100%) of the training was delivered as per the manual and by staff/service user dyads. Only 53% of teams received the intervention as a team, predominantly due to difficulties with staff release, leading to training being delivered to mixed cohorts of staff across several teams with separate team away days.

For team level ownership, all teams were able to identify areas of practice which they would like to change to become more recovery-oriented. Nine teams (60%) were able to agree team action plans with clear objectives and timescales, and nine teams (60%) received implementation support, which ranged from team reflective practice, to individual sessions with staff, to co-facilitation of recovery groups for service users. Only one of the teams in Sub-study 2 (Comprehensive evaluation) developed a team (recovery) action plan which was specific to their team and had clear objectives and timescales, and none of the teams (n=6) received implementation support, despite it being agreed as part of the action planning with four of these teams.

The recovery training facilitator was pro-active in following up implementation support with team leaders, however due to wider service changes and team leader vacancies it was not possible to deliver the planned support. No action was taken to enforce implementation support.

Overall, the standards for the implementation strategy were met, with pre-intervention briefing meetings taking place with all teams, and service management involvement in all teams (n=14) apart from one.

In summary, the OAR intervention was only partially delivered as planned. The delivery of the intervention and implementation strategy were fully achieved, with mixed levels of achievement for team level ownership intervention, and lower levels of achievement for attendance, team delivery and implementation support.

7.2.4 Results for Objective 1.4 (Mediating variables)

This objective sought to assess change on mediating variables described in the OAR model, shown in Section 5.9. The mediating variables were assessed from four sources: a) change in staff attitude (RAQ-7) and knowledge (RKI) pre-post training, b) care plan audit, c) survey of service user experience and d) implementation of team (recovery) action plans. Data for this objective were drawn from Sub-study 2 (comprehensive evaluation) for all areas apart from change in staff attitude and knowledge which was drawn from Sub-study 1 (staff outcomes).

Change in staff attitude (RAQ-7) and knowledge (RKI)

Changes in staff attitude (RAQ-7) and knowledge (RKI) from before training to the end of training are shown in Table 7.11.

Table 7.11 Pre-post training change in RAQ-7and RKI (n=176)

Sub-scales	Mean change (s.d.)*	Std Error Mean	95% Confidence Interval of Difference (Lower to Upper)	t	df	Sig. (2- tailed)
RAQ-7 sub-scales						
1. Recovery is possible	-0.48 (2.39)	0.18	-0.84 to -0.13	-2.67	175	0.01
2.Recovery is difficult	-0.12 (1.53)	0.11	-0.35 to 0.11	-1.03	175	0.30
RKI sub-scales						
1. Roles	-0.35 (0.62)	0.05	-0.44 to -0.25	-7.35	175	0.00
2. Non-linearity	-0.27 (0.58)	0.04	-0.36 to -0.18	-6.22	175	0.00
3.Self definition	-0.21 (0.58)	0.04	-0.30 to -0.13	-4.89	175	0.00
4. Expectations	-0.11 (0.93)	0.07	-0.25 to 0.03	-1.53	175	0.13

Negative scores show positive change, bold denotes p<0.05

There was a significant improvement for four of the six sub-scales.

Care plan audit

The care plan audit for study arm 1 (immediate delivery) is shown in Table 7.12.

Table 7.12 Care Plan Audit for arm 1 (immediate delivery)

Wave	1	2	OAR	3	4	5
Service users (n)	(96)	(93)	Number of entries (%)	(96)	(96)	(95)
Staff	301 (72)	319 (74)		373 (77)	405 (80)	388 (74)
Service user	12 (3)	23 (5)		25 (5)	33 (6)	32 (6)
Staff and Service user	30 (7)	19 (4)		12 (2)	12 (2)	18 (3)
Carer/Staff and Carer	10 (2)	21 (5)		10 (2)	9 (2)	9 (2)
Other	66 (16)	50 (11)		64 (13)	50 (10)	77(14)

In contrast to the intended reduction in the proportion of care plan entries with staff-only responsibility, the proportion was higher after delivery of the OAR intervention in study arm 1 (immediate delivery).

The care plan audit for Arm 2 (delayed delivery) is shown in Table 7.13

Table 7.13 Care Plan Audit for arm 2 (delayed delivery)

Wave	1	2	3	OAR	4	5
Service users (n)	(232)	(232)	(232)	Number of entries (%)	(225)	(177)
Staff	559 (75)	593 (75)	640 (74)		661 (76)	569 (75)
Service user	30 (4)	35 (4)	70 (8)		59 (7)	75 (9)
Staff and Service user	34 (5)	17 (2)	14 (2)		11 (1)	7 (1)
Carer/Staff and Carer	30 (4)	38 (5)	32 (4)		37 (5)	42 (6)
Other	95 (13)	104 (13)	104 (12)		102 (11)	79 (10)

In contrast to the intended reduction in the proportion of care plan entries with staff-only responsibility, the proportion was higher after delivery of the OAR intervention in study arm 2 (delayed delivery).

The intended changes in the overall trend of responsibility over time were not observed after delivery of the OAR intervention in either arm in this proxy measure of behavioural intent.

Service user experience

The service user experience questions were administered to all participants at baseline in Sub-study 2 (Comprehensive evaluation). Overall, they appeared to be limited in reliably gathering information about how care coordinators had worked with participants. Participants had difficulty in recalling information about the earlier part of their contact with mental health services. Additionally, the majority of participants did not recall safety concerns being discussed with them and the researchers were unable to ascertain whether this was because safety concerns did not exist, participants had

forgotten, or such discussions had not taken place. A summary of the responses to the questions for the first ten services users is shown in Table 7.14

Table 7.14 Summary of responses to questions on service user experience for Sub-study 2 (n=10)

Survey Questions: 'Did staff'?	Answers provided	(n)	Unable to answer (n)
Take time to find out more about how you were before you became unwell?	Discussion regarding history/ interests	(1)	(9)
Ask you how you have coped in the past with difficult and stressful events?	Nobody talks about my past	(2)	(8)
Ask you about the impact of your illness on you? And upon your life?	Prefer not to Staff talk about the present	(1) (1)	(8)
Ask you what helps you to take action to do something to manage your illness?	Spousal/Family Support Compensatory techniques Involvement in activities Good physical health/Eating well Positive attitude/Faith Living environment	(7) (4) (1) (2) (3) (1)	(0)
Make suggestions as to how you might manage your illness better?	Medication Information about resources No	(1) (2) (2)	(5)
Tell you about help or resources which might help you to manage your illness?	Information on resources No	(2) (2)	(6)
Discuss any safety concerns with you?	No	(10)	(0)

Overall, data from the questions were not reliable, nor did they add value to the process evaluation, and therefore a decision was made to discontinue their use.

Implementation of team (recovery) action plans

Team (recovery) action plans were developed during the team away day, following the identification of three areas of team practice/processes which team members wanted to take forward to implement within their teams. Only one team in Sub-Study 2 (Comprehensive evaluation) was able to develop an individual team (recovery) action plan with clear objectives and timescales. Three teams in arm 2 (delayed delivery) of Sub-study 2 developed a borough wide recovery action plan, one team developed a plan with no timescale or specific objectives and the remaining team did not develop an action plan. At the end of the OAR intervention period (four months post-training) team leaders were approached by the principal investigator, and asked to describe their progress on the implementation of these plans. No team in Sub-study 2 had implemented their (recovery) action plans. Lack of implementation was explored as part of the qualitative interviews in section 7.2.5.

Overall for sub-Objective 1.4 (Mediating variables), the results were mixed. The results for the paired samples t-test showed a positive statistically significant change for four of the six subscales: RAQ-7 sub-scale 1 (Recovery is possible), RKI sub-scales 1 (Roles), 2 (Non-linearity) and 3 (Self-definition). Results from the care plan audit showed no sustainable change in care planning practice following the OAR intervention. The service user experience questions were discontinued and therefore it was not possible to assess change in care delivery from a service user perspective. Finally, review of the team (recovery) action plans showed that within the five teams who had either a team or borough-wide plan, no implementation of the plan had taken place.

7.2.5 Results for Objective 1.5 (Context)

Data from two sources were used to evaluate this objective. First, qualitative interviews with staff to assess whether change in practice took place and to understand context factor influencing implementation. Second, further analysis of the measures of recovery

attitude (RAQ-7) and knowledge (RKI) was undertaken in order to ascertain factors influencing these outcomes.

Qualitative interview findings

Analysis of the qualitative interviews with staff in Sub-study 2 (Comprehensive evaluation) identified four themes: individual practice change, lack of team change, barriers to implementation and facilitators in changing practice.

Theme 1: Individual practice change

The majority of staff interviewed were able to identify areas of **individual practice change**, including care planning, communication with service users, therapeutic approach; specifically working more collaboratively with service users and in a less professionally boundaried manner, and focusing more on wellness.

'It's totally changed the way I do my care plan now. It's really changed. I've got a lady actually who I basically she's got a quite a long care plan but we did it, and she said to me, she said thank you X (participant's name) she said, you've really thought about what I said, it was about 14 different things but you know she obviously wanted them, she just felt she'd been heard as well.' (No.11, Arm 1)

'So what I do now is send one letter to the client and I copy it to the GP...it's got information in there that the GP needs to know, it's sent to the client, the client knows the GP is receiving a copy of that letter, it's got the information and words that the client said to me when I've done the feedback (of a diagnosis), it looks at the care plan and how they want things to be, so I think that is one thing that has really changed in my practice.' (No, 12, Arm 2)

Only one of the staff interviewed reported making no change to their own working practice following the recovery training.

'I haven't (worked differently) to be honest, I haven't thought about it.' (No.8, Arm 2)

Theme 2: Lack of team change

There was a perceived **lack of team change** towards a pro-recovery culture in all of the teams involved in Sub-study 2 (Comprehensive evaluation) and team (recovery) action plans had not been implemented.

'No not really....the way that we present to people for instance in, there is nothing wrong in the way that we present them (service users) but we present them as a problem really. (Within the team action plan) we wanted to begin to think about how to present as a person and then look at what had gone wrong. But we're still presenting in the same way.' (No.7, Arm 1)

The perceived lack of change was partly due to a lack of knowledge as to how other community staff might be working with their service users, which was reinforced by a reported lack of focus by the team on recovery and recovery-oriented practice following the training.

'I don't know how anyone is getting on with that (life history work) ... I wonder if anybody is doing the (well-being) care plans?' (No. 12, Arm 2)

Theme 3: Barriers to implementation

A number of **barriers to implementation** were identified, which were linked to the OAR intervention, internal team factors and the external environment.

Factors linked to the OAR intervention included **on-going resentment about the team recovery training**, and a preoccupation with some of some issues and concerns which arose during the training in the two teams where the relationship between the trainers and team became very strained.

'I think the general attitude about the whole recovery thing was really negative. The general view would be something that you know we were told we had to do, got no choice in that.' (No.8, Arm 1)

'I think in many ways it has split the team slightly, in that some people came away quite empowered from the training and some people didn't find the

training beneficial to them... it was not really taken very positively.’ (No.9, Arm 2)

As discussed in section 7.2.3, implementation support was not provided as intended to the six teams in Sub-study 2 following delivery of the team recovery training and action day. The **lack of specific focus on recovery**, and **lack of external implementation support** underpinned the lack of a shift towards a pro-recovery team culture.

No, there's been no mention of it (follow up of the team action plan). People can be quite cynical... so it would be nice to have an external person to kind of put it forward.’ (No.12, Arm 2)

The use of regular written and verbal communication about the wider research project was suggested, with reminders about the team action plans and specific practice implications, for example, such as the importance of doing life history work, would have been helpful in supporting teams to implement changes.

‘It would perhaps have been helpful to have updates on what you have learned so far,... and sending out emails or recovery newsletter or just a recovery update letter or something so that people know what you’re doing because we are at the centre of this (recovery development) aren’t we? You know it’s kind of ground breaking news.’ (No.12, Arm 2)

Internal team factors included **a lack of team leader support**, due to either the team leader not supporting or sanctioning the shift towards recovery-oriented practice, or vacant team leader posts in two teams in the four months following the team recovery training.

‘X (the team leader) didn’t really embrace the recovery training as much as I felt that myself and X (a colleague) did and I think to enable me to go on and make changes, I really needed to be supported by the team leader, being (as I am) in many ways one of the most junior people in the team as well.’ (No.9, Arm 2)

‘And someone to lead it you know because I think what’s happened in, certainly in this team, in the absence of a team leader, that you see the different professions, almost withdraw to their corner and ‘this is what I do’ and ‘I don’t

do that' and you know there is no one there coaxing them out of that.' (No.12, Arm 1)

In these same teams, the **pressure of time** was also a barrier to why a shift towards recovery-oriented practice could not be made, with staff doing only 'enough to get by' and having a lack of time to reflect on practice.

'(Staff) get bogged down in their caseload and their work, and it's time because (to do recovery) 'you've got to go out and spend another session with your service user and do a care plan.' (No.12, Arm 2)

The impact of **wider service changes** was identified as an important change barrier. A staff consultation paper on a proposed restructuring of community services was launched, which affected five of the six teams in Sub-study 2, and in particular the two teams in arm 1 (immediate start) in the six months after the team recovery training and action planning components of the intervention. A decision was made by the relevant service manager to stop the focus on recovery following the launch of the consultation paper, and the process was perceived by staff to have consumed their focus and energy during the six months following the training.

'I'm just trying to think because as a team, the training was really, really positive and we came up with some really good plans but all the changes (from the consultation) have become much more pressing.' (No.7, Arm 1)

'The day when we did action planning but it feels like some of those things that were discussed had to be put on hold in the environment that we're in, where everything has been restructured and how is that going to fit in with the way things are going in the team? I don't know at the moment because it just feels like for me it feels like everything's in flux with the consultation. I suppose when things are bedded down a bit, we can sort of revisit these things.' (No.11, Arm 1)

Implementing recovery-oriented practice was perceived to be separate to the proposed change to the way in which community services were delivered, and the possibility of considering how both potential agendas might interlink did not appear to have been considered.

The challenge of **shifting the model of traditional mental healthcare** at an individual and team level was also identified as a barrier.

'It's just habitual, 30 years of working in medical model isn't it, you know, knowing what's best for people and it is quite difficult to hold back and use another approach.. I think it will take a generation of clinicians to overcome because of the way that we are trained.... it's much harder in practice then it is in theory' (No.7, Arm 2)

Theme 4: Facilitators in changing practice

A number of **facilitators in changing practice** were identified. These included team ownership; specifically by maintaining a team focus and pro-recovery champions, as well as the fit with professional identity, and use of practice support tools.

The importance of on-going **team ownership** and **maintaining a team focus** on recovery and 'keeping it on the agenda' was stressed as facilitators to making pro-recovery team changes. In contrast to the view expressed in some of the interviews that external implementation support was required, others expressed an alternative view that the team needed to focus on the recovery agenda themselves. This involved the team taking regular time to focus or refocus on recovery, as well as the implementation of specific team focused recovery projects.

'I think have regular meetings, quarterly meetings, having designated time in multi-disciplinary team meeting to think about it, to reflect on the practice.'
(No.9, Arm 2)

A number of participants described the enthusiasm which existed following the training, and the need to 'hold' this motivation despite the delay caused by the proposed service changes. Delivering team-focused recovery projects was seen as a facilitator to this process.

'I think that all we have had is a bit of a time lapse isn't it and I still think that is work that is going to be carried out and as a team we are willing to do it. I think if we, I think if we get some buddy scheme (project identified in the action planning day) going I think that would really help. I think I'm really keen on that

idea...It came from the team. It really was a good recovery project and I think people wanted something good out of it.' (No.7, Arm 1)

Within the theme of team ownership, **pro-recovery champions** or named team members to take developments forward were seen as helpful to the process of implementation. The importance of these roles being taken by individuals with a genuine passion for recovery was stressed, and not the allocation of the role as another work task.

'You do need that follow up to take things forward because you know you get caught up in every piece of work that's going on...I think it would have driven things forward again, I think what we were looking for is for people to take responsibility in leading those areas so you know although it will affect the whole team then one person would be kind of linking with you (principal investigator), pushing it forward.' (No. 10, Arm 2)

'I became the 'life story' champion, and I said that I would support anybody that wanted to see a (collaborative) care plan, I can show them how to do it.' (No.12, Arm 2)

Practice support tools such as life history templates or well-being plans were seen as facilitators to implementing change towards a pro-recovery culture, as were the fit with the professional identity of certain professions, specifically occupational therapy and social workers.

Further analysis of recovery attitude (RAQ-7) and knowledge (RKI)

The impact of team and professional group member on the change scores in recovery attitude (RAQ-7) and knowledge (RKI) was investigated. Differences in the outcomes by team are shown in Appendix R and by professional group in Appendix S. For team, these showed that there was both positive and negative change by team for each of the six-subscales, with the exception of RKI Sub-scale 3 (Self-definition), whereby all teams moved in a positive direction. For professional group, all professions apart from social workers, showed positive changes in RAQ-7 Sub-scale 1 (Recovery is possible). For RAQ-7 Sub-scale 2 (Recovery is difficult) and RKI Sub-scale 4 (Expectations), three profession groups (psychiatrists, psychologists and social workers) moved in

negative direction. Change scores for the RKI Sub-scale 1 (Roles), 2 (Non-linearity) and 3 (Self-definition) moved in a positive direction for all professional groups.

To investigate the contribution of team and profession, linear regression models were applied to each of the two RAQ-7 and four RKI sub-scales. The linear regression for RAQ-7 Sub-scale 1 (Recovery is possible) change score is shown in Table 7.15.

Table 7.15 Linear regression for RAQ-7 Sub-scale 1 (Recovery is possible)

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	343.93 ^a	21	16.38	3.82	0.00
Intercept	243.90	1	243.89	56.91	0.00
Team	117.95	14	8.42	1.97	0.02
Profession	28.50	6	4.75	1.11	0.36
Pre RAQ-7 sub-scale 1	239.60	1	239.60	55.90	0.00
Error	660.02	154	4.29		
Total	1045.00	176			
Corrected Total	1003.95	175			

a. R Squared = .343 (Adjusted R Squared = .253)

Differences in the change scores for teams were significant in the outcome ($p= 0.02$) but not for professional group ($p=0.36$). The results for the Linear regression models for the other five are shown in Appendix T, and the results for all scales are summarised in Table 7.16

Table 7.16 Summary of the Linear regression models for RAQ-7 and RKI

Sub-scales	Profession	Team
	Sig.	Sig.
RAQ-7 Sub-scales		
1. Recovery is possible	0.36	0.02
2.Recovery is difficult	0.02	0.38
RKI Sub-scales		
1. Roles	0.00	0.19
2. Non-linearity	0.01	0.93
3.Self definition	0.04	0.53
4. Expectations	0.31	0.87

bold denotes p<0.05

Overall, there was some influence of team and especially profession on change in knowledge and attitudes.

Given the impact of profession upon outcome, baseline mean scores by profession were summarised in Table 7.17

Table 7.17 Mean scores between professions at baseline

Measure	Healthcare assistant	Nurse	Occupational Therapist	Psychiatrist	Psychologist	Social Worker	Support Worker
Sub-scales	(n=29)	(n=90)	(n=21)	(n=14)	(n=10)	(n=16)	(n=23)
Mean (s.d)							
RAQ-7							
1) Recovery is possible	15.52 (1.43)	15.83 (2.17)	16.71 (2.22)	15.50 (2.53)	16.90 (1.37)	15.50 (1.90)	14.96 (1.85)
2) Recovery is difficult	12.48 (1.94)	13.27 (1.40)	13.67 (1.06)	13.64 (1.08)	13.90 (0.99)	12.94 (1.12)	13.17 (1.11)
RKI							
1) Roles	3.19 (0.63)	3.63 (0.65)	4.12 (0.67)	3.84 (0.36)	4.28 (0.39)	3.72 (0.52)	3.24 (0.59)
2) Non-linearity	2.29 (0.63)	2.70 (0.64)	3.41 (0.73)	2.75 (0.40)	3.05 (0.61)	2.71 (0.56)	2.34 (0.57)
3) Self definition	3.81 (0.55)	3.89 (0.60)	4.22 (0.60)	3.83 (0.52)	3.72 (0.56)	3.83 (0.44)	3.93 (0.48)
4) Expectations	2.59 (0.81)	3.02 (0.93)	3.10 (0.92)	3.11 (0.74)	3.30 (0.67)	2.94 (0.63)	2.48 (0.83)

Whilst the scores are towards the high end of the range for all of the sub-scales (RAQ-7 range 4-20 for sub-scale 1 and 3-15 for sub-scale 2, and 1-5 for all of the RKI sub-scales), ceiling effects are not reached.

The intraclass correlation (ICC) was calculated for all sub-scales using baseline scores and professional group. The ICC for the RAQ-7 Subscale 1 (Recovery is possible) was 0.67 and for Subscale 2 (Recovery is difficult) was 0.72. For the RKI, the ICC for Subscale 1 (Roles) was 0.89, for Subscale 2 (Non-linearity) was 0.89, for Subscale 3 (Self-definition) was 0.60 and for Subscale 4 (Expectations) was 0.72. These results show that there was moderate to high level of homogeneity of the baseline level of recovery knowledge and attitude within professional groups.

Overall, in terms of context, the qualitative interviews suggested some change in practice at individual but not team level. Context barriers included on-going resentment about the team recovery training, the lack of specific focus on recovery, in particular external implementation support, the lack of team leader support, and the impact of wider service changes. Positive influences on implementation included team ownership, maintaining team focus on recovery and pro-recovery champions. There appeared to be consistency in levels of recovery knowledge and attitude before training by professional group. Professional group membership appeared to be a factor in the acquisition of recovery knowledge, and team membership had some impact upon attitude, but not upon recovery knowledge.

7.3 Results for Objective 2 (Optimise the evaluation)

There were two components to this research objective: testing the feasibility of the measures, and assessing the evaluation strategy.

7.3.1 Results for Objective 2.1 (Measures)

Each of the five measures was assessed for feasibility. The IMR was observed to be straightforward and quick to administer, however a number of issues arose with regard to seven of the 15 items. These are summarised in Table 7.18.

Table 7.18 Summary of issues with the IMR

IMR item	No	Issues
Personal goals	1	Question did not appear to be fully understood by all of the participants, regardless of diagnosis, even when the question was rephrased, for example 'are there things which you are working towards' or 'would like to be doing?'
Involvement in self-help activities	12	It was difficult to assess whether day-centres, which a number of participants were using, constituted a self-help activity. Day-centres form part of statutory service provision, and attendance can be staff rather than service user initiated. For some participants, it was evident that day-centres formed part of their coping mechanisms whereas for others, day centre attendance appeared to provide respite for carers
Relapse prevention	8	Led to confusion for participants with dementia as relapse is not relevant to the experience of dementia, and therefore a decision was also made to stop asking this question to participants with dementia and to use a total score of 13 items instead of 15
Relapse of symptoms	9	
Symptom distress	6	Required awareness by the participants of their mental health difficulties. The majority of participants with psychosis and those with more advanced dementia (observed as being 17 out of the 55 participants with dementia at baseline)
Impairment of function	7	appeared to have anosognosia and tended to deny any difficulties, casting doubt as to the reliability of their responses. For some participants with dementia, where carers were present at the time of the interview, several carers would either openly disagree with the participant's response or shake their head covertly in disagreement to the researchers
Coping	11	

Additionally, a number of participants and their carers commented negatively on the word 'recovery' in relation to the IMR scales. In response, the researchers provided a definition of the term, recovery as used within this thesis, and it was appeared that the word 'recovery' was problematic for both service users and carers.

For service users, the term was seen as either too simplistic and not fully representing their experiences, or of not having resonance.

'With the word 'recovery', there is the basic association with it, is that you had a really bad attack of swine flu and you had the correct antibiotics and you recovered and you are now wandering around still the person you were before you had swine flu and for me mental health problems don't work like that.....you just have to learn how to live with them and manage them.' (Service user, bipolar disorder)

Many of the carers interpreted the term as meaning a complete cure of the dementia, despite an alternative description of recovery, as used within this thesis, being provided.

"I don't think anybody can recover from the dementia can they?" (Carer)

There was however little disagreement among participants and their carers with the underpinning principles of recovery-oriented practice, particularly maintaining identity.

The most recent clinically-recorded rating for the Standardised Mini Mental State Examination (SMMSE) (Folstein et al. 1975) for the 17 participants with anosognosia showed a range of ratings, from mild to severe dementia. It was therefore not clear as to which point during the trajectory of dementia that use of the IMR might not be suitable.

The DEMQOL was easy and quick to administer, particularly for participants with mild dementia, for whom the rating scale (a lot, quite a bit, a little and not at all) appeared to be easy to understand. However the issues relating to anosognosia, discussed in relation to the IMR also applied. This fits with the limitation identified by the authors of the measure that performance of the measure for people with advanced dementia required further testing (Smith et al. 2007).

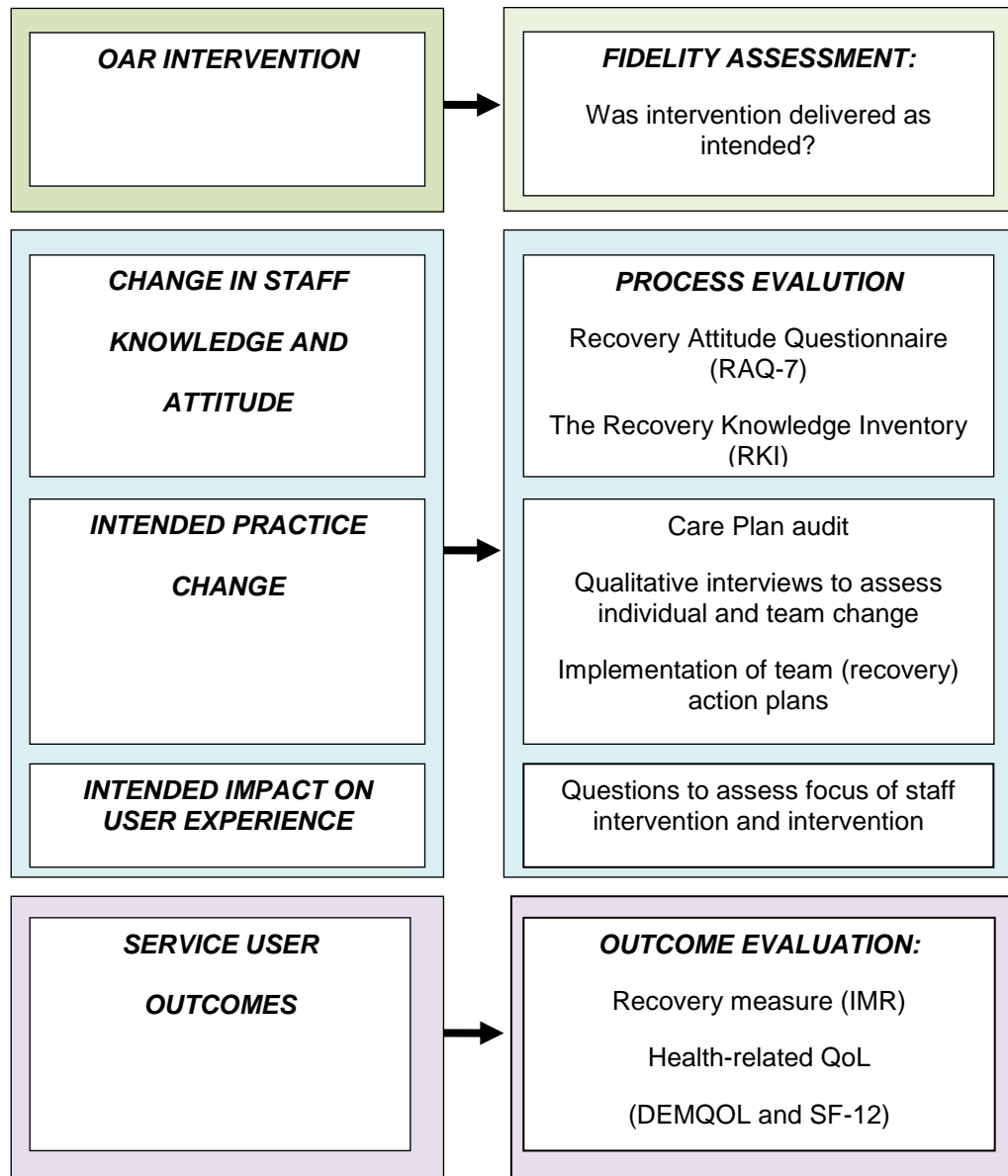
The SF-12, RAQ-7, and RKI were all straightforward and swift to administer, and no specific issues were identified by fieldwork observation with completion.

In summary, the fit of the IMR for older people was problematic, as well as the language. Furthermore both the IMR and DEMQOL appeared unreliable for participants with dementia who lacked awareness of their difficulties. The SF12, RAQ-7 and RKI all proved to be satisfactory.

7.3.2 Results for Objective 2.2 (Evaluation)

In assessing the efficacy of the evaluation strategy, it is useful to review the design of the strategy in light of the OAR model, which is provided in Figure 7.4

Figure 7.4 OAR Model and evaluation strategy



The evaluation strategy has three elements: fidelity assessment, process evaluation and outcome evaluation.

Approach to fidelity assessment

The fidelity assessment was undertaken as intended, and reliance on trainer feedback was identified as a potential issue. Two areas of omission in the fidelity checklist were identified: numbers of staff attending the action planning days and the content of and number of staff receiving implementation support.

Approach to process evaluation

The process evaluation sought to assess whether change took place in mediating variables as intended: change in staff knowledge and attitude, practice change and service user experience.

- 1) Staff knowledge and attitude change was assessed by completion of measures before and after the team recovery training component of the OAR intervention. Whilst these were acceptable to participants, assessment of sustained knowledge and attitude change later in the study was not undertaken.
- 2) Intended practice change was assessed by the completion of a care plan audit, by qualitative interviews and review of team (recovery) action plans. The methodology of the care plan audit was problematic and review of this element is indicated. Qualitative interviews and review of team (recovery) action plans were carried out, and no issues were identified with their completion.
- 3) The final component of the process evaluation was change in service user experience. As no alternative measures were identified which were suitable to older people, a number of questions were designed, but not piloted before Sub-study 2 (Comprehensive evaluation). As discussed in section 7.2.4, the questions did not perform well and their use was discontinued. The lack of a measure of service user experience meant that it was not possible to assess whether change in practice did take place, and review of this element of the evaluation strategy is needed.

Approach to outcome evaluation

In addition to the issues relating to the measures discussed earlier in this section, the cluster design of the study proved problematic in terms of variance in receipt of the intervention. Whilst the OAR intervention was found to have reached its target

population of staff with Sub-study 1 (Staff outcomes) with 73% of the target population receiving all of the training component of the intervention (section 7.1.1), lower levels of reach were achieved within Sub-study 2 (Comprehensive evaluation), with 64% of the target population receiving all of the training component of the OAR intervention. A breakdown of receipt of training for the two study arms is shown in Table 7.19.

Table 7.19 Receipt of intervention by eligible staff in Sub-study 2 (n=88)

Study Arm	Eligible Staff	Receipt of team recovery training		
		Complete	Partial	None
1 (immediate delivery)	37	24	6	7
2 (delayed delivery)	51	32	9	10
TOTAL	88	56	15	17

Of the 103 service user participants participating in the study, 39 (38%) had care co-ordinators who received the full training component of the intervention, 43 (42%) had care co-ordinators who received part of the intervention and 21 (20%) had care co-ordinators who received none of the intervention. Additionally, the follow-up rate for service users in the evaluation was lower than hoped, with only 63% of service users remaining in the study. As the unit of allocation (of the intervention) and unit of assessment differ, review of this element of the evaluation strategy is indicated.

Overall, the feasibility of the evaluation strategy was mixed, as summarised in Table 7.20.

Table 7.20 Summary of review of evaluation strategy

Domain	How successful
Fidelity	Fidelity assessment was satisfactory however reliance on trainer feedback brings potential bias. Details of action planning day and implementation support needed
Process	Assessment of change in staff knowledge and attitude was satisfactory, however assessment of sustained knowledge and attitude change was not undertaken Qualitative interviews and review of team (recovery) action plans to assess practice change were satisfactory. Methodology used for the care plan audit was problematic Change in service user experience was assessed by questions developed for the study. Questions were not suitable and their use was discontinued. This resulted in an inability to assess whether change in practice took place
Outcome	Design problematic due to difference between number of staff receiving intervention and the number of service users recruited and loss to follow up

7.4 Results for Objective 3 (Establish the trial parameters)

There were four components to this research objective: testing the hypotheses, sample size calculation, identifying an optimal recruitment and retention strategy. All of the data was drawn from Sub-study 2 (Comprehensive evaluation).

7.4.1 Results for Objective 3.1 (Hypotheses)

To test the hypotheses change between each time point for each measure was calculated. The expected pattern of change was improved outcomes in arm 1 between baseline and T1, and in arm 2 between T1 and T2. A linear regression model was applied to test the impact of study arm and team (cluster) upon the pattern of change. The results are shown in Table 7.21.

Table 7.21 Change between time points for each study arm

Outcome	Comparison	Arm 1 (immediate delivery)		Arm 2 (delayed delivery)		Linear Regression		
		<i>n</i>	Mean change (s.d)	<i>n</i>	Mean change (s.d)	Mean difference	Arm (Sig.)	Team (Sig.)
IMR	Baseline to T1	28	2.55 (7.13)	53	0.83 (4.97)	1.72	0.47	0.32
	T1 to T2	23	1.17 (4.69)	42	0.88 (4.61)	0.30	0.92	0.88
DEMQOL	Baseline to T1	10	-2.86 (17.07)	36	-1.17 (11.11)	-1.69	0.08	0.06
	T1 to T2	6	-1.55 (12.10)	27	3.74 (8.24)	-5.29	0.30	0.44
SF-12: PCS	Baseline to T1	18	0.62 (9.92)	17	2.21 (9.11)	-1.59	0.17	0.19
	T1 to T2	16	2.42 (10.92)	15	-3.61 (7.28)	6.03	0.54	0.69
SF-12: MCS	Baseline to T1	18	6.17 (11.66)	17	3.96 (15.39)	2.21	0.90	0.95
	T1 - T2	16	1.15 (13.55)	15	1.82 (11.55)	-0.66	0.56	0.55

The expected pattern of change of improved outcomes in arm 1 between baseline and T1, and in arm 2 between T1 and T2 was not observed, and the impact of study arm and team (cluster) was not significant in any of the outcomes. The high standard deviation was noted. The hypotheses that the OAR intervention would lead to improved recovery and QoL for users of OPMHS were not confirmed.

The intraclass correlation (ICC) was calculated on all measures, using outcomes between baseline and T2. The ICC for the IMR was 0.45, for the DEMQOL it was 0.63 and it was 0.66 for both composite scores of the SF-12.

To generate hypotheses for future investigation, three further exploratory analyses were undertaken.

First, to investigate the overall impact of the OAR intervention, data from arm 1 (immediate delivery) and arm 2 (delayed delivery) were pooled for baseline and T2 ratings. Differences in changes scores are shown in Table 7.22.

Table 7.22 Change in pooled outcomes between baseline and T2

Measure	Number	Mean change (s.d.)*	Std Error Mean	95% Confidence Interval of Difference (Lower to Upper)	t	df	Sig. (2-tailed)
IMR	65	-2.20 (6.42)	0.80	-3.79 to - 0.61	-2.76	64	0.00
DEMQOL	33	-1.43 (14.50)	2.52	-6.57 to 3.71	-0.57	32	0.57
SF-12 (PCS)	31	-0.97 (9.41)	1.69	-4.42 to 2.48	-0.57	30	0.57
SF-12 (MCS)	31	-5.61 (13.32)	2.39	-10.50 to -0.73	-2.34	30	0.02

*Negative scores show beneficial change, bold denotes p<0.05

Overall, outcomes improved over a 12 month period in two of the four measures, IMR and SF-12 (MCS), which demonstrated a change in outcomes during the period of Sub-study 2 (Comprehensive evaluation) regardless of the timing of the intervention.

Second, to explore the influence of diagnosis on responsiveness to the OAR intervention, the IMR ratings (the only measure administered to all participants) were compared between service users with a functional and an organic diagnosis, as shown in Table 7.23.

Table 7.23 Difference in IMR change scores by diagnostic group

Diagnosis (n)	Change score mean (s.d)	t	Df	Sig. (2-tailed)	Mean difference	95% CI of the difference
Organic (34)	-0.11 (4.97)					-
		-3.25	63	0.00	-4.84	-7.81 to -1.87
Functional (31)	4.73 (6.93)					

***Bold denotes <0.05**

Diagnosis influenced outcome. Differences in change scores between diagnostic groups were significant between baseline and T2, with participants with a functional diagnosis showing a higher level of recovery than participants with dementia.

Third, to investigate the impact of dose (level of receipt of training), linear regression models were estimated for all outcomes measures with dose (defined as level of receipt of the team recovery component of the intervention) as a covariate. The influence of dose on the DEMQOL change score between baseline and T2 is shown in Table 7.24.

Table 7.24 Impact of training dose on DEMQOL (n=33)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1013.47 ^a	1	1013.47	5.49	0.03
Intercept	863.76	1	863.76	4.68	0.04
Dose	1013.47	1	1013.47	5.49	0.03
Error	5719.00	31	184.48		
Total	6799.84	33			
Corrected Total	6732.48	32			

a. R Squared = .151 (Adjusted R Squared = .123)

Dose was an influence on change in DEMQOL between baseline and T2 ($p=0.03$). Dose was not significant in the other outcomes (Appendix V).

The hypotheses were not confirmed, and whilst there was an overall improvement in two of the four measures, IMR and SF-12 (MCS) at the end of the study, in investigating other possible candidate mediators in outcome, only diagnosis had an effect on outcome on the IMR and dose (receipt of team recovery training) on the DEMQOL. Team (cluster) differences were not observed to be significant in any of the analyses.

7.4.2 Results for Objective 3.2 (Sample size calculation)

The Cohen's d standardised effect size calculated from the overall change for the IMR Scale (shown in Table 7.22) was 0.3 and the ICC was 0.45. The overall sample size for a future randomised-controlled trial with the IMR as the primary outcome and power 90% and $p<0.05$ would therefore be 2132 participants (1,066 per arm) from 41 clusters (teams) each providing 52 service users participants.

7.4.3 Results for Objective 3.3 (Recruitment)

Recruitment of staff for the intervention has been addressed in section 7.2.2.

Service user recruitment for the evaluation was lower than planned. 103 service users were recruited into Sub-study 2 (Comprehensive evaluation) and the target of 150 service users was not achieved.

Recruitment involved sending out letters of invitation following care co-ordinator discussion and approval, which led to two barriers within the recruitment process

First, the care co-ordinators of 46 potential participants were unwilling to meet with the researchers, and the reasons for this were not clear. Second, there appeared to be considerable variation in care coordinator decision making as to which of their service users fitted the inclusion criteria, particularly as to whether service users with dementia had mental capacity, with some staff more willing than others to encourage participation. Overall, 60 potential service user participants were excluded due to a staff-rated lack of capacity, which the researchers were unable to verify. Additionally, some care co-ordinators also introduced one further category of 'not being engaged with services' as a reason for non-invitation to 42 service users as well as a desire to discuss involvement with family members before giving care co-ordinator approval, which in three cases was not undertaken in time to allow for recruitment.

7.4.4 Results for Objective 3.4 (Retention)

Retention for staff in the intervention was addressed in section 7.2.2.

Overall the follow-up rate for service users in the evaluation was lower than anticipated. 65 (63%) service users remained in the study, as shown in Figure 7.1 which was lower than expected (90%).

There was a higher rate of follow up for service user participants with affective disorders (76%) compared to those with dementia (60%) and psychosis (30%) as shown in Figure 7.2. However, these differences were not significant. Additionally, no significant difference in attrition between study arms was found.

Ten participants with psychosis were recruited to the study and their loss to follow up related primarily to reluctance to remain in the study. For participants with dementia, lack of follow up was predominantly linked to increased severity with consequent loss of capacity (n=4), and movement out of the area into residential placement (n=4). Over the 12 months of data collection, 14 (13%) of the service user participants died.

No other factors were identified as impacting upon attrition.

This chapter has provided the results of the two Sub-studies, measured against the three research objectives. The strengths, limitations and implications of these findings will be discussed in Chapter 8, along with a discussion of the overall thesis.

Chapter 8 Discussion

This chapter brings together and discusses critically the main findings arising from the OAR study and synthesises these with those from the programme of research as a whole described in this thesis. The contribution to the evidence base of recovery will be presented and discussed including the strengths and limitations of the research, and overall scientific and clinical implications.

8.1 Thesis findings

Qualitative interviews with 28 service users and 10 carers using grounded theory methodology were described in Chapter 3. They were used to develop a conceptual framework for the experience of recovery for older people with mental health problems, and a linked framework for people with dementia. Key similarities with, and differences from the experience of recovery in adults of working age were identified. These included: the impact of illness, the significance of personal responsibility, and specific coping strategies. Key differences for older people included: the prominence of an established and permanent sense of identity, continuity of social networks, valued roles and activities as both coping strategies, and mechanisms to reinforce identity. Additional areas of difference for people with dementia related to the stage of illness, and the role of carers in facilitating opportunities for recovery to take place. The participant profile within the study was intentionally broad, which means that more in-depth exploration about the experience of recovery for specific groups of service users, for example, those with a recent diagnosis of early dementia, did not take place. It is suggested that differences in the experience of recovery for different groups of users of OPMHS should be explored

Chapter 4 reports three focus groups with service users, carers and staff which identified the clinical practice implications for staff working in OPMHS. The conceptual framework of recovery for older people, and the linked framework for people with dementia were used to explore working practices which might support recovery. These included the need for understanding about recovery and how it applies to older people, as well as the deployment of identity supporting and resilience enhancing behaviours by staff. It is however suggested that identification and evaluation of practice implications for specific groups of service users, eg those with early dementia should be explored.

Building on these studies, a preliminary OAR model was developed in Chapter 5, made up of a team-based recovery intervention and goals for that intervention. The final OAR model was generated along with supporting implementation and evaluation strategies following a pilot with two clinical teams.

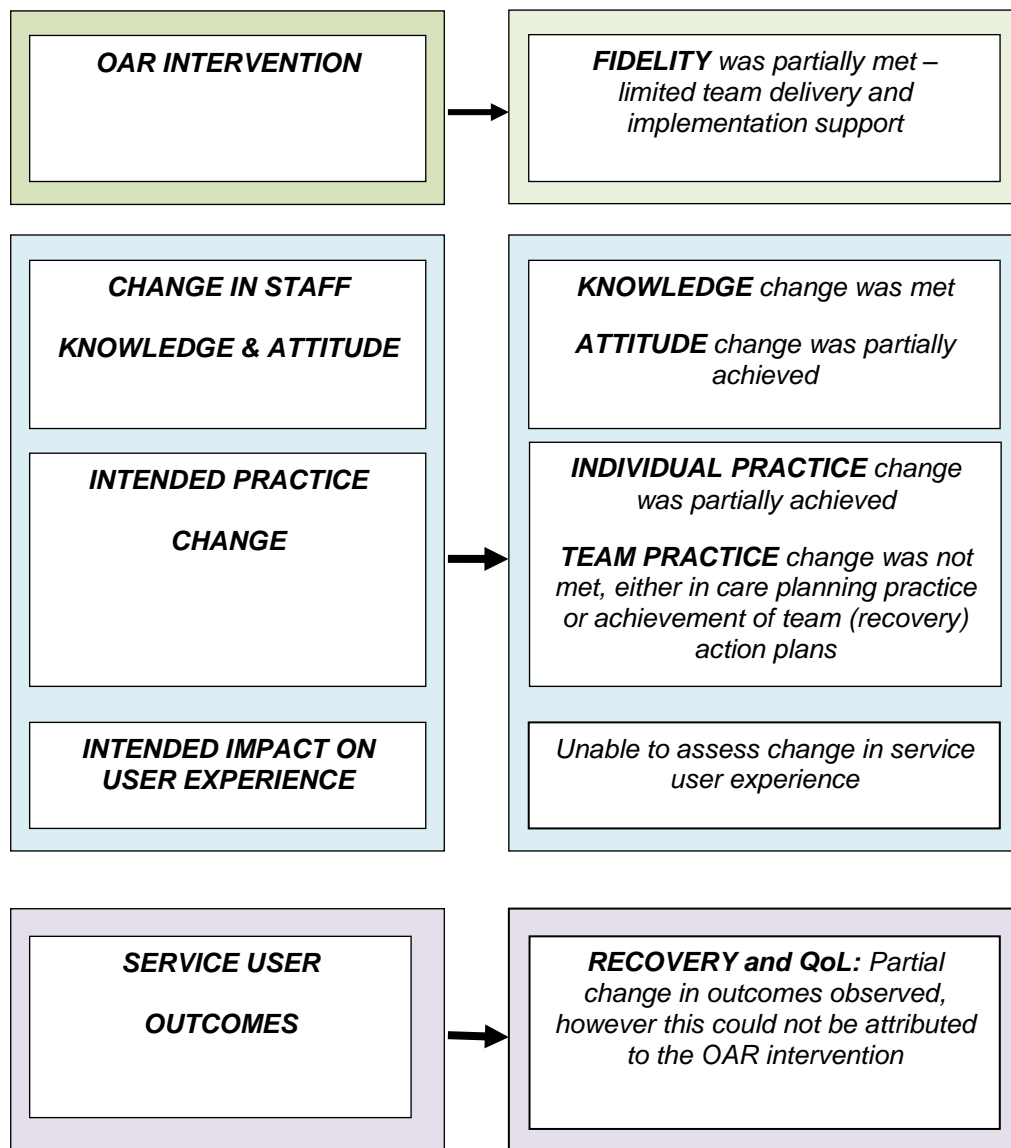
Chapters 6 and 7 described the evaluation of the OAR intervention in 15 clinical teams. The findings in relation to each of the three research objectives are discussed as follows.

8.1.1 OAR Study: Research Objective 1 (Optimise the intervention)

Overall, the mediating variables described in the OAR model, as shown in Section 5.9 did not change consistently following the OAR intervention. Implementation appeared to be limited at an early stage by attitude only partially being influenced. The impact of the intervention appeared to be limited to individual change rather than wider team level change.

There was some evidence of change in knowledge and attitudes immediately following the training, but this did not lead to behaviour change (as audited in care plans) or longer-term engagement in the later stages of the intervention. The OAR model broke down at the behavioural intent phase – what in the OAR Model is called the Intended Practice change element. The findings show that greater attention needs to be focused on supporting and sustaining behaviour change. The validation of the OAR model is summarised in Figure 8.1.

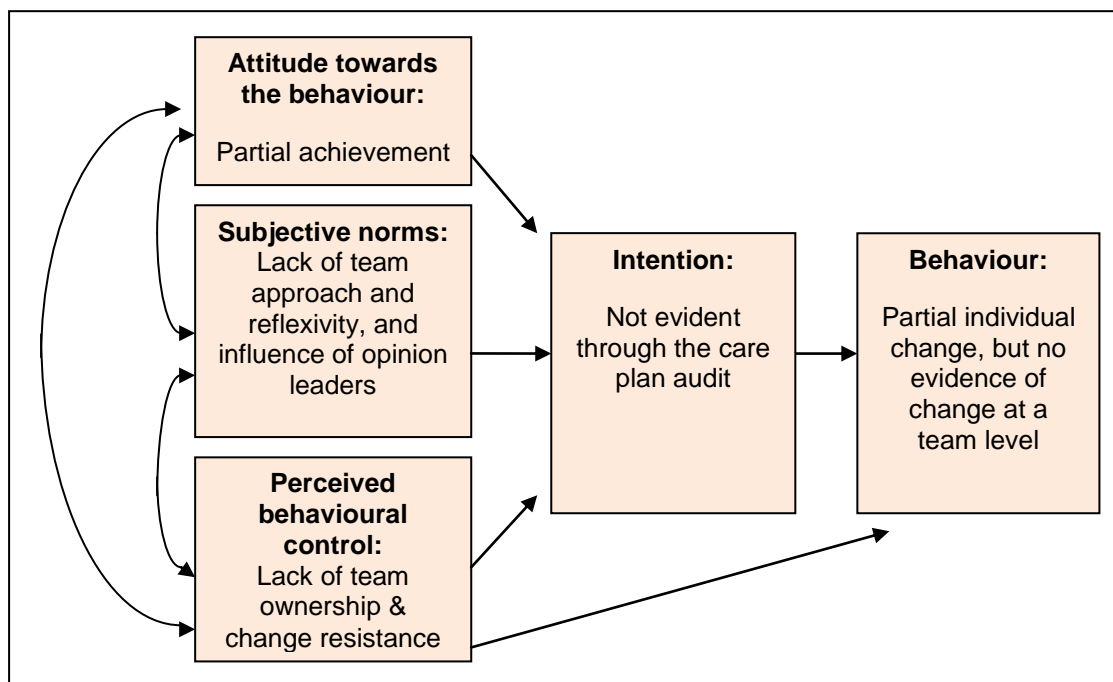
Figure 8.1 Validation of the OAR Model



As discussed in Section 5.1, the intervention was developed using the theory of Planned Behaviour (Ajzen 1991). This theory proposes that attitude towards the behaviour, in this case attitude towards recovery-oriented practice, is one of three components influencing behavioural intent. The findings made clear a lack of team focus (reflexivity) upon recovery oriented practice and implementation support, as well as the pivotal role of dissenting opinion leaders, all of which could have affected subjective (and team) norms with each team. Furthermore, in some teams, the timing of the OAR intervention was perceived to have been problematic, due to change fatigue and/or wider service changes. In some of these teams, participants felt the OAR intervention had been ‘foisted’ onto their teams, with little choice about the timing of its

delivery or fit with their service. It is likely that this impacted upon the sense of behavioural control in participants, and as such, there may have been a deliberate decision to take control by not implementing recovery-oriented practice. The theory of Planned Behaviour as applied to the outcomes of the mediating variables at a team level is shown in Figure 8.2.

Figure 8.2 Theory of Planned Behaviour as applied to mediating variables



Overall, the lack of behaviour change arose from the OAR intervention insufficiently impacting upon attitudes, subjective norms and perceived behavioural control. Factors influencing these outcomes appeared related to either limitations in the OAR intervention as well as specific organisational factors. These are now discussed in relation to behaviour change theory as well as the literature on recovery transformation, and potential methods of optimising the intervention are proposed.

The OAR intervention (impact upon knowledge and attitude)

Whilst the mean change in four of the six recovery attitude and knowledge sub-scales was significant, the overall mean change in these sub-scales were modest (between 0.21 – 0.48). Further, review of baseline scores (Section 7.2.5) showed that scores for all professional groups were towards the top of the range, and therefore the extent to

which the change scores are meaningful can be questioned. Six potential modifications to the OAR intervention are identified.

Amendment to the OAR intervention (scope)

The scope of the OAR intervention was very broad, and sought to address recovery-oriented practice in relation to a wide range of service users, including those with a recent diagnosis of dementia as well as those with a persistent psychotic illnesses. This may have made the specific practice implications insufficiently defined for staff. As noted in Section 8.1, there is a need for further research to explore how recovery-oriented practice is tailored to best meet the needs of different service user groups.

In optimising the OAR intervention, there is a need to understand which principles of recovery-oriented apply consistently with all groups of users of OPMHS, and where differences in practice might apply. For example, the specific working practices which support the maintenance of identity in service users with psychotic illnesses may be different to the working practices which seek to educate carers as to how they might support the maintenance of identity for people with moderate to advanced dementia. The task of ensuring that the overall philosophy and values underpinning working practices is consistent, as well as clear articulation of the differences in practice for different groups of service users could be addressed in four ways.

First by using an approach such as values-based practice (Woodbridge and Fulford 2003) to articulate a supporting recovery philosophy. Values-based practice highlights the significance of values in guiding clinical behaviour and decision-making in care delivery, and places emphasis on the articulation of values (of both service users and staff) as well as highlighting key principles, such as the importance of the service user's perspective and values, the significance of language as well as the importance of partnerships between professionals and service users (Fulford 2004). Values-based practice and recovery-oriented practice are complimentary, for example identifying strengths, working on service user goals and promotion of positive-taking (National Institute of Mental Health Excellence 2004). Values-based practice has been used to define policy, service development and practice in mental health services for children and adolescents (Fulford and Williams 2003, Williams and Fulford 2007) and it is proposed that similar exploration might be helpful in OPMHS. The development of a values-based recovery philosophy for OPMHS could be undertaken as a multi-disciplinary initiative and could help to engage different professions more firmly as well as helping to strengthen wider organisational commitment to recovery.

Second, the OAR intervention would be enhanced by undertaking further research to understand both the experience of recovery for different groups of service users, as well as the practice implications for staff. The findings of this research could be incorporated into the OAR intervention.

Third the development and use of specific protocols and recovery-oriented practice standards such as those developed by Davidson and colleagues (Davidson et al. 2009). These practice standards have been developed across 8 domains, and make clear the recovery-oriented working practices are for each domain and how achievement might be measured at three levels: service user feedback, individual working practices and wider organisational processes and policies. For the OAR intervention, recovery protocols could be co-produced with service users and carers for different groups of service users, for example, a protocol for recovery-oriented practice at the point of diagnosis of dementia.

Finally, the implementation of the practices addressed in the OAR intervention would be strengthened through adoption within OPMHS of recovery interventions for service users such as the IMR programme (Mueser et al. 2006) discussed in Section 2.3.1. Additionally interventions intended to address recovery and medical co-morbidities such as the HOPES intervention (Pratt et al. 2008) or the I-IMR programme (Mueser et al. 2012) discussed in Section 2.5.4 could be used. Such programmes have been manualised, and would provide clear guidance to staff on the delivery of the intervention, in addition to an underpinning focus on recovery-oriented practice. As such, they would enhance delivery of the OAR intervention, as they would support the development of a =recovery-oriented organisational culture. Further, interventions such as the HOPES or I-IMR programmes would focus on the medical co-morbidity needs of service users, which was highlighted within the framework for recovery and older people (Chapter 3), but not specifically addressed within the OAR intervention.

Recommendation 1: Exploration of the underlying values (and attitudes) of staff to support the development of a values-based philosophy for recovery-orientation within OPMHS.

Recommendation 2: Further research to understand the experience of recovery for different groups of service users, and as well as the recovery-oriented practice implications, and subsequent modification to the OAR intervention.

Recommendation 3 Co-production of recovery protocols and recovery-oriented practice standards based on the findings from recommendations 1 and 2.

Recommendation 4: Use of recovery interventions such as the IMR programme or the HOPES/I-IMR programme to enhance implementation of the OAR intervention, and strengthen recovery-oriented practice.

OAR Intervention (Professional group)

Two issues relating to professional group were identified. First, lower levels of reach for psychiatrists. Second, the impact of professional group membership upon outcomes for recovery knowledge.

The process evaluation showed that reach of the team recovery training component of the OAR intervention was adequate for all professional groups apart from psychiatrists. The reasons for this were not formally investigated, however at least four explanations are possible. First, a number of participants expressed the view during the qualitative interviews for acceptability that the level of training was pitched too low for psychiatrists (Section 7.2.1). However, the level of engagement by psychiatrists in the OAR intervention was lower at the beginning of the team recovery training at which point the content would have been unknown. Second, the challenges of inter-professional training include differences in language, values and training background (Leathard 2013), and it may be that the inter-professional approach did not meet the anticipated needs of psychiatrists. Third, it is possible that the recovery as a concept was more challenging to psychiatrists, for whom the existing model of traditional mental health care provision is closely intertwined with their power, which may have led to a sense of being threatened (Slade et al. 2008). Fourth, the OAR intervention and the wider programme of work was initiated and led by the principal investigator, who was an occupational therapist within the OPMHS, a profession that might be perceived to have lower professional standing in the healthcare organisational hierarchy. It is possible that this may have decreased the credibility, and therefore the acceptability of the OAR intervention to psychiatrists.

Further, a meta-analysis of training effectiveness has highlighted the importance of individual and context characteristics on the motivation to learn, which has been found to be a significant factor in the successful transfer of learning into practice (Colquitt et al. 2000). In considering individual characteristics, age, gender, expectations about the training and cognitive ability amongst other factors impact upon motivation to learn. If

any of these characteristics differ between professional groups, this may lead to differential uptake. Capturing more socio-demographic data within the OAR study would have allowed for exploration as to whether factors related to staff age and gender impacted upon knowledge and attitude outcomes. Additionally, understanding expectations about the OAR intervention prior to delivery of the intervention would have allowed for a tailoring of the intervention to better address expectations.

The consequent impact of psychiatrists not engaging in the intervention was identified in the qualitative interviews by non-psychiatrists as a factor which undermined the implementation of recovery-practice within teams. This is consistent with other studies of recovery training, whereby lack of engagement by psychiatrists in recovery training has acted as a barrier to subsequent practice change (Gilburt et al. 2013).

Unexpectedly, team membership did not emerge as a predictor of responsiveness in recovery knowledge on three of the four RKI Sub-scales, whereas professional group membership was a predictor. Differences in recovery knowledge between professions were apparent at baseline, with increased homogeneity within professional groups. One possible explanation is that attitude might be more easily influenced by team environment, as opposed to the acquisition of new knowledge which might be more heavily influenced by professional norms and philosophy. This has implications for how change in recovery attitude and knowledge might best be achieved in practice, and whether different approaches are required for each. There was considerable variation in knowledge outcomes by professional group, with nursing generally achieving higher mean change scores compared to other professional groups (Appendix S). In contrast, recovery knowledge moved in a negative direction in two of the RKI Sub-scales following the team recovery training for psychiatrists, psychologists and social workers.

One conclusion might be that the intervention was appropriately tailored to towards nursing as the largest workforce professional group (57% of the eligible staff population) at the cost of benefit for other professional groups. Overall, the results suggest the need for a more nuanced approach within the intervention, and the use of both team and profession-specific components.

Recommendation 5: The OAR intervention needs to be revised into two components:

- **First a recovery training component, which addresses recovery knowledge delivered to uni-disciplinary groups of staff, tailored to the needs of each professional group. This would include ascertaining**

expectations about the recovery training component of the intervention prior to delivery.

- **Second a multi-disciplinary reflective practice forum, which addresses recovery attitude, team reflexivity and sustaining wider team practice change.**

Recommendation 6: Engagement with all professional groups as part of the development of a values-based recovery philosophy for OPMHS as discussed in Recommendation 1

Recommendation 7: Targeted engagement with psychiatrists who could act as pro-recovery opinion leaders is required as part of the implementation strategy.

Recommendation 8: Collation and analysis of socio-demographic data to review the impact of these factors upon staff outcomes within a future study

OAR intervention (Fit between trainers and team)

Fit between trainers and team was identified as a factor which either supported or undermined acceptability. This is consistent with the literature on consultancy, and the importance of fit between consultant and client in the success of consultancy (Fullerton and West 1996). Furthermore, research on the use of internal consultancy within mental health services, identified consultant/client fit as a key component in delivering effective consultancy interventions which support service change (Grey 2010). Fit was defined as the consultant and client being able to have 'difficult' conversations, characterised by both parties being able to give and receive difficult feedback to one another.

The salience of this theme was further demonstrated in the OAR study by the difficulty experienced by the trainers in challenging existing assumptions about 'doing recovery already' (an essential element of the training) in the two teams where the relationship between team and trainers was poor. It was not clear from the qualitative interviews which element took place first, poor fit or an inability to have the difficult conversations, nor was it clear which factors contributed towards poor trainer and team fit.

OAR intervention (Lack of evidence)

The lack of evidence supporting recovery for OPMHS service users affected the acceptability of the intervention. This is in keeping with concerns expressed about recovery-oriented practice within mental health services for adults of working age (Davidson et al. 2006). Evidence from longitudinal studies (discussed in Section 2.1.2) can be used to challenge this. In the OAR study, a decision was made to reduce the time spent providing an overview of the concept of recovery in relation to adults of working age, including the omission of data from longitudinal studies, based on participant feedback in the pilot study (Section 5.8). The potential impact of this decision upon the different learning styles of staff received the OAR intervention was not considered. Given the importance of expectations on training motivation, the omission of this information may have impacted upon the perceived acceptability of the intervention for different professional groups, as well as the underlying motivation to learn.

The development of the framework for recovery (Chapter 4) and related working practice implications (Chapter 5) as the underpinning evidence base for the OAR intervention immediately preceded development of the OAR intervention. No assessment of trainer knowledge of the research underpinning recovery (for both adults of working age and older people) was made; it is therefore possible that the evidence base was not fully understood by trainers.

Recommendation 9: To address to the needs and expectations of different professional groups, and to make the case to skeptical teams, trainers need a deep understanding of the recovery evidence base and be able to communicate this.

Recommendations 10: Development of an e-learning programme which allows inclusion of evidence and wider literature and resources supporting recovery than would otherwise be feasible within face-to-face training in order to address differing learning preferences.

OAR Intervention (Underlying attitudes)

It is possible that a perceived lack of evidence was not the only concern about the OAR intervention, and that it also related to underlying staff attitudes towards older people

with mental health problems. For example, there may have been an uneasiness about the concept of recovery, stemming from a pre-existing pessimistic outlook about older age and mental illness, which has been found in OPMHS (Dallaire et al. 2008, Bowers et al. 2005, National Development Team for Inclusion 2011). As discussed in Section 2.5.4, in addition to the general barriers which may affect the implementation of recovery-oriented practice, attitudes towards older people with mental health problems have been identified as a specific barrier within OPMHS (Dallaire et al. 2008). Within mental health services for adults of working age, underlying staff attitudes towards recovery and recovery-oriented practice have been investigated, and a number of influences have been identified. For example, scepticism towards recovery as being a 'new fad' (Piat and Lal 2012), or the significance of individual (staff) role perceptions (Le Boutillier et al. 2014b). Attitudes towards recovery were assessed using quantitative measurement in the OAR study, but underlying staff attitudes towards older people with mental health problems and their impact upon attitudes towards recovery were not explored and their impact is unknown. Further, as discussed previously, expectations about recovery training were not known. It is possible that pre-existing attitudes and expectations about the training may have been a factor in the partial achievement of attitude change, and subsequent lack of behaviour change.

Recommendation 11: There is a need to understanding underlying staff attitudes toward older people with mental health problems, and how these might underpin attitudes towards recovery, and expectations about recovery training.

Recommendation 12: To use the findings of such research to support the development of a values-based recovery philosophy for OPMHS as discussed in Recommendation 1.

OAR Intervention (implementation support)

Implementation support was provided to 9 (60%) of the 15 teams who received the OAR intervention. Implementation support was intended to increase team-level ownership and support the transfer of the learning from training to practice. Lack of implementation support was identified by staff as reducing the team focus on recovery. This is consistent with the literature on the importance of 'team reflexivity': activities which encourage reflection, questioning and action learning in order to support change and adaption (West 1996). The relative lack of demand for implementation support may

have meant that the OAR intervention was perceived solely as a training intervention, which in isolation is unlikely to change practice (Corrigan and McCracken 1995).

As discussed in the previous section, the challenge of supporting the transfer of learning into practice was identified in the Collaborative recovery training initiative (Uppal et al. 2010). This study sought to assess the use of recovery-oriented practice protocols in 173 staff who had received recovery training. Only 37% of staff who received the training were found to be using the protocols which were introduced in the training. In addition to organisational constraints, barriers to practice change included lack of staff confidence and anxiety about changing working practices. Higher caseloads and frequent service user contact were associated with higher levels of transfer into practice.

Implementation support was not widely delivered (Appendix Q) despite it being agreed during action planning days. The recovery training facilitator contacted team leaders to follow up on agreed implementation. However no further action was taken by the recovery training facilitator or the principal investigator in relation to team leaders who did not respond or deferred follow up. The absence of pre-specified implementation support and an agreed method of escalating concerns to service managers appears to have limited achievement of this component of the intervention. This contrasts with the attention given to the planning and contracting with team leaders and service managers for the team recovery training and action planning day components of the intervention. Overall, the OAR intervention was insufficiently focused upon supporting and sustaining behavior change, and modification is required.

Recommendation 13: The OAR intervention should focus more on supporting and sustaining behavior change. This would include two elements:

- **First, a prescriptive approach to implementation support is needed. This would include an on-going multi-disciplinary team reflective practice forum, as discussed in recommendation 5. On-going training and support to the team leader to ensure their active involvement and leadership and a clinical focus (to support transfer of learning into practice) would be key elements of such a forum.**
- **Second, as discussed previously in recommendation 3, implementation support should be underpinned by the use of recovery protocols (specific**

practice guidelines), and exploration of the implementation of these within the multi-disciplinary team reflective practice forum.

OAR Intervention (Duration of the intervention)

The OAR Intervention ranged between 4-7 days per team, and was delivered over a four month period comprising, three training modules, an action planning day and varying levels of implementation support. As discussed in the previous section, implementation support was insufficiently implemented. There is a lack of evidence as to the time required to change clinical practice, however in exploring the translation of research evidence into practice, three phases of implementation have been identified: Adoption in principal, Early implementation and Persistence of implementation (Tansella and Thornicroft 2009). Adoption in principal is the decision to implement a specific practice or endorse particular evidence. This may take place at a national, commissioning or service level, and facilitators include pressure groups, opinion leaders, national policy agenda and commissioning requirements including financial incentives. Early implementation is influenced by leadership and champions, professional and organisational culture, consistency between policy and practice guidance as well as successful knowledge transfer. Finally, persistence of implementation is influenced by consistency and persistence in policy and practice guidance, on-going training, professional and organisational culture as well as organisational and clinical systems to assess fidelity.

For the OAR intervention, adoption in principal of recovery-oriented practice was evident within the local OPMHS, with support for the wider programme of work including service-wide delivery of the OAR intervention, despite the absence of a commissioning requirement. The OAR intervention was targeted towards the early implementation phase of translation but this was not effective due to the limitations in the OAR interventions which have been discussed, as well as four organisational factors which will be explored in the next section. It is however also possible that the amount of time given to the expected change in practice was insufficient and that a longer period of time should have been allowed. Further the OAR intervention should address both early implementation and persistence of implementation phases of the translation (of evidence) into practice as made clear in recommendation 13, with on-going support and training to team leaders to order to enable them to continue to facilitate reflective practice forums.

Recommendation 14: The OAR intervention is delivered over 6-12 months, with an on-going sustaining component to ensure persistence of implementation.

Organisational factors (Team approach and the role of opinion leaders)

The importance of a team approach and the role of key individuals in supporting the acceptability of the intervention is in keeping with the literature on the spread and adoption of innovation in relation to clinical practice change (Fraser and Plsek 2003). This literature informed the implementation strategy, which was focused on creating a tension and awareness of the need to change as a team. Participant feedback that not receiving the team recovery training component as i) a team and ii) in a way which was tailored to the team context undermined acceptability is consistent with this theory, and further signifies the importance of a team approach as part of the intervention.

The importance of using existing social systems to communicate about change, and the underpinning role of opinion leaders in supporting or sabotaging the process also emerges from this work. Opinion leaders can have the credibility with peers which external facilitators often lack, and so the ability to influence directly the behaviour of colleagues. Responding swiftly to 'dissenting' opinion leaders is important, however there is a lack of evidence as to how best to engage and work with opinion leaders (Greenhalgh et al. 2004). Further, as shown in Figure 8.2, key individuals appeared to have negatively influenced team 'norms' about acceptability of the intervention and implementation of recovery-oriented practice.

Recommendation 15: There is a need for a strategy for engaging with opinion leaders, including 'dissenting' opinion leaders.

Organisational factors (team culture and change readiness)

The identification of team culture as a factor influencing both acceptability and implementation is consistent with the literature on recovery implementation and wider Organisational Development (OD). Facilitators and barriers to successful implementation of a pro-recovery programme over a two year period were evaluated (Whitley et al. 2009). Four influences were identified: leadership, organisational culture, training and staff supervision. Services which had an underlying organisational culture with a strong sense of innovation and positive attitude towards new practice in general

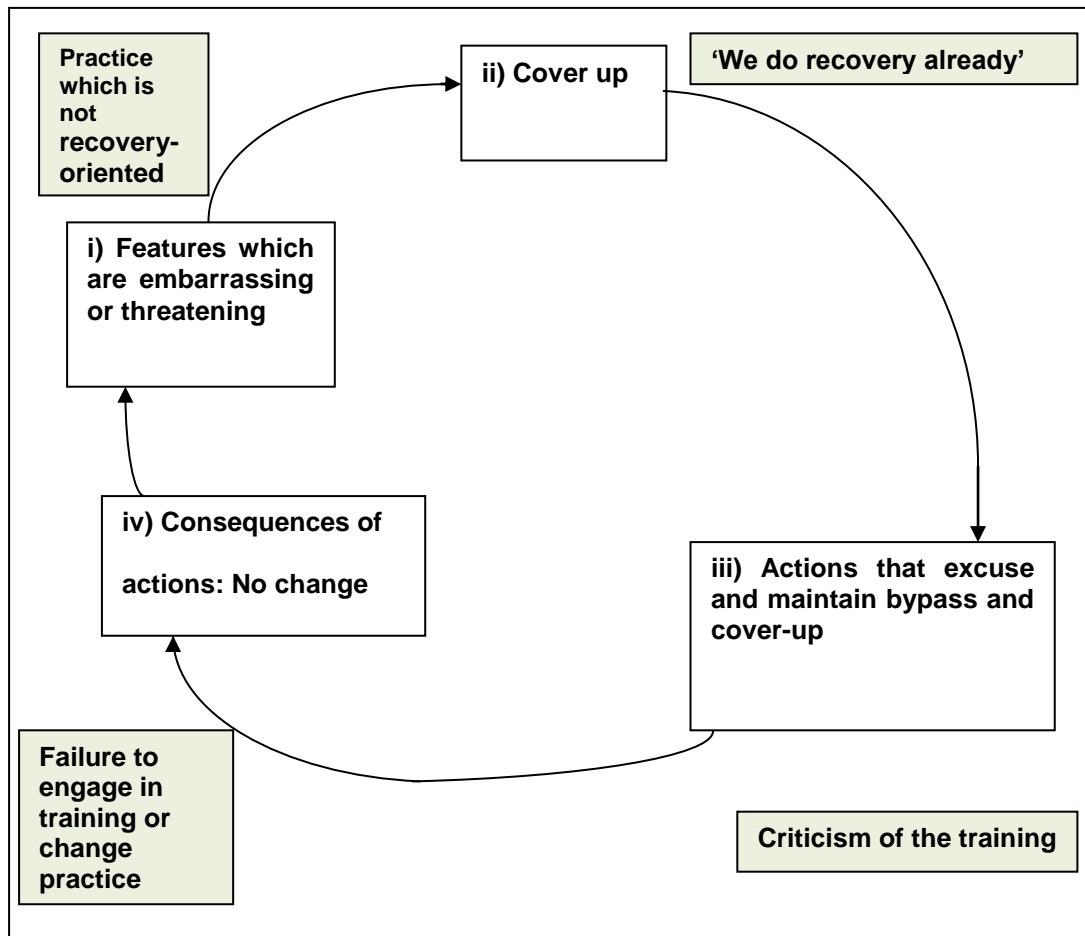
achieved higher fidelity scores. In comparison, those with lower fidelity scores expressed a strong preference for the status quo, with significant organisational inertia; in these services, implementing a recovery-oriented intervention was seen as an additional burden or threat. Training was only effective in producing recovery-oriented practice change when the other positive facilitators: leadership, organisational culture and staff supervision were also present. Additionally, as discussed earlier, facilitators in the translation of evidence into practice at the early implementation phase include consistency of local policy and practice guidance, leadership and champions (Tansella and Thornicroft 2009).

The model of organisational defensive routines (Argyris 1990) explains psychological resistance to change at a team or organisational level. In this model, exposing areas of concern leads to embarrassment or a sense of threat, which leads in turn to concerns being bypassed and ignored. Energy instead is focused on mundane tasks or complaints, which ultimately leads to a lack of action on areas of concern. These processes are often 'undiscussable' (i.e., taboo) and their 'undiscussability' is not discussed. Furthermore, there is avoidance of the dissonance between espoused theory ('what we say we do') and theory in use ('what we actually do'). The OAR study findings are consistent with this theory, as the OAR intervention:

- i. Identified practice which may not have supported recovery, leading to embarrassment or a sense of threat, and a questioning of one's role as a healthcare professional, at a time of service change and job insecurity;
- ii. This led to 'concerns' being bypassed, through the assertion that 'we do recovery already';
- iii. This in turn led to actions to justify this bypass, such as criticising the training either at the time or afterwards, disengagement from the training, leading to a consequent inability to reflect upon and change practice;
- iv. This led to a lack of change at team level.

This formulation is shown (in green) in Figure 8.3.

Figure 8.3 Organisational Defensive Routines in the OAR Study



Recovery-oriented practice involves significant change to established ways of working, and could be viewed as a threat to the existing team culture. Both organisational culture and organisational defensive routines manifest themselves unconsciously, are not clearly expressed and can be highly resistant to change (Schein 2004).

Two approaches to optimise the intervention are possible. One option would be for the trainers to have a background in OD and so be able to understand and work with these underlying processes. In practice, however, it may prove challenging to identify trainers with both the necessary recovery knowledge as well as OD skills. Alternatively, a framework to support implementation such as an assessment of change readiness or organisational climate, as discussed in the next section could be undertaken to assess both team culture and the timing of the intervention.

Organisational Factors (timing)

Timing was identified as a factor influencing implementation, in addition to team culture, particularly in relation to wider organisational change within the local OPMHS and change fatigue. An instrument such as the Organisational Readiness to Change Assessment (ORCA) could be used (Helfrich et al. 2009). The ORCA provides a framework for assessing change readiness, which comprises strength of the evidence for change, context (organisational culture, leadership and the extent to which performance is regularly reviewed) and skill of the change facilitators. Alternatively a framework such as the Replicating Effective Programs (REP) model could be used (Kilbourne et al. 2007). The REP framework identifies two distinct stages prior to implementation: pre-assessment of the potential barriers to change, including the fit of the intervention to the context, and pre-implementation by convening a local steering group who approve and tailor the intervention to the local context. Both frameworks involve identifying, and addressing context specific barriers to implementation *before* delivery of the intervention. Both frameworks are consistent the literature on successful practice change, which highlight the need to tailor interventions to address identified obstacles to change (Grol 1997, Bero et al. 1998).

Further organisational climate has been shown to have an impact upon trainer motivation to learn (Colquitt et al. 2000). A measure of organisational climate such as the Work Environment Scale (WES) (Moos 1986) and the Team Performance Inventory (West et al. 2005) would allow for assessment of organisational climate in order to tailoring the intervention to context

Recommendation 16: A framework for assessing change readiness or organisational climate should be included as part of the implementation strategy for the OAR intervention to address both team (organisational) culture and change readiness, and also allow for tailoring of the intervention to context.

Organisational factors (organisational commitment)

Overall there were difficulties with fidelity in the delivery of the OAR intervention. These included lower than expected attendance levels, not being able to deliver the team training component of the intervention as a team approach, poor use of implementation support and limited implementation of team recovery (action) plans. These difficulties

suggest that leadership support and organisational commitment may not have been consistently provided to enable implementation of the OAR intervention.

Within the OAR study, staff feedback identified that there was a lack of team leader support. Support by service managers was not investigated and therefore is not clear. Within the OPMHS, the service managers with line-management responsibility for participating teams held both the authority to make clear an expectation of full attendance and follow-up of team (recovery) action plans, and also could have provided support to address potential difficulties with attendance and implementation. Whilst the tension in having more direct service manager support of the OAR intervention as a centrally-owned initiative as opposed to solely team-level ownership is recognised, reliance upon team level ownership to develop a pro-recovery culture was insufficient. As discussed earlier leadership has been identified as the strongest facilitator in implementation of recovery-orientation (Whitley et al. 2009). In a separate study which sought to understand staff attitudes towards recovery-oriented service reform, limited leadership support was found to undermine pro-recovery practice change (Piat and Lal 2012).

In addition to leadership, wider organisational commitment was required. As discussed in Section 2.3.1 organisational commitment to recovery involves commitment to recovery, not as an 'add on' but as an intrinsic way that a service runs (Farkas et al. 2006). Organisational commitment encompasses recovery vision, workplace support structures, improvement based on service user feedback, care pathways and workforce planning (Le Boutillier et al. 2011). Apart from the development of the OAR intervention and a linked service user and carer involvement project, the OPMHS had not addressed any of these wider components of recovery transformation. As discussed earlier, consistency between policy and practice is a requirement of early implementation of translating research into practice (Tansella and Thornicroft 2009). Furthermore the proposed restructuring of community services did not consider how recovery might be embedded as part of the redesign process, nor were clear recovery-oriented practice expectations made to teams. The restructuring of community services acted both as a barrier to implementation and also represented dissonance between espoused theory 'we support recovery' and theory-in use 'we will change our services without considering recovery' (Argyris 1990). Recovery was seen as an 'add on' within the OPMHS, with the OAR team recovery training and action planning day components of the intervention giving the illusion of 'contributing something' towards the recovery agenda when the wider system transformation was not addressed. Linked to this was a staff belief that recovery was something to do when time and resources allow

(Davidson et al. 2006). Studies of staff attitudes towards implementing recovery-oriented practice have identified the challenges for staff of managing conflicting priorities, as supporting recovery may not meet wider organisational requirements (Le Boutillier et al. 2014a). The need to address wider organisational constraints was also identified by staff in a study which assessed the transfer of the learning into practice following delivery of the Collaborative recovery training package to 173 staff (Uppal et al. 2010). It is therefore apparent, that in the absence of organisational commitment to overcome these challenges for staff, recovery-oriented practice change is unlikely to happen.

Recommendation 17: Implementation of the OAR intervention requires organisational commitment.

In summary, a number of modifications have been identified to optimise the OAR intervention. No single change intervention has been shown to be effective in changing practice in all circumstance (Grimshaw et al. 2001), and multi-faceted interventions have more impact (Boaz et al. 2011), especially when tailored to context (Bero et al. 1998, Grol 1997). In optimising the OAR intervention, more emphasis (and research) is needed to define the working practices which are specific to each group of service users, activities which support and sustain practice change (such as reflective practice forums), the use of specific recovery protocols, the division of the intervention into two elements (recovery knowledge being addressed within professional group, attitude and consequent practice change being addressed within team), and delivery of the intervention over a longer period of time. Organisational factors which need to be addressed to optimise the OAR intervention include assessment of change readiness and organisational climate prior to delivery, tailoring of the intervention to team context, identification of opinion leaders and wider organisational and leadership commitment, including the multidisciplinary development of a values-based recovery philosophy for OPMHS.

8.1.2 OAR Study: Research Objective 2 (Optimise the evaluation)

The choice of measures and the evaluation strategy were investigated.

Measures

Two issues were identified with the measures used. Self-report measures were problematic for participants with more advanced dementia due to anosognosia, and difficulties with the suitability of some of the language and concepts covered with the IMR and their fit with recovery for older people.

Whilst anosognosia is recognised to be a factor in self-report in people with dementia, it has not been found to significantly correlate with QoL ratings (Ready et al. 2004, Vogel et al. 2006). Additionally, severity of dementia does not appear to directly influence health-related QoL (Fuh and Wang 2006, Vogel et al. 2006). This is consistent with the investigation of SMMSE scores within the OAR study following researcher observations of anosognosia, which found no apparent pattern linked to severity.

In one longitudinal study which followed up 122 people with Alzheimer's disease over an 18 month period, self-reported well-being was not found to change significantly despite increasing severity of dementia (Livingston et al. 2008). Other studies also suggest that people with dementia rate their QoL positively (Ready et al. 2004, James et al. 2005). Taken together, these findings suggest that people with dementia often view themselves as living well with their illness, and assumptions that such-ratings are due to a lack of insight or reduced ability to make such assessments are not supported by evidence. Instead it is possible that a process of adaptation of learning to live with dementia takes place, along with a change in expectations (Banerjee et al. 2009). Such a process of adaptation is in keeping with the 'disability paradox' whereby over half of the people with substantial disabilities report their QoL as good or very good (Albrecht and Devlieger 1999). In this process of adaptation, the person's view of self, the world, their context and social relationships all act as influences in this process, rather than disability severity. Of note is that sense of self and relationships were identified as factors influencing recovery for older people, including those with dementia (Chapter 3). These factors make clear the complexity of assessing QoL for people with dementia. However, it is suggested that the use of both self-rated and carer proxy-rated measures may be helpful.

A measure such as the DEMQOL: Proxy, a 31-item care giver-rated measure of health related QoL in dementia (Smith et al. 2005) could have been used in the OAR study. It is recognised that proxy-rated measures assess health-related QoL differently to self-appraisal by people with dementia (Sloane et al. 2005). Further, proxy-rated measures generally score lower than self-reports. Using both self-report and proxy-rated measures would have provided a wider data source within the OAR study.

Recommendation 18: The use of self-rated and proxy-rated measures for people with dementia is needed.

There was no measure within the OAR study which assessed identity and resilience. This is problematic as these are core components of recovery for users of OPMHS. Further, as discussed in the earlier in this section, adjustment to disability will be influenced by sense of self and relationships, and may not therefore be adequately addressed by QoL measures. Whilst quantity and quality of relationships may be more easily assessed, measurement of identity or a 'sense of self' is problematic. This is due to difficulties both in defining identity and the variation in the way in which identity is understood and conceptualised. Different approaches to the measurement of identity have been explored. A further challenge is measuring this concept over time for a person with dementia experiencing cognitive decline (Caddell and Clare 2010). Eleven different approaches to understanding dementia have been identified within a systematic review (Caddell and Clare 2010). For example, if identity is understood as being influenced by autobiographical memory, then measurement might involve quantitative assessment of performance in this area, or a social constructionist understanding which might explore communication and qualitative assessment of the use of personal pronouns such as 'I' or 'me' with others (Caddell and Clare 2010). Of relevance to the concept of identity as described in relation to recovery within this thesis, could be the Self-identity in Dementia Questionnaire (Cohen-Mansfield et al. 2000). The measure explores four different of types of role identity (professional, family-role, leisure activities, and personal attributes) and assesses the importance of each of these to the person with dementia over time, and the extent to which these areas are or can be maintained. The measure involves self-report, and proxy report (carers and staff) (Cohen-Mansfield et al. 2006). Of pertinence to recovery is the emphasis on the maintenance of roles as well as engagement in meaningful occupation as a means to enhance and measure identity.

Further, the IMR was identified as being problematic in terms of language and fit with older people.

Further, although not a formal focus of the evaluation, some participants and their carers commented negatively about the word 'recovery'. Concerns related to a dislike of the term as well as an interpretation of the term as meaning 'cure'. This is consistent with the existing literature discussed in Section 2.5.5 which identified concerns about the language of recovery not fitting with the experience of recovery for service users, carers and professionals (Adams 2010, Cheffey et al. 2013, Hill et al. 2010). There was

however little disagreement among participants with the underpinning principles of recovery-oriented practice. In future research, it will be helpful to establish the most acceptable term for recovery-related ideas.

The findings from this programme of research suggest that it would be useful to have a measure of recovery developed for older people.

Recommendation 19: A measure of recovery for older people is needed, which establishes the most acceptable term for recovery-related ideas.

Evaluation strategy

Five issues were identified in relation to the evaluation strategy. These included breadth of the fidelity assessment, the care plan audit and service user experience components and scope of the process evaluation. Additionally, recruitment and retention difficulties impacted upon the outcome evaluation.

In the fidelity assessment, reliance on trainer feedback could have introduced bias. Observation of the intervention delivery would have enhanced the reliability of the assessment. For example, it is not known whether the trainers adopted a process consultancy approach (Schein 1999) in their delivery of the intervention as intended. Further, there was a lack of focus upon the action planning day and implementation support components of the intervention.

Recommendation 20: Assessment of all elements of the OAR intervention and random observation of delivery of the intervention is required.

The process evaluation sought to assess whether change took place in the mediating variables described in the OAR model. The assessment of knowledge and attitude change, review of progress from the team (recovery) action plans and qualitative interviews were satisfactory

In relation to the care plan audit, the absence of a pre-planned analysis strategy was a limiting factor, because the analysis challenges only became apparent once all data had been collected, at which point it was not possible to amend the data collection processes. If repeating the study, an early analysis of a small dataset would help to develop the analysis strategy. There is some evidence from other studies that care plan audits can capture change (Gilbert et al. 2013) but data linkage will be needed. Additionally, it is likely that resources involved in using the CRIS system will reduce

both because of familiarity and because the process could in principle be automated (Stewart et al. 2009). Additional items could be added to the audit, such as completion of WRAP plans, or life histories as a more tailored measure of practice change.

Recommendation 21: The care plan audit should be retained, but future research will need to ensure a pre-planned analysis strategy from early analysis of a small dataset to allow data linkage as part of an interrupted time series design. Further use of automation of coding, as well inclusion of WRAP plans and life histories into the audit should be explored.

Within the process evaluation, focus was primarily placed upon the team recovery training component, as opposed to the action planning day and implementation support components of the OAR intervention. Measures of staff attitude and knowledge could have been repeated following the action planning day or implementation support to explore whether these elements of the intervention impacted further on attitude and knowledge. This is important because the model appeared to fall down at the stage of supporting and sustaining behaviour change. Greater attention is needed on these aspects of the OAR intervention.

Recommendation 22: Repetition of measurement of staff attitude and knowledge change throughout delivery of the OAR intervention.

The method of assessment of service user experience was unreliable. This is important because without accurate assessment of this component, it is not known definitely whether change in practice took place.

Recommendation 23: A systematic review on measurement of service user experience of OPMHS is needed. This will identify where a suitable alternative measure exists or whether the development of a new measure for service user experience is required.

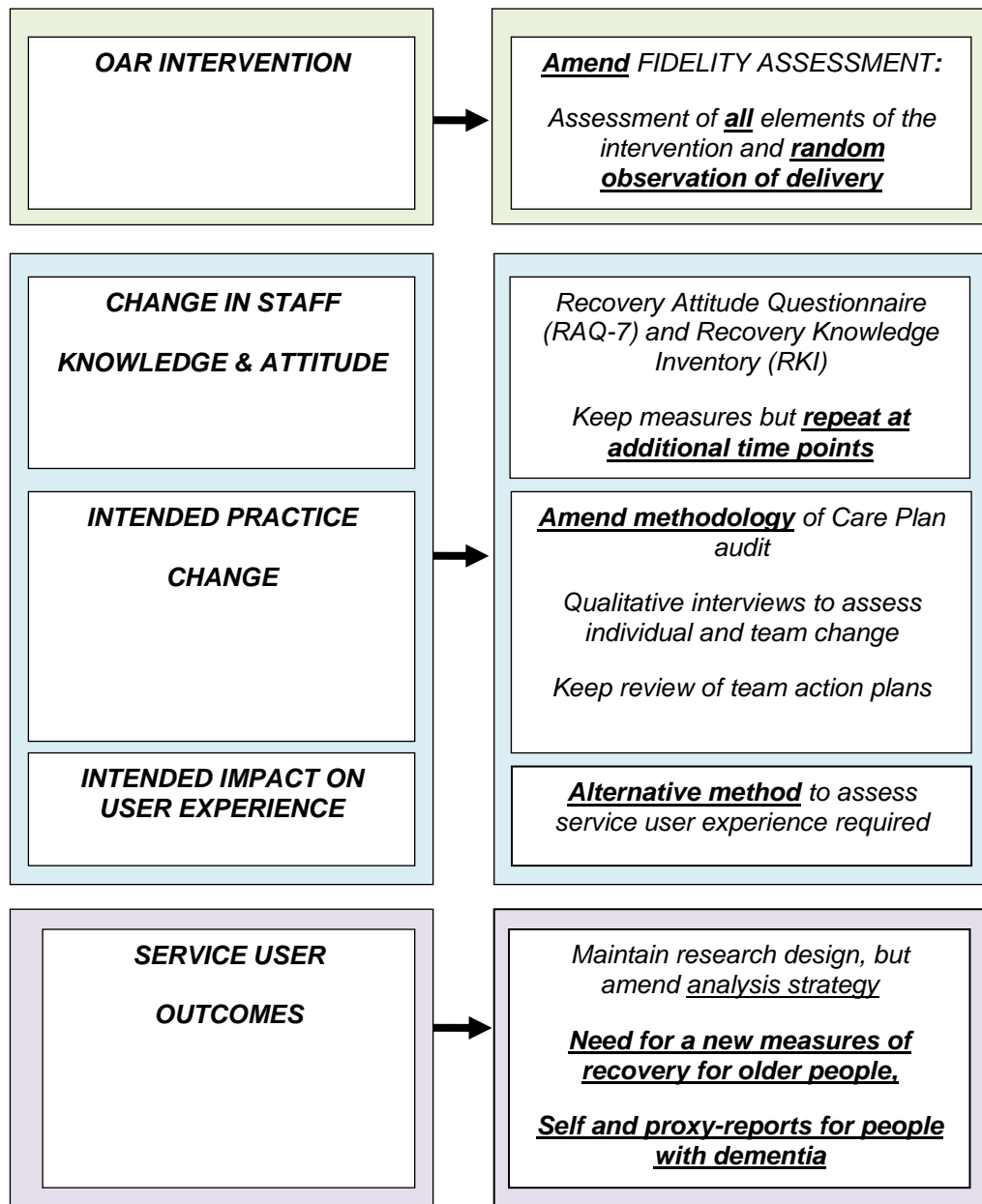
In respect of the outcome evaluation, the main issue was the variance in the level of the intervention received. Only 64% of the target staff population in Sub-study 2 (Comprehensive evaluation) received all the team training component of the OAR intervention. 21 of the 103 service user participants (20%) had care co-ordinators who received none of the OAR intervention. Additionally, 37% of the service user participants were users were lost to follow-up. However, given the importance of both

team and organisational support in implementing recovery-oriented practice change, the OAR intervention is only likely to be effective as a team based intervention, so an alternative to a cluster design is not evident. In any further study, the analysis strategy could be adjusted to address these issues in the three ways (Dunn 2013). First, partial implementation could be assessed through a CACE analysis in order that a dose-effect relationship can be identified. Second, the analysis could more robustly account for clustering through the use of multi-level modelling. Third, attrition could be addressed through multiple imputation followed by strict intention to treat analysis. Finally, there is a need for stronger recruitment and implementation strategies.

Recommendation 24: Need to adjust the analysis strategy in order to address issues relating to the cluster design in a future trial.

The evaluation strategy for the OAR study was modified as shown in Figure 8.4.

Figure 8.4 OAR model and modified evaluation strategy



8.1.3 OAR Study: Research Objective 3 (Establish trial parameters)

In considering the development of trial parameters for a future definitive trial, hypotheses, sample size calculation and factors required for optimal recruitment and retention strategies were assessed.

Hypotheses

The OAR study did not find that the OAR intervention led to improved recovery and quality of life for users of OPMHS. The reasons for this include the following.

1. It may be that the recovery based practice as espoused in the OAR intervention does not improve recovery or quality of life in older people with mental health problems and dementia.
2. As discussed in Section 8.1.1, the design of OAR intervention requires optimisation, which is evident from the lack of change in mediating variables. It is also recognised that the length of the OAR may have been insufficient, and that staff practice may have been unlikely to have consistently changed in the 2 month (Arm 2: delayed delivery) and 8 month (Arm 1: immediate delivery) period following delivery of the intervention.
3. The OAR intervention may have been too broad for the mix of service users in the study. The heterogeneity in the clinical population is evident through the large standard deviation (sd) in all outcomes (Table 7.21). This reflects service user participants coming from three broad diagnostic groups, with varying levels of illness severity, living situation and of service use. Data on service use and the overall impact of illness and disability were not collected as part of the OAR study and would be of help in seeking to understand and explore differences in outcome more fully.
4. Fidelity was problematic: the intervention was not fully delivered as intended, and implementation support was incomplete. Both of these factors are likely to have contributed towards the lack of change in service user outcomes.
5. None of the measures specifically assessed the extent to which identity had been maintained and or whether resilience had been enhanced, which were both active ingredients of the intervention. As discussed in section 8.1.2, the need for an instrument which measure the specific domains of recovery for older people with mental health problems is clear
6. Another potential influence on the outcome evaluation for participants with dementia is the extent to which health-related QoL could reasonably be expected to change over a 12 month period. Maintenance of health-related QoL may have been a more appropriate outcome. Furthermore, there is a lack of information on the natural history of QoL for people with dementia so the use of a health-related QoL measure as an outcome measure for the OAR intervention needs to have been seen as exploratory.

Assessment of outcome through subjective ratings increases ecological validity but may be insufficiently sensitive to change.

7. 20% of the service user participant sample had care co-ordinators who did not receive the OAR intervention.

8. As shown by the sample size calculation described in Section 7.4.2, the study was not powered to be a definitive trial. This means that possible statistically significant findings may have been identified had the sample been larger.

Sample size

The OAR study was designed to generate a sample size calculation for a future definitive study (Section 7.4.1). These show that, with the same effect size, 2,132 participants would be required for a future definitive trial, with 41 clusters. This is based on the IMR Scales, and the need for a new measure of recovery has been identified. However, it is clear that it would be premature to undertake a definitive RCT at this stage on the data generated here. The recommendations to optimise the intervention and evaluation elements of the OAR intervention should be prioritised and tested prior to any future RCT.

Recruitment and retention

Overall, reliance upon care co-ordinators within the process appeared to cause inconsistency with the recruitment of service user participants. This included additional inclusion and exclusion criteria being added, researcher-observed difference between professional groups in assessing capacity and differential willingness to meet with the researchers. Whilst not formally verified, this is of concern because it suggests that potential participants might have been denied the opportunity to participate in research they might have wished to be involved in. This would also result in selection bias with the staff least interested in recovery being less likely to meet with the researchers and so clients being under-represented. Such difficulties could potentially be overcome by initiatives such as Consent for Contact (South London & Maudsley NHS Foundation Trust 2014). Consent for Contact allows service users and carers to be placed onto a research register, whereby permission is given in advance for researchers to contact them directly regarding possible involvement in research. Within this initiative, staff are encouraged to discuss the initiative with all service users and carers on their

caseloads, rather than individual research projects. The outcome of the discussion is recorded, and the level of non-discussion is monitored.

Service user retention was lower than expected at 63%, with higher levels of participants with dementia and psychosis being lost to follow-up. There is a need to factor in higher levels of attrition for people with dementia and psychosis

Recommendation 25: Use of an initiative such as Consent for Contact to support recruitment

8.2 Strengths and limitations of the OAR Study

Strengths and limitations were identified in relation to the research presented in Chapters 3, 4 and 5. Additionally, there are seven main strengths of the thesis.

First, in the absence of empirical research in relation to recovery and older people, this thesis has made a contribution towards building the evidence in this area. It has made clear that recovery has applicability to older people with mental health problems, including those with dementia (Chapter 3). This thesis has also sought to design, delivery and evaluation a recovery intervention for staff working in OPMHS, as well as identifying areas for improvement. As such, this thesis provides a research base for those advocating and supporting recovery transformation within OPMHS.

Second, the thesis has identified three existing knowledge gaps. The knowledge gaps comprise a) the experience of recovery for specific groups of users of OPMHS, b) the practice implications for specific groups of users of OPMHS and c) the underlying attitudes of staff working in OPMHS towards older people with mental health problems which may underpin attitudes towards recovery.

Third, the thesis has identified five areas for further research. These involve addressing the three knowledge gaps as well as the need to develop a specific measure of recovery for older people, as well as modification and piloting of amendments to the OAR intervention and evaluation strategies.

Fourth, the research took place in the context of routine service delivery with a broad range of service users, carers and staff. The research took place in an OPMHS which followed a traditional model of mental health care delivery. As such the findings can be seen as both representative and generalisable. Additionally, the findings provide useful

information to other OPMHS seeking to implement recovery-oriented practice within their services.

Fifth, the OAR study was successful in recruiting staff into the recovery team training component of the OAR intervention. Of a total of 249 eligible staff, 204 (82%) received part or all of the team recovery training, with 177 (71%) receiving all of the training. This provided a large sample of paired staff measures (n=176). This means that this component of the OAR intervention has been tested with over 80% of the eligible workforce, and therefore the findings are likely to be representative.

Sixth, in the OAR study, a high number of nurses and healthcare assistants (n=120) received part or all of the recovery team training component of the OAR intervention, with 108 (78%) of the eligible nursing workforce receiving all of the training. The results were therefore representative of the local workforce population. As nursing is the largest profession within the local OPMHS, and more generally in mental health services working with older people, the generalisability of the findings is enhanced.

Seventh, the OAR study collated a significant amount of data and information. Three separate research objectives were addressed, using both service user and staff data, testing of different research methods and measures, and exploration of factors influencing acceptability, recruitment, retention and implementation. The OAR study has been able to identify knowledge gaps and areas for future research. The issues identified, such as difficulties with recruitment of people with dementia and factors affecting implementation, have applicability to OPMHS generally and are not limited to recovery-related research or service development.

There are eight main limitations to the overall thesis. First, service user and carer involvement in the research process was lower than planned. Service user and carer involvement took place in three ways:

- a) One service user was involved in the analysis of transcripts which led to the development of the conceptual framework for recovery (Chapter 3)
- b) Four service users and two carers from an involvement project in the OPMHS were involved in the focus group which developed the practice implications (Chapter 4)
- c) Two service users were involved in the Training Advisory Group (TAG) which developed and reviewed the training content material in the OAR Intervention (Chapter 5)

- d) Co-presentation of the thesis findings at two international recovery conferences

It is however recognised that balance and power in each of these stages was not adequately addressed. Further involvement could have been more widespread across the research process. This is due primarily to service user and carer involvement within the local OPMHS being underdeveloped at the beginning of the programme of research. As discussed in Section 2.3.1, service user and carer involvement is an underpinning component of recovery-oriented mental health service delivery. Further service user and carer involvement in OPMHS is generally poorly developed in comparison to mental health services for adults of working age (National Development Team for Inclusion 2011, Age Concern 2007, Bowers et al. 2005). A decision was made at the beginning of the programme of work that service user and carer involvement within the local OPMHS would be prioritised over research engagement as it would support recovery orientation within the service, as well as bringing about a bottom-up approach to change. It is however recognised that both activities could have been undertaken concurrently using a collaborative research approach (Bryant et al. 2012). The involvement of older people in research is an area of development, and can provide an opportunity for older people to directly influence service provision (Leamy and Clough 2006). The use of a framework to guide the process of involving service users and carers could have been helpful. One framework developed for older people and their carers in relation to community research (Warburton et al. 2009) identified the following areas:

- The need to see the involvement of older people in research as a process, and within this, provide adequate training and support
- The need to clarify respective roles, and make clear the levels of involvement, which may vary at different stages of the research
- Articulation of the differing expectations and priorities of service users, carers and researchers, particularly regarding the purpose of the research, how it can be used and the time the process will take
- Ensuring good representativeness and diversity of older people, and the need to consider how housebound and hard to reach groups might be engaged

Second, the scope of the overall thesis was wide, and at times overly ambitious, particularly given the lack of evidence and experience of recovery-oriented practice within OPMHS. As such the thesis could have focused on a more in-depth exploration

of a specific area, for example, the experience of recovery to a specific group of service users. In practice, a division at the stage of commencing the thesis would have been problematic as the funding provided for the related programme of work carried an expectation of implementation of recovery-oriented practice with all service users and within all teams. Furthermore, with the exception of the memory service, all the clinical services provide mental health services to users with both functional and organic mental health problems. It was not feasible in the time allowed to assess the needs of different groups of service users separately. Further it was also considered that that it would be difficult to change practice, if staff were being asked to follow one philosophy with one group of service users, but not with others at that point in time. Overall a decision was made to obtain breadth of coverage as is common with health services research, with the recognition that depth may be sacrificed. By doing this, it has been possible to identify further areas of research in this area which were not known before the research took place. As discussed in Section 8.1.1, given that recovery has now been shown to be a concept which is relevant for older people with mental health problems, there is a now a need to define the experience of recovery and the practice implications for different groups of users more clearly, for example the experience for older people with early dementia compared to older people with late-onset psychosis.

Third, a decision was made not to carry out a systematic review on the literature on recovery and older people. This was due to time constraints and to the widely held perception that research and service development in relation to recovery and people was underdeveloped. It was decided that the time required for a systematic review would be disproportionate to the likely outcome. It is however possible that relevant research may exist which has not been included within this thesis.

Fourth, attitude and knowledge change could have been more robustly investigated in the OAR study. Pre-post measures were only given and assessed in participants receiving all of the team recovery training component of the OAR intervention. This means that a full dose-effect relationship cannot directly be investigated for the team recovery training component of the intervention. Measures were not repeated following the action planning day, or after implementation support. This means that the duration of effect of the team recovery training is unknown, as is the impact upon attitude and knowledge of the other two components of the intervention.

Fifth, no carer or clinician-rated measure for participants with dementia was included in the OAR study. In particular, use of a carer-rated measure would have been beneficial

given the important contribution of carers in facilitating recovery for people with more advanced dementia, as discussed in Chapter 3.

Sixth the role of the principal investigator in co-leading and analysing the staff focus groups in Chapter 4, as well as undertaking and analysing the majority of the qualitative interviews with staff in the OAR study (Chapters 6 and 7) could have introduced bias into the research. It is possible that social desirability may have underpinned the responses given by staff participants, many of whom knew the principal investigator, and would have been aware of her pro-recovery outlook in light of her role in leading the wider programme of work. Further, it is possible that the principal investigator's own views and familiarity with the local OPMHS may have influenced both the conduct of the focus groups and interviews and the analysis. Involvement of other researchers in the focus groups, and use of the framework for recovery to structure the focus groups would have reduced this impact. Further the involvement of an independent researcher to agree a coding framework for the staff qualitative interviews, as well as regular use of academic supervision throughout the research addressed this possibility. Use of an independent researcher to either carry out or analyse the qualitative interviews would have further reduced social desirability bias.

Seventh, the decision not to randomise delivery of the intervention. The decision was made due to organisational and funding constraints. Although in principle the funder requirement of access for all teams to the intervention was not incompatible with a randomised design, for example using a waiting-list control, in practice the constraints on possible order of entry of teams into the study did not allow random allocation. The implication of this design decision was reduced certainty, for two reasons. First, order of entry to the study was non-random, with more stable teams entering the study earlier. There may have been secular (time-trend) effects which systematically impacted on outcome, such as the organisational changes which were taking place or improved quality of training. These effects would not have been split equally across arms. Second, the absence of a clear control group required a more complicated analysis, making interpretation of findings more problematic.

Eighth, the time constraints and output requirements of the funders and wider programme of work meant that there was insufficient time and flexibility at certain points to fully explore different aspects of the study prior to delivery. In particular, this meant that:

- Trainer understanding of the conceptual framework for recovery and older people and of the wider evidence base for recovery was not assessed
- Ad-hoc assessment of trainer fidelity was not undertaken
- The service user experience questions were not piloted
- The implementation support component of the OAR intervention was not piloted
- It was not possible to assess the acceptability of the DEMQOL or the SF-12 with participants prior to their administration

Piloting of all of these elements would have allowed for earlier detection of the difficulties encountered and subsequent amendment.

8.3 Reflexivity

Throughout the completion of the thesis, as the principal investigator, I was aware of my role in leading the wider project (as the professional lead for occupational therapy within the local OPMHS) as well as my thinking as an occupational therapist, and the impact of these upon the research process.

In considering my role as the professional lead for occupational therapy within the OPMHS, I was keen to position the research in a broader theoretical context, rather than occupational therapy-specific perspective. This was because I was conscious of the risk that the research and related service development could be perceived as an OT initiative which related to occupational therapists solely, and therefore not of relevance to other professional groups. My outlook was underpinned by recovery being strongly endorsed within the mental health strategy developed by the UK professional body for occupational therapy (College of Occupational Therapists 2006), and anecdotal evidence that occupational therapists are generally supportive of recovery transformation. In positioning the research in this way, I focussed on literature and evidence from contemporary perspectives on recovery and successful ageing, with more of a sociological underpinning as opposed to an occupational therapy and occupational science knowledge base, and as such sought to use these approaches in the development of theory, and dissemination of the research. I do however recognise that such of distinction might have been artificial given the overlap which exists between the philosophical foundations of occupational therapy and the elements of recovery (Krupa et al. 2009).

As an occupational therapist, I became interested in recovery because of the fit between some of the concepts and my own clinical observations of older people's experience of mental illness. Points of connection included the significance of personal responsibility, the limitations of professional 'advice', and a recognition that solutions which are worked out with the person with the 'problem' (those with lived experience) are more likely to be successful than those identified solely by the professional.

During the completion of the qualitative study (Chapter 3), as an occupational therapist I was very struck by the descriptions given by participants of the significance of their on-going engagement in and adaption of well-established meaningful roles, occupations and relationships as means to reinforce a sense of self and manage one's illness, in order to promote recovery (I'm back to being me'). This fitted with both my personal experience as an occupational therapist, and is also consistent with the philosophical and knowledge base of occupational therapy (Krupa et al. 2009), in terms of the value of engagement in occupations and the way in which our sense of self as an occupational being is developed from our participation in occupation over time as means to create an occupational identity (Kielhofner 2008). Another overlap with occupational identity (being defined by what we do) is the impact of engagement in occupation and our interpretation of this upon our relationships with others (Christiansen 1999).

In managing the impact of my role and thinking as an occupational therapist I sought to ensure that reflexivity and rigour in the research process was addressed in four ways. First, during the completion of the first two qualitative studies (Chapters 3 and 4) I was able to meet regularly with an independent qualitative supervisor in order to consider by own standpoint during the data collection and analysis. Additionally, I received guidance on the analysis strategy for the qualitative element of the process evaluation in the OAR study (Chapter 6) from the same independent qualitative supervisor. Second, neither of my PhD supervisors were occupational therapists and were therefore able to provide academic guidance upon my development of theory from a broader theoretical perspective. Third, multiple researchers were involved in the data collection and the analysis of data within the qualitative studies (Chapter 3 and 4), and in the analysis of the qualitative element of the OAR study (Chapter 6), which enhanced the rigour of the analysis. Finally, the use of grounded theory techniques for the qualitative study (Chapter 3) ensured that emerged themes were reviewed in relation to existing literature on recovery and successful ageing literature rather than reliance solely upon my interpretation.

8.4 Ethical considerations

Involvement in this research was not anticipated to cause pain, discomfort, or adverse effects for service user participants. Other ethical considerations are now considered.

8.4.1 Ethical considerations for service user and carer participants

At the point of recruitment into the study, each service user and carer participant was given a study information sheet which explained the research as well as the direct benefits and burdens of being involved. It made clear that participation in the research was voluntary and that participants could withdraw at any time. It also made clear that withdrawal from the study would not affect the provision of any ongoing medical or social care. Recruitment into the qualitative study and piloting of recovery measures (Chapters 3 and 5) involved care co-ordinators discussing participation in the study with potential participants before passing details onto the research worker. The benefit of this gate-keeper role by care co-ordinators was that it would have allowed wider discussion about participation in the research with a known professional prior to expression of interest, which would have reinforced the principle that involvement was voluntary. In contrast, for the outcome evaluation in the OAR Study (Chapters 6 and 7), potential service user participants were approached for invitation into the study through a letter from the care co-ordinator (Appendix L) with a study information sheet and a stamped addressed envelope which asked the service user to return a slip to the research team if they did not wish to be contacted by the researchers. Whilst no approach to potential participants was made without discussion with care co-ordinators, service users had to opt-out of being contacted about involvement in the research, rather than opting in. 31 service users out of a group of 244 potential participants returned the slip to say that they did not wish to be approached about the study, and a further 43 potential participants declined when telephoned about involvement and 10 potential participants declined at interview. It is possible that some of service user participants who agreed to take part may not have done so had involvement been first discussed with the relevant care co-ordinator, and therefore this gate-keeping function of care co-ordinators can be seen as beneficial in promoting participant choice. Overall, the gate-keeping role of care co-ordinators in this research is mixed. Whilst there are potential benefits, the limitations discussed in section 8.1.3 may have limited the opportunities for participants to be involved in research they wished to take part in. It is concluded that the use of an initiative such as Consent for Contact (recommendation 25) would be beneficial in addressing ethical as well as recruitment concerns, as it would allow for the wider discussion about potential involvement in research (generally)

to take place with a known professional, but without inviting care co-ordinator opinion or judgement about the specific research project.

For service users or carers with dementia, an assessment of capacity was made regarding participation. If the service user was unable to give such consent, then they were not recruited into the study or involvement in the study was discontinued if this was identified at the point of repeat measures. This decision was made earlier in the design of the study due to the exploratory nature of the research. Whilst this decision may have reduced some of the ethical issues involved, it is recognised that this decision may have limited the generalisability of the findings, through the exclusion of those with advanced dementia. Lack of capacity could have been addressed had assent been assumed, and as such could have been included within the application for ethical approval. Additionally, had a carer-completed proxy measure been used, data on participants who lacked capacity could have been gathered, although as discussed in section 8.1.2, carer proxy ratings are often lower than self-report for people with dementia.

The benefits for service user and carer participants of being involved in the qualitative interviews in Chapter 3 included the opportunity to talk about positive experiences, and aspirations for the future. For some participants, there was exploration of whether mental health services or other agencies might be able to help in achieving these. The potential to become involved in involvement activities which sought to improve current service provision more generally for users and carers was explored as a possible opportunity for five participants, who subsequently joined the service user and carer advisory group in the local OPMHS.

Whilst the qualitative interviews did not seek to explore traumatic life events, distress could have arisen from exploring emotions about the future and the past. Additionally, for carers, the qualitative interviews could have increased the sense of carer burden already experienced, as well as potentially increasing the sense of responsibility for the service user. Additionally, it is possible that distress could have been caused by exploring emotions with the carer about the future and the past of the person with dementia, as this may have increased the loss and grief experienced. In all interviews, the researchers were aware of the local service provision and also held information about local carers groups and services to provide as necessary. In anticipation of possible distress, an agreement was put in place that the researchers would liaise with

the appropriate care coordinator so that follow-up could take place. In completing the qualitative interviews, whilst on occasions some service user and carer participants became upset, this did not lead to undue distress, and it was agreed with participants that follow-up with care co-ordinator was unnecessary. Both researchers had clinical experience of working with older people with mental health problems and their carers, and were familiar with local service provision. Managing participant responses during the qualitative interviews may have been problematic without these skills and knowledge, and as such may be a previously unspecified requirement for carrying out this type of research.

Finally, with the exception of service user and carer participant involvement in the focus group in Chapter 4, the concept of recovery, and the intended purpose of the OAR intervention was not explored with service user and carer participants. This was in order to reduce the possible biasing impact which such disclosure may have had in respect of social desirability. However, as discussed in sections 8.1.1 and 8.1.2, further research which explores service user needs and preferences for recovery-oriented practice as well as the most acceptable term for recovery-related ideas is indicated.

8.4.2 Ethical Considerations for staff

A steering group was convened at the beginning of the programme of work, which included the service director, senior professionals and managers from the local OPMHS. This steering group made explicit that whilst there was a service commitment that the OAR intervention should be provided to all staff working in the local OPMHS, involvement with the evaluation of the OAR intervention was voluntary and staff would be invited, rather than expected to take part. Consent for completion of staff measures of recovery knowledge and attitude was undertaken by the research worker, who held no position of authority over any of the participants. For staff involvement in the focus groups and the qualitative interviews, only staff willing to participate and who gave their full written consent to participate were recruited. All staff approached about involvement were given full information about the research, which made clear that staff had a full choice as to whether participate or not. No incentives were offered and no pressure was placed upon staff to encourage participation in the research.

To address the burden of time, completion of the staff measures was included within the recovery training sessions. For the qualitative interviews, participants were offered an interview at a venue of their choice, either team base or other venue in order to

reduce the time involved, and any inconvenience caused by traveling. The focus groups took place at a convenient location. All activities took place in working time.

The benefits to staff of being involved in the focus groups and qualitative interviews included the opportunity to talk about the positive aspects of their own clinical practice, to reflect upon their own good practice and learning, and to identify further learning or development needs to support practice, team or career development. Staff were able to directly explore areas of uncertainty at the time of the focus groups or interview. Additionally, involvement in the research provided an opportunity for staff to contribute towards a new body of research and to improve current service provision for users and their carers, both of which could have enhanced staff satisfaction levels within their work environment. However, some staff could have found it difficult to acknowledge insufficient knowledge about recovery or express concerns about the concept, which may have led to embarrassment or discomfort. This may have been more likely within the qualitative interviews because some of those interviewed were approached due to a perception (by trainers) that they had not actively engaged in the training component of the OAR intervention. Additionally, there may have been concern, particularly at the time of wider service change, that non-engagement in the research or information regarding their level of recovery would be fed back to managers. As discussed in Section 7.2.1, the trainers perceived that for some staff, there was a perception that the focus on recovery related to an underlying agenda of reducing the number of staff employed by the local OPMHS. This was not identified by any staff in the qualitative interviews, nor was it explored, therefore it is unclear as to whether this may have been a concern. At the time of approach for the qualitative interviews (by email), the voluntary nature of participation in the research was emphasised, and potential participants who did not respond to the email were not approached again regarding involvement, and non-involvement was not fed-back to managers. Furthermore, confidentiality was maintained within the completion of the interviews, analysis and subsequent dissemination of the findings.

Finally, the wider literature on recovery-oriented practice was not explored with staff participants in the focus groups in Chapter 4, and nor was the OAR model shared in the process evaluation in Chapters 6 and 7. Further, the reasons (engagement or non-engagement) for approach for potential involvement in the qualitative interviews were not shared. This was due to an awareness of the need to reduce the potential social desirability bias within the research, particularly in relation to the wider work role of the principal investigator discussed in section 8.2. Further, as empirical evidence for

recovery and recovery-oriented practice in relation to older people was lacking, the overall aims of the thesis were exploratory, and as such, a more inductive approach to enquiry throughout the thesis was sought. Since completion of the research, the findings of the research, including the OAR model, have been shared widely within the local OPMHS, and have been used to inform further development of practice and strategy in this area.

8.5 Scientific Implications

The scientific implications which emerge from this thesis for future OAR research have been summarised in three areas: knowledge gaps, optimising the OAR intervention and optimising the evaluation of the intervention.

The scientific implications in relation to knowledge gaps are summarised in Table 8.1.

Table 8.1 Scientific implications arising from knowledge gaps

Knowledge gap	Recommendations
Uncertainty regarding the experience of recovery for specific groups of service users	Qualitative research aimed at understanding the experience of recovery for different groups using a participatory research approach. Use of these findings to modify the OAR intervention as necessary
Uncertainty about the specific practice implications for different groups of service users	Qualitative research aimed at understanding the practice implications for different groups of service users using a participatory research approach. Use of these findings to modify the OAR intervention as necessary
Uncertainty regarding the impact of underlying staff attitudes towards older people with mental health problems, and how these might underpin attitudes towards recovery and expectations of recovery training	Qualitative interviews with staff aimed at understanding underlying attitudes and expectations of recovery training. Use of these findings to modify the OAR intervention, and to develop a supporting values-based recovery philosophy for OPMHs

The implications for optimising the OAR intervention are summarised in Table 8.2.

Table 8.2 Implications for optimising the OAR intervention

Issue identified in thesis	Recommendations
OAR intervention too broad, and practice implications insufficiently defined	Incorporate specific practice implications for different groups of service users into the OAR intervention. Development of a supporting values-based recovery philosophy. Adoption of recovery interventions such as the IMR or the HOPES/I-IMR programmes, to support implementation of recovery-oriented practice as well as addressing physical co-morbidities
OAR intervention insufficiently focussed on supporting and sustaining behaviour change Influence of professional group on outcomes and engagement	Prescriptive implementation support, to include a multi-disciplinary reflective clinical practice forum, using recovery protocols (co-produced for specific groups of service users) as well as team leader involvement Redesign of the OAR intervention into two components: a) Recovery training which addresses recovery knowledge for delivery to uni-disciplinary groups to include expert consultation on the revised content prior to delivery. More tailored approach to all professional groups for both training and wider values-based practice recovery philosophy, to include engagement with psychiatrists who could act as pro-recovery opinion leaders. b) An on-going multi-disciplinary reflective practice forum, which addresses recovery attitude, team reflexivity and wider team practice change (as above). Expert consultation on the revised content prior to delivery and piloting to refine the modifications
Concern about evidence base for recovery and older people	Trainers to hold awareness and be able to draw upon the full evidence supporting recovery. Development of a supporting e-learning package
The length of OAR intervention insufficient	The OAR intervention to be delivered over 6-12 months, with an on-going sustaining component to ensure persistence of implementation.
The impact of team culture and timing of the intervention	Revise implementation strategy to include a framework which identifies and addresses context specific barriers <i>prior</i> to delivery of the OAR intervention and allows tailoring to context
Influence (positive and negative) of key individuals	Revise implementation strategy to include engagement of opinion leaders, well as strategy for dissenting opinion leaders
Lack of organisational commitment	OAR intervention needs to be supported by stronger leadership support, as well as development of a supporting values-based practice recovery philosophy and wider service redesign to enable recovery transformation

The implications in relation to optimising the evaluation of the OAR intervention are summarised in Table 8.3

Table 8.3 Implications for optimising the evaluation of the OAR intervention

Issue identified in the thesis	Recommendation
<p>Difficulties with self-report measures for people with dementia</p> <p>Measures used within the OAR study did not capture core components of recovery for older people</p>	<p>Use of proxy-rated measures as well as self-report measures for people with dementia</p> <p>Development of new measure of recovery for older people, which establishes the most acceptable term for recovery-related ideas</p>
<p>Lack of sufficient focus on action planning day and implementation support and reliance upon trainer feedback in fidelity assessment</p> <p>Methodology used for the care plan audit was problematic</p>	<p>Fidelity assessment of all elements of the intervention and random observation of delivery of the OAR intervention</p> <p>Use of a pre-planned analysis strategy developed from early analysis of a small dataset to allow data linkage as part of an interrupted time series analysis. Use of automated coding. Inclusion of WRAP plans and life histories</p>
<p>Lack of sufficient focus on the action planning day and implementation support in assessment of mediating variables</p> <p>Unable to assess service user experience</p>	<p>Repetition of measurement of staff attitude and knowledge change throughout delivery of the entire intervention, and collation of staff socio-demographic data</p> <p>A systematic review on measurement of service user experience in OPMHS. Dependent on results, identification of a suitable alternative or development of a new measure</p>
<p>Difficulties related to the cluster design arising from partial implementation, the impact of cluster and attrition</p>	<p>Need to amend the analysis strategy in order to address issues relating to cluster design more robustly in a future trial</p>
<p>Lack of supporting service user information</p> <p>Reliance upon care co-ordinators led to difficulties with service user recruitment</p>	<p>Collation of HoNOS 65 + and SMMSE ratings</p> <p>Use of an initiative such as Consent for Contact as part of the service user recruitment strategy</p>

8.6 Clinical Implications

There are four direct clinical implications for OPMHS.

(i). There is a need for a bottom up pressure for system change within OPMHS. In addition to the scientific implications identified within this thesis, there is a need to continue to strengthen service user and carer involvement within OPMHS so that it is a sustainable movement which can challenge the current paradigm of service delivery.

(ii). There is an on-going need for education about recovery and older people for staff working within OPMHS. In order to support the translation of these research findings, communication and learning between OPMHS implementing recovery-orientated practice should be prioritised (Tansella and Thornicroft 2009). The learning from this thesis should be disseminated, both at academic conferences, as well as to wider staff forums. For example, the development of a recovery e-learning programme which can be accessed by a wider number of staff and services should be considered. This would include making clear the working practices which support recovery for people with dementia as well as those with functional mental health problems, as well as the evidence base and wider literature supportive recovery transformation. The inclusion of specific recovery protocols would support this process. The purpose of such an e-learning programme would be to increase understanding about the evidence base for recovery and older people, to increase awareness that the concept of recovery has applicability to older people and to promote sharing of good practice between services. Such a development would complement the OAR intervention

(iii). It will be important for OPMHS to engage in initiatives which have generally been taken up by mental health services for adults of working age, even if the evidence for older people is lacking. Practical examples might include a co-produced dementia educational programme for people with a recent diagnosis of dementia as part of the development of recovery college (Perkins et al. 2012), or development of web-based self-management programmes tailored to older people.

(iv) The development of more older-people specific practice support tools and recovery protocols is required. For example, tools which are suitable for people with dementia such as amended WRAP plan which includes family/carers, physical and mental health problems, and plans to address eventual loss of capacity, rather than relapse (Cheffey et al. 2013).

Involvement of service users and carers in all of these development activities should be the norm.

8.7 Conclusions

This thesis contributes usefully to the evidence base for recovery and older people. It has shown that the concept of recovery has applicability for older people with mental health problems, including those with dementia. It has demonstrated where the concept and working practices deviate from what is described for adults of working age. A model comprising an intervention and intended effects has been developed, tested and modified. The thesis has also identified a number of knowledge gaps and areas of future research. It concludes that an RCT at this stage would be premature, but makes recommendations to optimise the intervention as well as the evaluation, to inform a further feasibility study.

Overall, the research makes a distinct contribution to knowledge in six areas:

- 1) A conceptual framework of recovery for older people (Daley et al. 2013)
- 2) Identification of the clinical practice implications for staff in OPMHS
- 3) Development and piloting of a model comprising an intervention and intended effects, and supporting evaluation and implementation strategies
- 4) A mixed-methods feasibility study of the intervention with 15 teams
- 5) Identification of factors to enhance optimisation of the intervention and evaluation strategy to inform a future definitive trial.
- 6) Identification of context factors influencing change within OPMHS

This work makes clear that positive change in knowledge, attitude and practice is possible for staff working in OPMHS. Within the local OPMHS, this research and related programme of work introduced the concept of recovery into the service, and has allowed for wider dialogue about recovery which has supported the introduction of a number of initiatives which are not captured within this thesis. Furthermore this research has generated interest from other OPMHS who are keen to implement recovery-oriented practice within their services. This programme of research can be used to take forward the recovery agenda more widely within OPMHS.

Appendix A. Ethics Approval



National Research Ethics Service

Camden & Islington Community Research Ethics Committee

REC Offices
South House, Royal Free Hospital
Pond Street, London
NW3 2QG

Telephone: 020 7794 0500 extn 36906
Facsimile: 020 7794 1004

19 November 2009

Ms Stephanie K. Daley
MHOA Directorate
South London & Maudsley NHS Foundation Trust
115 Denmark Hill
Maudsley Hospital
London
SE5 8AZ

Dear Ms Daley

Study Title: What is the applicability of the philosophy and practice of personal recovery for older people with mental health problems?

REC reference number: 09/H0722/66
Protocol number: Version 2

Thank you for your letter of 16 November 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

The Sub-Committee would like to raise the following points:

1. Thank you for your justification for proceeding with Part 2 of the proposed study. The sub-committee are content for this to happen but request that a report is completed (and submitted to the REC) stipulating how Part 1 has informed Part 2; please note this is only required to be brief and focused on the specific adaptations made to the planned intervention.
2. It is suggested that you make the following amendments to the Participant Information Sheet; 1) Include a heading "Why have I been invited?" (and delete "you have been chosen" wherever it occurs), followed by a heading "Do I have to take part", followed immediately by a clear statement "No. ..."; 2) Amend the "Benefits of

This Research Ethics Committee is an advisory committee to the London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

taking part" heading to "Risks and Benefits...", and include something like "some people may get upset by discussing..." and "there can be a pause." For further guidance on the approved format and wording please refer to the NRES guidance for Participant Information Sheets:
<http://www.nres.npsa.nhs.uk/applications/guidance/#PIS>

3. Please note the Version number of the revised protocol submitted as part of your Response to Provisional documents should have been Version 2; it has been labelled as such; please amend your own copy.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		22 July 2009
REC application		22 July 2009
Protocol	Version 1	22 July 2009
Investigator CV	C.I.s CV - Stephanie Daley	22 July 2009
Evidence of insurance or indemnity	Zurich Municipal for KCL	31 July 2009
Letter from Sponsor	Gill Lambert, Research Governance/Clinical Trials Facilitator, SLaM/loP R&D Office	26 September 2008

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Investigator CV	Supervisor's CV - Prof. Sube Banerjee	
Referees or other scientific critique report	Reviewer - Dr Rachel Perkins, SW London and St George's Mental Health NHS Trust; review requested by Guys' and St Thomas' Charity	21 October 2008
Offer of grant and correspondence with funder	Guys' and St Thomas' Charity	21 January 2009
Protocol	Version 2	01 October 2009
Participant Information Sheet: FORM 1 - Service user qualitative interviews	Version 2	17 October 2009
Participant Information Sheet: FORM 3 - Carer qualitative interviews	Version 2	17 October 2009
Participant Information Sheet: FORM 5 - Service user quantitative measures	Version 2	17 October 2009
Participant Consent Form: FORM 2 - Service user qualitative interviews	Version 2	17 October 2009
Participant Consent Form: FORM 4 - Carer qualitative interviews	Version 2	17 October 2009
Participant Consent Form: FORM 6 - Service user quantitative measures	Version 2	17 October 2009
Schedule of Forms		
Response to Request for Further Information		16 November 2009
Participant Information Sheet: FORM 7 - Service user focus groups	Version 2	17 October 2009
Participant Information Sheet: FORM 13 - Service user quantitative measures (pilot)	Version 2	17 October 2009
Participant Information Sheet: FORM 11 - Staff qualitative interviews	Version 2	17 October 2009
Participant Information Sheet: FORM 14 - Staff focus groups	Version 1	17 October 2009
Participant Information Sheet: FORM 9 - Staff quantitative measures	Version 2	17 October 2009
Participant Consent Form: FORM 15 - Staff focus groups	Version 1	17 October 2009
Participant Consent Form: FORM 10 - Staff quantitative measures	Version 2	17 October 2009
Participant Consent Form: FORM 8 - Service user focus groups	Version 2	17 October 2009
Participant Consent Form: FORM 12 - Staff qualitative interviews	Version 2	17 October 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0722/66

Please quote this number on all correspondence

Yours sincerely



Ms Stephanie Ellis
Chair

Email: katherine.ouseley@royalfree.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Sponsor and Research Governance contact - Jenny Liebscher, R&D Office, Institute of Psychiatry/ South London & Maudsley NHS Foundation Trust*

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Appendix B. R & D Approval

**Institute of
Psychiatry**

at The Maudsley

Research and
Development Office

Box P005
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel +44 (0)20 7848 079
Fax +44(0)20 7848 0147
www.iop.kcl.ac.uk/RandD

KING'S
College
LONDON
Founded 1829

Ms Stephanie Daley
MHOA Directorate, SLaM
Maudsley Hospital
115 Denmark Hill
London SE5 8AZ

11 January 2010

Dear Ms Daley,

Trust Approval: R&D2010/001 What is the applicability of the philosophy and practice of personal recovery for older people with mental health problems?

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval applies work in the Older Adults directorate and relates only to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including the extension to other Trust Directorates, will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached but is also available on the R&D Office website.

http://admin.iop.kcl.ac.uk/randd/downloads/RD_Approval_Amendment_Form.doc

I can confirm that King's College London will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework

South London and Maudsley 
NHS Foundation Trust

- http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf.
- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy. http://admin.iop.kcl.ac.uk/randd/downloads/Confidentiality_Policy_080219.pdf.
- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.
- Informing the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.
- Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.
- Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.
- Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Jenny Liebscher jennifer.liebscher@kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely



Jenny Liebscher
R&D Governance and Delivery Manager
SLaM/IoP R&D Office

Enc. R&D Approval Amendment Form

Appendix C. Service user topic guide

Could you tell me a little about how you spend your time?

What is day to day life like for you?

What activities have you enjoyed doing in the past?

How does this compare to how you spend your time now? What gets in the way?

To what extent has your (mental or physical) illness and/or ageing impacted on this?

How do you manage your illness?

What helps you to do this?

What is important for you for the future?

How would you describe your role (added in after 6th interview)

What would you like to be doing with your time?

How might mental health services or other agencies support you in this?

Appendix D. Carer topic guide

Could you tell me a little about how X spends his or her time?

How would you say that day to day life is like for X?

What activities has X enjoyed doing in the past?

How this compares to what X spends their time doing now? What gets in the way? Do you know what X might like to be doing with his/her time?

To what extent has X's (mental or physical) illness and/or ageing impacted on this?

How would you describe X's role/s (added after 6th interview)

What might help X to manage his/her illness?

Are you aware of anything which is important to X for the future?

Appendix E. Initial Coding Framework

Acceptance of Risk

Avoidance of

- Isolation
- Activity

Building Confidence

Choice

Coping with Change

- Impact of Illness on Personality
- Change in role
- Acceptance
- Environmental

Dislike of Day centres

Enjoyment of Life

Frustration

Giving something back

- Community Involvement
- Service involvement

Goals for the Future

Home Environment

- Negative
- Positive

Lack of Information

Responsibility for overcoming or managing illness

- Internal
- External

Loss

- Deteriorating physical health
- Meaningful activities
- Significant Relationships
- Social Network
- Valued role

Meaningful Activity or Occupation

- Adaptation of occupation or activity
- Continuation of activity or occupation
- Impact of Illness on activity or occupation
- Lack of activity
- Shared activity (spouse, partner or friend)

Medication

Neglect

Poor insight into own problems

Outlook for Future

Fearful
Positive

Physical Health

Good Health
Problems

Positive Coping Strategies

Carer's support
Engagement in activity
Engaging with Service support
Family support
Having Information
Insight into own Problems
Peer Support
 Carers
 Users
Perspective or Attitude
Routine
 Managing illness (carer)
Social Engagement
Taking Control

Positive relationship with Carer**Recovery - No Resonance****Self-Reliance****Social Connection**

Getting Out
Impact of illness
Social Isolation
Social Networks
 Family
 Formal (Service based)
 Informal (Friends and Acquaintances)
Social Organisations

Spirituality**Valued Role (Identity)**

In Occupation or Activity
Member of Social Organisations
Personal achievements
Personal Skills
Relationships
 Family member
 Friend
 Neighbour
 Spouse or Partner
Sharing Expertise

Appendix F. Focussed coding framework

Focussed coding framework
Continuation/adaption of meaningful occupation/activity
Overcoming and managing illness
Positive coping strategies
Acceptance of change
Mental health service support
Internal/external responsibility for managing/overcoming illness/problems
Impact of Physical Health
The maintenance of valued social roles
Positive personal identity (as distinct from illness/diagnosis)
Social Connections
Reciprocal Giving

Appendix G. Summary of theoretical sampling

Type of participants (n)	Key theoretical questions required for developing themes	Amendments to topic guides: key questions for participants
Service users with psychosis (2)	Is the experience of managing illness for an older person with psychosis similar/different from the experience of those with affective or organic disorders?	<p>What prompted you to find ways of managing your illness?</p> <p>What helped you to start doing this? What got in the way before?</p>
Service users with affective disorders	What are the factors involved in the initiation of active coping strategies for older people with affective disorders?	<p>Could you tell me a little about when you were at your most unwell? What impact did it have on you?</p> <p>What ways did you find to manage your illness?</p> <p>What prompted you to find ways of managing your illness?</p>
Service users with mild dementia (2)	What are the factors involved in the initiation of active coping strategies for people with dementia?	<p>Can you tell me a little about what it was like for you to find out that you had a dementia?</p> <p>What prompted you to find ways of managing your illness? What helped you to start doing this?</p> <p>What got in the way before?</p>
Carers (2)	At what point do spousal carers take over responsibility and control for people with dementia?	<p>Could you tell me a little about X's illness, and how it progressed?</p> <p>At what point did you feel that you needed to take responsibility for X in order to manage day-to-day life? What did that mean practically? How did X re-act to you taking over control? Has X been able to maintain any control over his/her life?</p>

Appendix H. Example of Theoretical Memos

28th June 2010 – Joint Coding session with Research worker – Social Connections - agreed theme is ***maintaining*** social connections – and also generation beliefs regarding the ***perceived value of getting out. Being part of the world*** is a separate theme – not clear whether it relates as coping strategy or as part of recovery – to keep separate at the moment

3rd July 2010 – Joint coding session with Service user researcher – Loss/acceptance of change - Rather than acceptance of change – rename theme to ***attitude to change*** – can be defined in different ways; ***acceptance/enjoying, changing, observing, rethinking, ambivalent or resistant***. Could be seen as a ladder, similar to recovery star or stages of recovery (Andresen et al)

Adapting to the change can be done consciously (thinking) or not (not thinking) – not clear which is preferable?

5th July 2010 - Constant comparison – Coping Strategies - Is ***positive relationship with carer/spouse*** a coping strategy rather than a stand-alone theme? Rename ***positive relationship with spouse***.

14th July 2010 – supervision - Role of carer in supporting the person with dementia for their recovery – context is different for older people than for younger adults – dynamic of married spouses – couples function as a unit – cannot see it separately, it is more than a proxy response – illness is in the context of their life together (see McCurry and Drossel, – nurture the dyad)

Appendix I. Peer reviewed publication

Abstract

Objective: To evaluate whether a conceptual framework of recovery developed for working adults holds value for users of older people's mental health services, including those with dementia.

Method: 38 qualitative interviews were undertaken with service users and carers from an older people's mental health service in South London, and analysed using grounded theory methods.

Results: Components of recovery which appear to be meaningful to older people with mental disorder include: a) the impact of illness, b) the significance of personal responsibility, and c) specific coping strategies. Unlike their younger peers, older people did not aspire to a new and revised sense of identity, nor did they seek peer support from others with lived experience of mental illness. Three components of recovery were identified as being distinct to older people: the significance of an established and enduring sense of identity; coping strategies which provide continuity and reinforce identity; and the associated impact of physical illness. Finally, two additional components of recovery were identified for people with dementia: a) the changing experience over time, and b) support from others.

Conclusion: Mental health policy is increasingly framed in terms of "recovery". This paper provides empirical evidence of how it applies to users of older people's mental health services. Practice implications include the need to focus on the maintenance of identity, and embed the values of empowerment, agency and self-management within service delivery.

Background

The recovery movement in mental health has developed over the last decade into a dominant paradigm in policy and practice. It has evolved from recognition of the value of the narratives of adults of working age with a lived experience of mental illness, and the movement has sought to redefine expectations and outcomes in mental disorder. Within this new framework for understanding mental illness, recovery is led and instigated by the person with the mental illness, and may or may not involve input from mental health services. The process of recovery typically involves taking back control of one's life and one's illness, and taking personal responsibility for one's own recovery (Roberts and Wolfson 2004). A decrease in symptoms is not a pre-requisite for recovery. Key components include: hope, acceptance, agency, peer support, valued social roles and connectedness (Bellack 2006, Andresen et al. 2003, Ralph 2000, Ridgway 2001). A definitive framework informed by a recent systematic review of available literature on recovery (Leamy et al. 2011) is summarised in Table 1.

Table 1: Key components of recovery (Leamy et al, 2011)

Components of Recovery	Recovery processes
Connectedness	Peer support & support groups, relationships, support from others, being part of the community
Hope and Optimism about the future	Belief in possibility of recovery, Motivation to Change, Hope inspiring relationships,
Identity	Dimensions of Identity, Rebuilding/ redefining positive sense of identity, overcoming Stigma
Meaning in Life	Meaning of mental illness experiences, Spirituality, Quality of Life, Meaningful life and Social roles, Rebuilding Life
Empowerment	Personal responsibility, Control over Life, Focussing on Strengths

The impact of the recovery philosophy upon mental health service policy, delivery and research for adults of working age has been substantial across North America, Australia, and UK, and is likely to continue to be an important influence. Equivalent developments and research in older people's mental health services have not yet taken place, and the possible implications of a recovery approach are just starting to be explored (Hill et al. 2010, Adams 2010, Martin 2009, Woods 2007). However the priority placed on recovery by policy makers and user groups means that it is likely that older people's mental health services will need to respond to the recovery agenda. In doing so, they will need to be clear about whether the concept needs to be modified.

In this paper we present a conceptual framework for recovery for users of older people's mental health services derived from an exploration of the beliefs and experiences of service users and carers through a series of in-depth qualitative interviews. We have aimed to investigate two research questions:

1. Are components of recovery identified by adults of working age meaningful to older people with mental health problems?
2. Are there additional components of recovery which are specific to dementia?

We have sought to identify key similarities and differences from the existing concept of recovery, and have explored the emerging practice implications.

Method

Sample and setting

Participants were over 65 years of age and were users of older people's mental health services. Participants were recruited via mental health professionals across eleven community mental health teams in South London. Staff were asked to approach service users on their caseloads about potential involvement in the interviews, and were given a study information sheet to assist with this task. The recruitment strategy was to include as wide a variety of users as possible. All service user participants were, in the judgment of staff, able to give informed consent, and all had a clinical diagnosis.

Service users with dementia were asked to identify their main care-giver, if they had one, who was subsequently approached about involvement in the study. Carer participants were family members and partners providing informal care, and included five female and five male carers. Eight of the service user and carer participants were dyads.

Procedure

Ethical approval was obtained from the NRES Committee London (Camden & Islington) in November 2009. Topic guides for service user and carer participants were developed from a review of the recovery literature in relation to adults of working age. Key topics included: day-to-day life, use of time, impact of illness, coping mechanisms and future plans and goals.

The majority of interviews were carried out in participants' own homes. Service user and carer participants were interviewed concurrently in different rooms. Written consent was obtained, and interviews were conducted by two researchers (SD and DN) in 2010, and lasted between 45 and 60 minutes.

Analysis

30 interviews were audio-recorded, transcribed verbatim and checked for accuracy. The transcripts were then analysed using grounded theory techniques. Grounded theory is a systematic methodology which identifies patterns of meaning from data in order to construct theory (Glaser and Strauss 1967). The process of analysis started with descriptive coding whereby, the researchers (SD and DN) independently coded three transcripts in order to identify preliminary themes, which they jointly reviewed with an independent qualitative researcher (JM), and agreed an initial coding framework.

The remaining 27 transcripts were coded using constant comparison techniques which involved reviewing coding and data between existing and new transcripts in order to: a) identify new codes, b) check the use of codes for consistency, and c) explore relationships between different codes. Emerging themes were reviewed with the qualitative researcher (JM) and also a service user in respect of her lived experience. An initial conceptual framework was developed, and eight final focused interviews were undertaken and analysed using theoretical sampling to refine our understanding of emerging themes and produce a final conceptual framework. The analysis was supported by the use of NVivo 8 (QSR International, 2008).

Results

Participants

Thirty eight interviews were completed, comprising twenty-eight service user participants and ten carer participants. Table 2 characterises the service user participants.

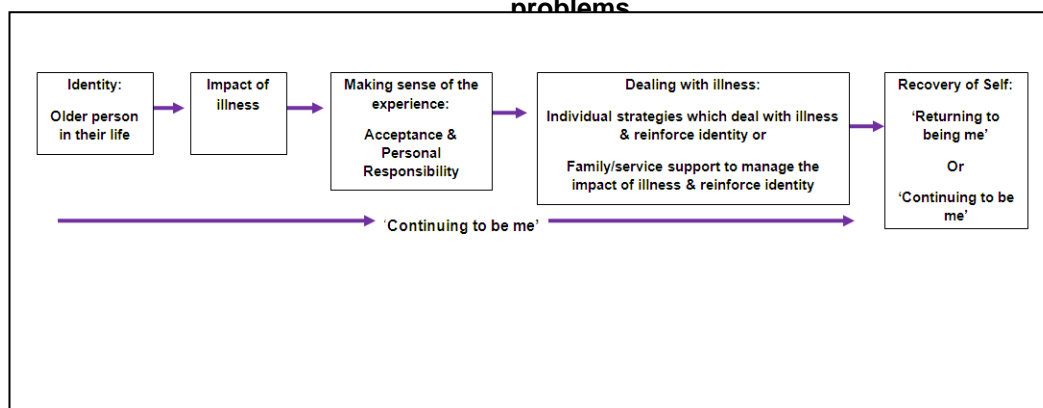
Table 2: Socio-demographic and clinical characteristics of service user participants

Characteristic	Type	Number (Percentage)
Gender	Female	16 (57)
	Male	12 (43)
Age	65 - 75 years	12 (43)
	76 – 85 years	13 (46)
	86 years	3 (11)
Ethnicity	White British	20 (71)
	White other	3 (11)
	Afro-Caribbean	2 (7)
	Asian	3 (11)
Living Situation	Lives alone	14 (50)
	With spouse	9 (32)
	Lives with family	2 (7)
	Supported housing	2 (7)
	Residential care	1 (4)
Diagnosis	Dementia	11 (39)
	Psychosis	3 (11)
	Affective Disorders	14 (50)
MMSE for participants with Dementia	21 – 30 (Mild impairment)	7 (64)
	11-20 (Moderate impairment)	4 (36)
Previous use of mental health services before 65 years	Previous use of services	9 (33)
	No previous use of services	19 (67)

Conceptual framework

A conceptual framework for the experience of recovery for users of older people's mental health services developed from the analysis is shown in Figure 1. An overarching core category of 'Continuing to be me' was identified, which encompassed the following five themes; Identity, Impact of Illness, Making Sense of the Experience, Dealing with Illness, and Recovery of Self.

Figure 1: Conceptual Framework for recovery in older people with mental health problems



Core Category: 'Continuing to be me' - The single core category identified from the analysis was 'Continuing to be me.' This related to the permanent and established sense of identity which service user participants held, and the significance of this in their experience of mental illness. Service user participants had a clear sense of who they were and how they defined themselves. This sense of 'who I am' permeated all of the interviews and appeared to be key in buffering the impact of the illness. The goal of 'continuing to be me' or 'getting back to being me' was evident in the activation of coping strategies which reinforced a sense of self, and as a measure of progress and successful outcome.

Theme One: Identity - All of those interviewed had an established and enduring sense of identity, and all described, in detail, the history of their lives before becoming unwell. The journey of recovery from mental illness appeared primarily to be connected to the extent to which the pre-existing sense of identity could be maintained or regained.

Theme Two: Impact of Illness - Loss of established roles, social networks and occupations. Participants discussed the overwhelming sense of loss which accompanied their experience of mental illness. Participants with both functional and organic illnesses described losing interest in the people and activities which were important to them, and withdrawing from the world.

Impact of co-existing physical illness - Participants with both functional and organic mental health problems described difficulties with their physical health, which impacted upon their mental health and their ability to continue with important roles and activities. The impact of, and need to manage both mental and physical illnesses appeared to be experienced as a whole.

Impact of dementia - For people with mild dementia, the impact of the illness appeared to be experienced most strongly in relation to the completion of every-day tasks and activities, as well as their short-term memories.

'I still do cook. I liked cooking when I was normal I did a lot of good fancy cooking... Well now I only do the basic stuff.' (No.26, female service user with mild dementia)

Participants with moderately severe dementia were unable to provide an account of the impact of their illnesses upon their lives.

Theme Three: Making Sense of the Experience - the analysis indicated that a number of processes facilitated or hindered the capacity of participants to make sense of the experience of illness. These included acceptance, or non-acceptance of illness as well as perceived responsibility for recovery. Responsibility for getting better and managing the impact of illness was seen by some participants as their personal responsibility

'I think there are a lot of people when they have mental illness or especially depression they seem to rely on the pills and that's it. You've got to help yourself as well. You've got to push yourself to do things.' (No.2, male service user with depression)

Whereas other participants believed it was the responsibility of either mental health services or others to enable recovery.

'I am not very creative because I am suffering from alcoholism ...I just find that I am unmotivated and I have a terrible depression. Dr X is trying to cure it.' (No.5, male service user with depression)

Theme Four: Dealing with Illness - a number of mechanisms were identified by participants, which had a dual role of both mitigating the impact of illness and promoting continuity, therefore reinforcing a sense of identity. Predominantly, these were selected on the basis of personal preference, availability of internal and external resources, including mental health services and applied to all participants. These are summarised in Table 3.

Table 3: Coping mechanisms for dealing with illness

Coping Mechanism	Includes	Example
Compensatory techniques	Use of diaries, lists and home re-organisation, practical help such as a cleaner	<i>'If she sends me down the shops... If she writes the items down, I'll be alright.'</i> (No.3, male service user with mild dementia)
Continuation of social networks, roles and meaningful activities	Continuation of existing, rather than new, social networks, roles and established activities.	<i>'Having loyal friends and not being completely on your own is important because when you start getting better, you've got friends to focus on haven't you?'</i> (No.2, male service user with depression)
Making sense of illness/ using information	Finding out more about illness, fully understanding diagnosis and ways of coping. Includes information from professionals, either individually or in groups	<i>'I thought 'thank god' I like knowing, the Alzheimer's – I know now what is me, and what is the Alzheimer's.'</i> (No.23, female service user with mild dementia)
Self-help activities	Undertaking activities which are perceived to be helpful to overall health and well-being such as diet, or getting fresh air	<i>'Every day, I will take a walk up to X and walk back. I do make a habit of going out.'</i> (No.8, female service user with panic disorder)
Being part of the world	Includes engaging with others and knowing what is going on in the world.	<i>'I don't want to sit here all day and wait for the news to come on. I'd rather get a newspaper; I'm still part of the world..'</i> (No.12, female service user with mild dementia)

Theme Five: 'Recovery of self' - for people who perceived that they were managing their illnesses well, a key outcome appeared to be the extent to which they felt that they had maintained, or regained their sense of self. Most of those with affective and psychotic disorders saw a successful outcome following mental illness as becoming, or progressing towards being their former selves again.

'Getting back to being me...it was just that I was slowly reverting back to my former self really.' (No.36, male service user with psychosis)

For people with dementia, this was more commonly expressed as being able to maintain a sense of self.

Two components of recovery emerged as being specific to people with dementia - the role of spousal carers of people with dementia in reinforcing a sense of identity - for people with dementia who were married or in a long term relationship, the impact of the illness and development of strategies to deal with the illness took place in the context of that partnership. From the analysis, it was evident that carers held a key role in either facilitating or hindering the use of coping strategies which both mitigated the impact of illness and providing continuity, thereby reinforcing a sense of identity – as is illustrated by the following couple:

‘I don’t do very much now at all apart from looking after my beloved’ (No.26, female service user with mild dementia)

Researcher: ‘Can you tell me what X would see as her role?’

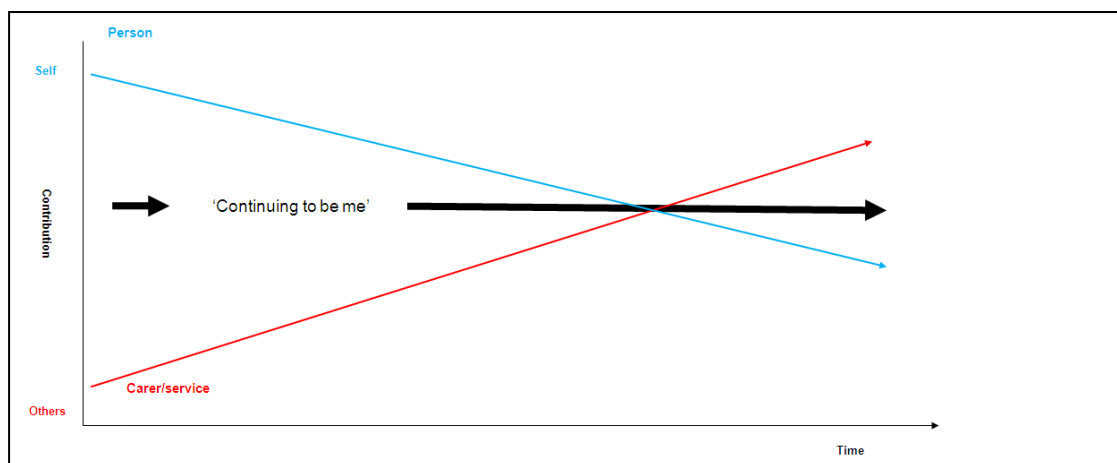
Carer: ‘Looking after me.’

Researcher: ‘Was it?’

Carer: ‘It still is.’ (No.27, male spousal carer)

The changing experience of recovery for people with dementia- from the analysis, the mechanism for maintaining a sense of self was seen to change over time for people with dementia. For participants with a mild dementia, personal responsibility for managing the impact of illness and personally instigating coping strategies which supported compensation and continuity were both evident. For participants with a more advanced dementia, where the subjective sense of awareness and therefore personal responsibility had decreased, carers reported that they had gradually taken on a more direct role in managing the impact of illness as severity increased. In situations where carers had been able to reinforce a sense of personal identity through continuity, it was evident that recovery continued to take place. These additional components are presented in Figure 2:

Figure 2: Additional components of recovery for people with dementia



Discussion

Analysis of 38 qualitative interviews using grounded theory methods has provided an empirically-derived conceptual framework for recovery for users of older people's mental health services, with five key components. Two additional components of recovery have been identified for people with dementia.

Recovery for older people compared to adults of working age - we have compared our findings to components of recovery identified by adults of working age. The components of recovery which appear to be meaningful to both groups are: a) the impact of illness, b) the significance of personal responsibility, and c) a number of specific coping strategies, most notably using information, being connected to others and to the world and self-help activities. In contrast to adults of working age, the older people interviewed did not aspire to a new and revised sense of identity. Support was derived from existing long term relationships as opposed to peer support from others with lived experience of mental illness, representing a significant difference in the sources and utilisation of support by older people compared to adults of working age (Lette 1989, Repper and Carter 2011, Deegan 1993).

We have identified three elements of recovery which appear to be distinct to users of older people's mental health services:

The significance of an established and enduring sense of identity in the experience of mental illness, both in terms of mediating the impact of illness, and in providing internal and external resources to deal with illness.

Coping strategies which provide continuity through the utilisation of existing networks, roles and activities, including peer support from long-term friendships. This finding is consistent with the literature on 'successful ageing' which proposes that the process of maintaining or adapting existing social networks, activities and roles enhances a positive and enduring sense of identity and adjustment to older age (Atchley 1989).

The impact of co-existing physical and mental illness, and the development and use of coping strategies to deal with both.

Recovery and people with dementia - the findings from this study, of the importance of 'continuing to be me' and the use of strategies involving compensation and continuity to re-enforce self are consistent with research on identity and coping for people with dementia ((De Boer et al. 2007, Caddell and Clare 2011, Clare 2002, Cotrell and Hooker 2005). Further, it is apparent that important elements of the concept of recovery as defined by adults of working age holds value for people with dementia, for example personal responsibility and connectedness but that some modification is required. Two key components appear to further influence the experience of recovery for people with dementia, namely a changing balance over time from personally initiated strategies, which provide compensation and enable continuity, to support from others.

Practice implications - there are three key practice implications arising from this study:

Maintenance of Identity - the study highlights the need for mental health professionals to focus on maintaining the identity of users of older people's mental health services. While a focus on identity is enshrined within the philosophy of person-centred care for people with dementia (Kitwood 1997), this is not routinely considered for users who have affective and psychotic disorders.

Promoting empowerment, agency and self-management - this study has demonstrated that users of older people's mental health services do perceive themselves as being responsible for managing their own illnesses, and of being able to develop coping strategies based on their own preferences and resources. This contrasts with the working practices evident within some older people's mental health services, where the principles of empowerment, agency and self-management are not routinely promoted (Bowers et al. 2005). Similarly to working age adult mental health services (Farkas et al. 2006, Shepherd et al. 2010), wider system change within older people's mental health services is indicated.

Facilitating the process of recovery for people with dementia - the need to take a staged approach to supporting the recovery of people with dementia is highlighted from this study. Work with users and carers about practical strategies to promote agency, compensatory techniques and continuity is indicated.

Limitations of the study

There are three main limitations to this study. Firstly, only participants who were willing and able to provide an account of their experiences took part. This should be acknowledged as a potential limitation, as it is possible that this group of participants may have been more likely to have an established sense of self, and have been more adept in managing and living well with their illnesses, and as such may not be fully representative of users of older people's mental health services.

Secondly, the majority of those interviewed (67%) had not experienced mental health problems until later life. Their sense of identity had developed for the most part without mental illness and without connection with mental health services. It is not clear whether this framework can be applied to older people with enduring mental health problems that have been present throughout adult life, and are users of working age adult services.

Finally, the participant profile within this study is intentionally broad, in-depth practice implications for specific groups of service users, for example, those with a recent diagnosis of early dementia, is limited.

Conclusions

This is the first study to empirically explore the relevance of the concept of recovery for older people with mental health problems compared to adults of working age. We have demonstrated that an established sense of identity and continuity are critically important to recovery for users of older people's mental health services.

This study has potential value in encouraging older people's mental health services to more actively respond to the narratives of service users and carers, and in doing so, consider how the principles of empowerment, agency and self-management can be embedded within their services.

This study also enables older people's mental health services to be clearer about where they may need to deviate from an established recovery policy agenda (Department of Health 2011) which has been developed without detailed consideration of differences in recovery across the life-span. There is a need for the recovery policy agenda to be revised to ensure that it works for people with mental disorder of all ages, not just those of working age. If it is not, then it runs the risk of generating services that work less well for older people than for people of working age and so embedding rather than addressing discrimination.

Appendix J. Staff topic guide

Study information sheet and consent form

What is your understanding of recovery?

What does recovery mean in practice for mental health professionals?

What does recovery mean in practice for older people?

How did you find the recovery training?

How did you find the team development day?

How did you find the implementation support (x)?

Have you been able to implement anything into your own practice?

If so what has helped this process?

If not, what has limited this process?

Has there been any impact on the way in which the team works following the recovery training?

If so, what is this – what do you think helped this process?

If not, what do you think limited this process?

What if anything would help the team and yourself to continue to develop (or begin to develop) recovery-orientated practice at this stage?

Appendix K. Training component of the intervention

Component	Content
Training Module1 Recovery and Older People	<p>Introductions/group rules - aims of the programme/day 1</p> <p>Recovery – what does this mean to you? What might it mean for older people? (In groups) What is different about recovery - Framework for recovery and older people</p> <p>Self- assessment – what elements of your practice are currently recovery-`oriented? What might you need to develop? (in pairs)</p> <p>Recovery-oriented language (lecture)</p> <p>Practical skills based exercise – ‘Who are you’ - hearing the story (in groups of three)</p> <p>What do you want for the future, what would be most important, what would your hopes be? (in pairs)</p> <p>Recovery-focused assessment (overview and practical exercise)</p> <p>Homework – bring in a picture which says something about you into the next session</p>
Training Module 2 Maintaining Identity	<p>Every picture tells a story – What is your story? (in pairs)</p> <p>How would you tell your story? (Practical exercise)</p> <p>Life story work + personhood (Kitwood, 1997)</p> <p>Supporting social inclusion – what is it, barriers and facilitating inclusion</p> <p>Practical exercise – supporting relationships/engagement in activities</p> <p>Well-Being plan – complete part of the plan with each other and reflect upon excise (in groups of three)</p> <p>Homework – reflect on a case-study care plan – how can this be rewritten/undertaken collaboratively</p>
Training Module 3 Enhancing Resilience	<p>Care planning –reflect upon homework exercise (in groups of three)</p> <p>Introduction to resilience and self-management</p> <p>Coping with loss and building resilience (practical exercise)</p> <p>Risk Management – how do we share risk (practical exercise)</p> <p>What is coaching? Using coaching techniques/Setting goals and managing Set-backs (workshop)</p> <p>‘Getting back to my old self’ – building confidence for discharge (practice exercise)</p> <p>Preparing for action planning day - Identify 3 developments you would like to make as a team basis and why you would want to develop this area of practice</p>
Action planning day	<p>Development of team (recovery) action plans for three areas identified in day three – plans to be developed with clear objectives which specify the desired outcome, action necessary to the achieve the outcomes, individuals responsible and timescales.</p> <p>Agreement of implementation support with the recovery training facilitator in light of team action plan. Feedback of team (recovery) action plan and implementation support to service manager</p>
Implementation support	<p>Advice on developing new team processes, educational supervision at a team or individual level, or co-working with staff with individual service users.</p>

Appendix L. Letter of invitation for service user participants

Dear

RE: XX SOCIAL INCLUSION AND RECOVERY PROJECT

I would like to tell you about a research project, which you are invited to help us with. The purpose of the research is to understand the extent to which our services help people to do the things which are important to them.

If you agree to take part, you would be contacted by one of the research team who would make a time to see you that was convenient for you. He or she would then ask you some questions to find out how you think you are managing your recovery, and how well you think our services may have helped you.

The research team would like to know how the answers to these questions may change over time and so we they would make another appointment to see you six months later after the interview. There are no right or wrong answers the sorts of things they will ask about, this is not a test of you. They just want to ask about whether our services have helped you.

This information will be used to review and improve the way in which we run our services.

I enclose an information sheet which describes the project and what it involves in more detail. There is no obligation for you to participate in this research but it would be excellent if you felt able to help with this. You have been chosen because you are currently under the care of our service at the moment.

I enclose a form and a stamped addressed envelope, which you should send back to the research team if you are **not** happy for them to contact you to discuss involvement in this study. If you do not send the form back then they will be in touch in the next week or so.

If you have any questions about being involved in this research, please do not hesitate to contact me. Alternatively you may wish to speak to a member of the research team (Stephanie Daley or David Newton directly). They would be more than willing to discuss any aspect of the research in more detail with you.

Appendix M. Service user experience questions

We would like to ask you some questions about your experience about using our services

- 1. Did staff take time to find out more about how you were before you became unwell?

.....

- 2. Have staff asked how you have coped in the past with difficult and stressful events?

.....

- 3. Did staff ask you about the impact of your illness on you? And upon your life?

.....

- 4. What if anything helped you to take action to do something to manage/ overcome your illness?

.....

- 5. Did staff talk to you about how you might manage your illness better?

.....

- 6. Did staff tell you about help or resources which might be available to you which would help you to manage your illness better?

.....

- 7. Did staff discuss any concerns which they might have about your safety?

.....

Appendix N. Trainer guide

Can you tell me what teams you have been involved in delivery the intervention to?

What you think went well about the training and action planning day?

Why do you think that was?

Are there were things that you felt with reflection went less well?

If so, why was that?

Is there anything which you think you could have done differently?

Do you think there is anything else which could have been done differently?

Is there anything else that we haven't touched on?

Appendix O. Acceptability Coding Framework

Codes	Sub-codes
Training Dyad	<ul style="list-style-type: none"> Breakdown of relationship Negative impact of the training on dyads Reciprocal relationship Use of service user experience Neutrality of trainers
Team Culture	<ul style="list-style-type: none"> Burnout Defensiveness
Role of Team leaders	<ul style="list-style-type: none"> Supporting the process Dealing with bad behaviour
Content	<ul style="list-style-type: none"> Flexibility Different learning styles Respect for colleagues Link with policy Junior staff more receptive Lack of evidence base
Trainers	<ul style="list-style-type: none"> Overcoming 'we do it already' challenge Self-assessment
Role of key individuals	<ul style="list-style-type: none"> Positive Negative On-going role
Organisational commitment	<ul style="list-style-type: none"> Need for clear message Supporting change
Arm 2	<ul style="list-style-type: none"> Impact of wider service changes Hidden agenda Cynicism Impact of doctors not attending

Appendix P. Context Coding Framework

Codes	Sub-codes
Individual practice change	Care plan approach GP letters Focus on wellness Differences in boundaries
Lack of team change	Change not noticed Not knowing about change Action plans not implemented
Barriers	Wider service changes Lack of team leader support General pressure Overcoming traditional way of working Recovery difficult in practice Lack of flexibility in service delivery On-going issues from training
Facilitators	On-going champions Fit with professional identity Practice support tools 'Maintaining enthusiasm' Focussed time External support Internal 'team' support Regular updates

Appendix Q. Fidelity Assessment Raw Data

Team	Staff in team	Partial receipt	Full receipt	OAR Intervention	Action plan	Implementation Support
1	16	12 (75%)	11 (69%)	3 training days & team away day	Y	Attendance at clinical meeting x 3 Individual meetings x 2: Well-Being plan
2	16	11 (69%)	11 (69%)	3 training days & team away day	Y	Individual supervision x 2 staff, Attendance at Staff meeting x 3, Meeting with Manager x 3
3	14	5 (35%)	4 (28%)	3 training days & team away day	Y	Attendance at clinical meeting x 3 Individual supervision sessions (6) x 1 staff
4	13	13 (100%)	9 (69%)	3 training days & team away day	Y	Attendance at staff meetings x 3
5	13	8 (61%)	5 (38%)	3 training days & team away day	N	None – difficult training experience
6	22	20 (91%)	18 (82%)	3 training days with team 7 & team away day	Y	Individual meetings x 6: Well-Being plan Co-facilitation of Recovery group x 6 sessions
7	22	20 (91%)	18 (82%)	3 training days with team 8 & separate team away day	Y	Co-facilitation of Recovery group x 6 sessions
8	22	19 (86%)	18 (82%)	3 training days & team away day	Y	None – service consultation
9	15	11 (73%)	11 (73%)	3 training days & team away day	N	None – difficult training experience
10	22	21 (95%)	21 (95%)	3 training days with team 11 & separate team away day	Y	Additional training – Collaborative working x 6 sessions
11	23	23 (100%)	23 (100%)	3 training days with team 10 & separate team away day	Y	X 3 reflective practice sessions
12	13	10 (77%)	7 (53%)	3 training days and away day with teams 13 & 14	N	None – Manager left
13	13	10 (77%)	8 (61%)	3 training days and away day with team 12 & 14	N	None - Manager left
14	13	11 (85%)	9 (69%)	3 training days and away day with teams 12 & 13	N	X 3 visits to plan for information days
15	12	10 (83%)	8 (66%)	2 training days & team away day	N	None - difficult training experience
Total	249	204	181			Bolds denotes met fidelity standard

Appendix R. Differences in change scores by team

The results show that there was change in both directions for each of the six-sub-scales, with the exception of RKI Sub-scale 3, whereby all teams moved in a positive direction. Seven teams showed positive change in all sub-scales, and eight teams showed negative change on at least one sub-scale.

The results for RAQ-7 Sub-scale 1 show that team-level change scores ranged from +1.40 (showing more positive attitude) to -1.11 (showing less positive attitude), with four teams (4, 7, 13, 14) moving in a negative direction.

Differences in change scores by team (n=15)

Team	RAQ-7 Sub-scale 1	RAQ-7 Sub-scale 2	RKI Sub-scale 1	RKI Sub-scale 2	RKI Sub-scale 3	RKI Sub-scale 4
	Mean (s.d)					
1	1.00 (2.53)	0.44 (0.54)	0.51 (0.84)	0.44 (0.54)	0.27 (0.50)	0.36 (0.50)
2	0.18 (1.94)	0.27 (0.46)	0.11 (0.45)	0.27 (0.46)	0.16 (0.35)	0.04 (0.65)
3	0.75 (1.50)	-0.08 (0.21)	0.21 (0.14)	-0.08 (0.21)	0.30 (0.420)	0.12 (0.85)
4	-1.11(2.47)	0.05 (0.50)	0.24 (0.49)	0.05 (0.50)	0.26 (0.72)	-0.11 (1.41)
5	1.40 (1.14)	0.01 (0.45)	0.26 (0.57)	0.01 (0.45)	0.24 (0.36)	-0.50 (1.32)
6	0.39 (2.60)	0.24 (0.59)	0.24 (0.68)	0.24 (0.59)	0.40 (0.95)	0.39 (0.99)
7	-0.17 (4.18)	0.26 (0.60)	0.29 (0.46)	0.26 (0.60)	0.34 (0.45)	0.17 (0.98)
8	1.22 (1.80)	0.44 (0.67)	0.37 (0.39)	0.44 (0.67)	0.00 (0.64)	0.00 (0.64)
9	1.00 (2.10)	0.08 (0.48)	-0.05 (0.53)	0.08 (0.48)	0.10 (0.52)	-0.17 (0.75)
10	1.10 (2.10)	0.40 (0.59)	0.77 (0.82)	0.40 (0.59)	0.08 (0.71)	0.31 (0.86)
11	0.83 (1.83)	0.20 (0.68)	0.52 (0.79)	0.20 (0.68)	0.22 (0.53)	1.06 (1.24)
12	0.29 (2.69)	0.29 (0.67)	0.22 9 (0.53)	0.29 (0.67)	0.26 (0.28)	-.028 (0.99)
13	-0.25 (2.12)	0.23 (0.61)	0.14 (0.43)	0.23 (0.61)	0.23 (0.33)	0.56 (0.90)
14	-0.44 (2.07)	0.39 (0.75)	0.21 (0.29)	0.39 (0.75)	0.33 (0.47)	-0.33 (0.66)
15	0.25 (1.17)	0.21 (0.210)	0.16 (0.52)	0.21 (0.25)	0.05 (0.30)	0.12 (0.74)

Appendix S. Differences in change scores by profession

All professional groups, apart from social work, showed positive changes in RAQ-7 Sub-scale 1. For RAQ-7 Sub-scale 2 and RKI Sub-scale 4, three profession groups (psychiatrists, psychology and social work) moved in negative direction. Change scores for the RKI Sub-scale 1, 2 and 3 moved in a positive direction for all professional groups.

The results for RAQ-7 Sub-scale 2 show that for professional groups, mean change scores ranged from +0.50 (showing more positive attitude) to -0.87 (showing less positive attitude) with three professional groups (psychiatrists, psychology and social work) moving in a negative direction.

The results for RKI sub-scale 1 showed that for professional groups, mean change scores ranged from 0.47 to 0.07, and that all groups moved in a positive direction.

The results for RKI sub-scale 2 show that for professional groups, mean change scores ranged from 0.58 – 0.06 and that all groups moved in a positive direction.

The results for RKI sub-scale 3 show that for professional groups, mean change scores ranged from 0.33 – 0.01, and that all groups moved in a positive direction.

Differences in change scores by professional group (n=7)

Professional group	RAQ-7	RAQ-7	RKI	RKI	RKI	RKI
	Sub-scale 1	Sub-scale 2	Sub-scale 1	Sub-scale 2	Sub-scale 3	Sub-scale 4
	Mean (s.d)	Mean (s.d)	Mean (s.d)	Mean (s.d)	Mean (s.d)	Mean (s.d)
Healthcare Assistant	0.18 (2.28)	0.17 (2.12)	0.31 (0.72)	0.28 (0.61)	0.10 (0.60)	0.21 (0.81)
Nurse	0.63 (2.67)	0.12 (1.25)	0.47 (0.62)	0.26 (0.60)	0.33 (0.67)	0.04 (1.04)
OT	0.22 (1.55)	0.50 (1.04)	0.29 (0.75)	0.33 (0.47)	0.04 (0.38)	0.44 (1.08)
Psychiatrist	0.25 (3.24)	-0.25 (1.98)	0.13 (0.61)	0.11 (0.44)	0.30 (0.41)	-0.06 (0.94)
Psychologist	0.38 (1.41)	-0.87(1.46)	0.07 (0.50)	0.38 (0.46)	0.17 (0.33)	-0.18 (0.65)
Social Worker	0.00 (2.35)	-0.21(1.85)	0.31 (0.50)	0.58 (0.59)	0.26 (0.29)	-0.07 (0.83)
Support Worker	1.05 (2.09)	0.45 (1.57)	0.17 (0.42)	0.06 (0.56)	0.01 (0.51)	0.25 (0.60)

Appendix T. Linear Regression for RAQ-7 and RKI

The linear regression model for change in the RAQ-7 sub-scale 2 (recovery is difficult) change score is presented as follows:

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	177.34 ^a	21	8.44	5.53	.000
Intercept	117.67	1	117.67	77.06	.000
Team	23.05	14	1.65	1.08	0.38
Professional group	23.44	6	3.91	2.56	0.02
Pre RAQ-7 sub-scale 2	120.02	1	120.02	78.60	.000
Error	235.15	154	1.54		
Total	415.00	176			
Corrected Total	412.49	175			

a. R Squared = .430 (Adjusted R Squared = .352)

Change scores for professional groups were significant in the outcome ($p= 0.02$) but not for team ($p= 0.38$).

The linear regression for RKI sub-scale 1 (Roles and responsibilities) change score is presented as follows:

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	27.83 ^a	21	1.33	5.05	.000
Intercept	19.32	1	19.32	73.63	0.00
Team	4.93	14	.35	1.34	0.19
Professional group	7.08	6	1.18	4.50	0.00
Pre RKI sub-scale 1	16.72	1	16.72	63.74	0.00
Error	40.40	154	.262		
Total	89.31	176			
Corrected Total	68.24	175			

a. R Squared = .408 (Adjusted R Squared = .327)

Change scores for professional groups ($p= 0.00$) were significant in the outcome, but not for team ($p= 0.19$).

The linear regression for RKI Sub-scale 2 (Non-linearity of the process) change score is presented as follows:

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	11.48 ^a	21	.547	1.79	.03
Intercept	8.59	1	8.59	28.08	.000
Team	2.16	14	.154	.50	0.93
Professional group	5.19	6	.865	2.83	0.01
Pre RKI sub-scale 2	5.92	1	5.92	19.36	.000
Error	47.14	154	.31		
Total	71.59	176			
Corrected Total	58.62	175			

a. R Squared = .196 (Adjusted R Squared = .086)

Change scores for professional groups (p 0.01) were significant in the outcome, but not for team (p= 0.93).

The linear regression for RKI sub-scale 3 (Self-definition) change score is presented as follows:

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	25.74 ^a	21	1.23	5.753	0.00
Intercept	23.30	1	23.29	109.30	0.00
Team	2.76	14	.20	.93	0.53
Professional group	2.95	6	.49	2.31	0.04
Pre RKI sub-scale 3	20.78	1	20.78	97.54	0.00
Error	32.81	154	.21		
Total	66.57	176			
Corrected Total	58.56	175			

a. R Squared = .440 (Adjusted R Squared = .363)

Change scores for professional groups (p 0.04) were significant in the outcome, but not for team (p= 0.53).

The linear regression for RKI sub-scale 4 (Expectations) change score is presented as follows:

Source	Type Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	41.12 ^a	21	1.96	2.70	0.00
Intercept	25.43	1	25.43	35.02	0.00
Team	5.97	14	.43	.59	0.87
Professional group	5.24	6	.87	1.20	0.31
Pre RKI sub-scale 4	26.40	1	26.40	36.35	0.00
Error	111.83	154	.73		
Total	155.00	176			
Corrected Total	152.95	175			

a. R Squared = .269 (Adjusted R Squared = .169)

Change scores for both teams (p= 0.87) and professional groups (0.31) were not significant in the outcome.

Appendix U. Linear Regression by study arm and team

Linear Regression for IMR (Baseline to T1)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	87.10 ^a	2	43.56	1.29	0.28
Intercept	124.82	1	124.82	3.71	0.06
Arm	18.17	1	18.17	0.54	0.47
Team	33.20	1	33.20	0.99	0.32
Error	2625.54	78	33.67		
Total	2877.38	81			
Corrected Total	2712.63	80			

a. R Squared = .032 (Adjusted R Squared = .007)

Differences in the IMR change scores between baseline and T1 was not significant for study arm (p=0.47) or for team (p=0.32).

Linear Regression for IMR (T1 to T2)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1.86 ^a	2	0.93	.043	.96
Intercept	11.44	1	11.44	0.52	0.47
Arm	0.25	1	0.25	.011	0.92
Team	0.54	1	0.54	.025	0.88
Error	1354.84	62	21.85		
Total	1419.23	65			
Corrected Total	1356.69	64			

a. R Squared = .001 (Adjusted R Squared = -.031)

Differences in the IMR change scores between T1 and T2 was not significant for study arm (p=0.92) or for team (p=0.88).

Linear Regression for DEMQOL (Baseline to T1)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	564.27 ^a	2	282.13	1.90	0.16
Intercept	57.19	1	57.19	0.38	0.54
Arm	472.17	1	472.17	3.17	0.08
team	541.77	1	541.77	3.64	0.06
Error	6400.18	43	148.84		
Total	7073.25	46			
Corrected Total	6964.44	45			

a. R Squared = .081 (Adjusted R Squared = .038)

Differences in the DEMQOL change score between baseline and T1 was not significant study arm for (p=0.08) or for team (p=0.06)

Linear Regression for DEMQOL (T1 toT2)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	187.01 ^a	2	93.51	1.15	0.33
Intercept	60.57	1	60.57	0.74	0.40
Arm	92.15	1	92.15	1.13	0.30
team	49.66	1	49.66	0.61	0.44
Error	2445.89	30	81.53		
Total	2888.00	33			
Corrected Total	2632.90	32			

a. R Squared = .071 (Adjusted R Squared = .009)

Differences in the DEMQOL change score between T1 and T2 was not significant for study arm (p=0.30) or for team (p=0.44).

Linear Regression for SF12 PCS (Baseline to T1)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	180.87 ^a	2	90.44	1.02	0.37
Intercept	23.26	1	23.26	0.26	0.61
Arm	171.59	1	171.59	1.93	0.17
team	158.69	1	158.69	1.79	0.19
Error	2842.63	32	88.83		
Total	3091.23	35			
Corrected Total	3023.50	34			

a. R Squared = .060 (Adjusted R Squared = .001)

Differences in the SF12 PCS change between baseline and T1 was not significant for study arm ($p=0.17$) or for team ($p=0.19$).

Linear Regression for SF12 PCS (T1 to T2)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	295.45 ^a	2	147.72	1.64	0.21
Intercept	126.03	1	126.03	1.40	0.25
Arm	35.41	1	35.41	0.39	0.54
team	14.31	1	14.31	0.16	0.69
Error	2515.71	28	89.85		
Total	2818.88	31			
Corrected Total	2811.15	30			

a. R Squared = .105 (Adjusted R Squared = .041)

Differences in the SF12 PCS change between T1 and T2 was not significant for study arm ($p=0.54$) or for team ($p=0.69$).

Linear Regression for SF12 MCS (Baseline to T1)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	43.43 ^a	2	21.72	0.11	0.89
Intercept	173.28	1	173.28	0.91	0.35
Arm	2.95	1	2.95	0.02	0.90
team	0.78	1	0.78	0.00	0.95
Error	6097.05	32	190.53		
Total	7050.84	35			
Corrected Total	6140.49	34			

a. R Squared = .007 (Adjusted R Squared = -.055)

Differences in the SF12 MCS change between Baseline and T1 was not significant for study arm ($p=0.90$) or for team ($p=0.95$).

Linear Regression for SF12 MCS (Baseline to T1)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	64.63 ^a	2	32.32	0.20	0.82
Intercept	9.50	1	9.50	0.06	0.81
Arm	56.42	1	56.42	0.35	0.56
Team	61.20	1	61.20	0.38	0.55
Error	4563.39	28	162.98		
Total	4695.27	31			
Corrected Total	4628.02	30			

a. R Squared = .014 (Adjusted R Squared = -.056)

Differences in the SF12 MCS change between T1 and T2 was not significant for study arm ($p=0.56$) or for team ($p=0.55$).

Appendix V. Linear Regression for impact of dose

Linear regression for IMR change score between Baseline and T2

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	65.69 ^a	1	65.69	1.61	0.21
Intercept	31.94	1	31.94	0.78	0.38
Dose	65.69	1	65.69	1.61	0.21
Error	2573.28	63	40.85		
Total	2953.53	65			
Corrected Total	2638.97	64			

a. R Squared = .025 (Adjusted R Squared = .009)

For the change score for the IMR, the dose of training was not significant in the outcome between Baseline and T2 ($p= 0.21$).

Linear regression for SF12 PCS change score between Baseline and T2

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	208.33 ^a	1	208.33	2.47	0.13
Intercept	55.23	1	55.23	0.65	0.43
Dose	208.33	1	208.33	2.47	0.13
Error	2447.74	29	84.41		
Total	2685.07	31			
Corrected Total	2656.08	30			

a. R Squared = .078 (Adjusted R Squared = .047)

For the change score for the SF12 PCS, the dose of training was not significant in the outcome between Baseline and T2 ($p= 0.13$).

Linear regression for SF12 MCS change score between Baseline and T2

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	23.64 ^a	1	23.64	0.13	0.72
Intercept	278.36	1	278.36	1.52	0.23
Dose	23.64	1	23.64	.129	0.72
Error	5297.91	29	182.69		
Total	6297.41	31			
Corrected Total	5321.55	30			

a. R Squared = .004 (Adjusted R Squared = -.030)

For the change score for the SF12 MCS, the dose of training was not significant in the outcome between Baseline and T2 ($p= 0.72$).

References

- Adams, T. (2010) 'The applicability of a recovery approach to nursing people with dementia', *International Journal of Nursing Studies*, 47(5), 626-634.
- Age Concern (2007) *Improving services and support for older people with mental health problems*, London: Age Concern.
- Age Concern and Mental Health Foundation (2006) *Promoting mental health and well-being in later life*, London: Age Concern
- Ajzen, I. (1991) 'The theory of planned behavior', *Organizational Behavior and Human Decision Processes*, 50(2), 179-211.
- Albrecht, G. L. and Devlieger, P. J. (1999) 'The disability paradox: high quality of life against all odds', *Social Science and Medicine*, 48(8), 977-988.
- Allott, P., Loganathan, L. and Fulford, K. W. (2002) 'Discovering hope for recovery', *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, 21(2), 13-33.
- Alzheimer's Society (2013) 'Living with Dementia', *Alzheimer's Society*,
- Anderson, D. (2011) 'Age discrimination in mental health services needs to be understood', *The Psychiatrist*, 35(1), 1-4.
- Anderson, D., Banerjee, S., Barker, A., Connelly, P., Junaid, O. and Series, H. (2009) *The Need to Tackle Age Discrimination in Mental Health: A Compendium of Evidence*, 35, London: Royal College of Psychiatrists.
- Anderson, R. (2008) 'New MRC guidance on evaluating complex interventions', *BMJ*, 337.
- Andresen, R., Oades, L. and Caputi, P. (2003) 'The experience of recovery from schizophrenia: towards an empirically validated stage model', *Australasian Psychiatry*, 37(5), 586-594.
- Anthony, W. A. (1993) 'Recovery from mental illness: The guiding vision of the mental health service system in the 1990s', *Psychiatric Rehabilitation Journal*, 16(4), 11-23.
- Antonucci, T. C. and Akiyama, H. (1987) 'Social networks in adult life and a preliminary examination of the convoy model', *Journal of Gerontology*, 42(5), 519-527.
- Appleby, L. and Philp, I. (2005) *Securing better mental health for older adults*, London: Department of Health.

- Arain, M., Campbell, M. J., Cooper, C. L. and Lancaster, G. A. (2010) 'What is a pilot or feasibility study? A review of current practice and editorial policy', *Medical Research Methodology*, 10, 67.
- Argyris, C. (1990) *Overcoming Organizational Defenses: Facilitating Organizational Learning*, Boston: Allyn and Bacon.
- Armitage, C. J. and Conner, M. (2001) 'Efficacy of the theory of planned behaviour: A meta-analytic review', *British Journal of Social Psychology*, 40(4), 471-499.
- Atchley, R. C. (1989) 'A continuity theory of normal aging', *The gerontologist*, 29(2), 183-190.
- Australian Health Ministers (2012a) *A national framework for recovery-oriented mental health services: policy and theory*, Canberra: Australian Government.
- Australian Health Ministers (2012b) *National mental health policy*, Canberra: Australian Government.
- Banerjee, S., Samsi, K., Petrie, C. D., Alvir, J., Treglia, M., Schwam, E. M. and del Valle, M. (2009) 'What do we know about quality of life in dementia? A review of the emerging evidence on the predictive and explanatory value of disease specific measures of health related quality of life in people with dementia', *International Journal of Geriatric Psychiatry*, 24(1), 15-24.
- Barbui, C. and Cipriani, A. (2011) 'Cluster randomised trials', *Epidemiology and Psychiatric Sciences*, 20(04), 307-309.
- Barker, P. and Buchanan-Barker, P. (2010) 'The tidal model of mental health recovery and reclamation: application in acute care settings', *Issues in Mental Health Nursing*, 31(3), 171-180.
- Bartlett, R. and O'Connor, D. (2007) 'From personhood to citizenship: Broadening the lens for dementia practice and research', *Journal of Aging Studies*, 21(2), 107-118.
- Basset, T., Cooke, A. and Read, J. (2003) *Psychosis Revisited*, Brighton: Pavilion Publishing.
- Bassett, T. and Repper, J. (2005) 'Travelling Hopefully', *Mental Health Today*, 11, 16-18.
- Bedregal, L. E., O'Connell, M. and Davidson, L. (2006) 'The Recovery Knowledge Inventory: assessment of mental health staff knowledge and attitudes about recovery', *Psychiatric Rehabilitation Journal*, 30(2), 96-103.
- Bellack, A. S. (2006) 'Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications', *Schizophrenia Bulletin*, 32(3), 432-442.
- Beresford, P. (2013) *Beyond the Usual Suspects*, London: Shaping Our Lives.

- Berg, B. and Liune, H. (2012) *Qualitative Research for the Social Sciences*, Boston MA: Pearson International Edition.
- Bero, L. A., Grilli, R., Grimshaw, J. M., Harvey, E., Oxman, A. D. and Thomson, M. A. (1998) 'Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings', *BMJ*, 317(7156), 465-468.
- Bird, V., Leamy, M., Le Boutillier, C., Williams, J. and Slade, M. (2011) *REFOCUS: Promoting recovery in community mental health services*, London: Rethink.
- Bleuler, M. (1978) *The schizophrenic disorders : long-term patient and family studies*, New Haven: Yale University Press.
- Boardman, J. and Roberts, G. (2014) *Risk, Safety and Recovery*, London: Centre for Mental Health,
- Boardman, J., Shepherd, G., Perkins, R. and Repper, J. (2011) 'Creating recovery-orientated mental health services: 10 organisational challenges', *Psychiat Prax*, 38.
- Boaz, A., Baeza, J. and Fraser, A. (2011) 'Effective implementation of research into practice: an overview of systematic reviews of the health literature', *BMC Research Notes*, 4(1), 212.
- Bonney, S. and Stickley, T. (2008) 'Recovery and mental health: a review of the British literature', *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140-153.
- Borkin, J. R., Steffen, J. J., Ensfield, L. B., Krzton, K., Wishnick, H., Wilder, K. and Yangerber, N. (2000) 'Recovery Attitudes Questionnaire: Development and evaluation', *Psychiatric Rehabilitation Journal*, 24(2), 95.
- Bowers, H., Eastman, M., Harris, J. and Macadam, A. (2005) 'Moving out of the shadows: a report on mental health and well-being in later life', *Help & Care Development Ltd. BGOB & HtA*.
- Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N. and Double, D. (2012) 'Psychiatry beyond the current paradigm', *The British Journal of Psychiatry*, 201(6), 430-434.
- British Psychological Society. Division of Clinical Psychology, Kinderman, P. and Cook, A. (2000) *Understanding mental illness: Recent advances in understanding mental illness and psychotic experiences*, translated by British Psychological Society.
- Brooker, D. (2004) 'What is person-centred care in dementia?', *Reviews in Clinical Gerontology*, 13(03), 215-222.
- Bryant, W., Parsonage, J., Tibbs, A., Andrews, C., Clark, J. and Franco, L. (2012) 'Meeting in the mist: Key considerations in a collaborative research partnership with people with

mental health issues', *Work: A Journal of Prevention, Assessment and Rehabilitation*, 43(1), 23-31.

- Bunn, F., Goodman, C., Sworn, K., Rait, G., Brayne, C., Robinson, L., McNeilly, E. and Iliffe, S. (2012) 'Psychosocial factors that shape patient and carer experiences of dementia diagnosis and treatment: a systematic review of qualitative studies', *PLoS Medicine*, 9(10).
- Burgess, P., Pirkis, J., Coombs, T. and Rosen, A. (2011) 'Assessing the value of existing recovery measures for routine use in Australian mental health services', *Australian and New Zealand Journal of Psychiatry*, 45(4), 267-280.
- Caddell, L. S. and Clare, L. (2010) 'The impact of dementia on self and identity: a systematic review', *Clinical Psychology Review*, 30(1), 113-126.
- Caddell, L. S. and Clare, L. (2011) 'I'm still the same person: The impact of early-stage dementia on identity', *Dementia*, 10(3), 379-398.
- Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D. and Tyrer, P. (2000) 'Framework for design and evaluation of complex interventions to improve health', *BMJ: British Medical Journal*, 321(7262), 694.
- Campbell, M. K., Elbourne, D. R. and Altman, D. G. (2004) 'CONSORT statement: extension to cluster randomised trials', *British Medical Journal*, 328(7441), 702-708.
- Care Services Improvement Partnership (2005) *Everybody's Business: Integrating Mental Health Services for Older People*, London: HMSO.
- Care Services Improvement Partnership (2007) *10 high impact changes for mental health services: Supplementary guidance for older people's mental health services*, London: HMSO.
- Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence (2007) *Joint Position paper 08: A common purpose: Recovery in future mental health services*, London: HMSO, Social Care Institute for Excellence.
- Carers Trust (2014) 'What is a carer?', [online], available: <http://www.carers.org/what-carer> [accessed
- Carstensen, L. L., Isaacowitz, D. M. and Charles, S. T. (1999) 'Taking time seriously: A theory of socioemotional selectivity', *American Psychologist*, 54(3), 165.
- Charmaz, K. (2006) *Constructing grounded theory*, London: Sage Publications.
- Cheffey, J., Hill, L., Roberts, G. and Marlow, R. (2013) 'Supporting self-management in early dementia: a contribution towards 'living well'?', *Advances in Psychiatric Treatment*, 19(5), 344-350.

- Chew-Graham, C., Baldwin, R. and Burns, A. (2004) 'Treating depression in later life: we need to implement the evidence that exists', *BMJ: British Medical Journal*, 329(7459), 181.
- Christiansen, C. H. (1999) 'Defining lives: Occupation as identity: An essay on competence, coherence, and the creation of meaning', *American Journal of Occupational Therapy*, 53(6), 547-558.
- Ciampi, L. (1984) 'Is there really a schizophrenia? The long-term course of psychotic phenomena', *The British Journal of Psychiatry*, 145(6), 636-640.
- Clare, L. (2002) 'We'll fight it as long as we can: Coping with the onset of Alzheimer's disease', *Aging & mental health*, 6(2), 139-148.
- Clare, L. (2003) 'Managing threats to self: awareness in early stage Alzheimer's disease', *Social Science and Medicine*, 57(6), 1017-1029.
- Cleary, A. and Dowling, M. (2009) 'Knowledge and attitudes of mental health professionals in Ireland to the concept of recovery in mental health: a questionnaire survey', *Journal of Psychiatric and Mental Health Nursing*, 16(6), 539-545.
- Cohen-Mansfield, J., Golander, H. and Arnhem, G. (2000) 'Self-identity in older persons suffering from dementia: Preliminary results. ', *Applied Nursing Research*, 14(4), 193-200.
- Cohen-Mansfield, J., Parpura-Gill, A. and Golander, H. (2006) 'Utilization of self-identity roles for designing interventions for persons with dementia', *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 61(4), P202-P212.
- Cohen, P. and Cohen, J. (1984) 'The clinician's illusion', *Archives of General Psychiatry*, 41(12), 1178.
- Coleman, R. and Smith, M. (2002) *Working with voices*, Keepwell London, UK.
- College of Occupational Therapists (2006) *Recovering Ordinary Lives: The Strategy for Occupational Therapy in Mental Health services 2007 – 2017*, London.
- Collier, E. (2010) 'Confusion of recovery: One solution', *International Journal of Mental Health Nursing*, 19(1), 16-21.
- Colquitt, J. A., LePine, J. A. and Noe, R. A. (2000) 'Toward an integrative theory of training motivation: a meta-analytic path analysis of 20 years of research', *Journal of Applied Psychology*, 85(5), 678.
- Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L. A., Grey, D. D., Floyd, C. B., Hudson, W. B., Macfarlane, R. T. and Carter, T. M. (2012) 'Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning', *Schizophrenia Bulletin*, 38(4), 881-891.

- Cook, R. and Farewell, V. (1996) 'Multiplicity considerations in the Design and Analysis of Clinical Trials', *Journal of the Royal Statistical Society: Series A (Statistics in Society)*, 59(1), 93-110.
- Copeland, M. (2005) 'Well Recovery Action Planning' in Allott, P., ed. *Wellness Recovery Action Plan: A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and distressing emotional feelings or experiences*, London: Sefton Recovery Group.
- Corrigan, P. W. and McCracken, S. G. (1995) 'Psychiatric rehabilitation and staff development: Educational and organizational models', *Clinical Psychology Review*, 15(8), 699-719.
- Cotrell, V. and Hooker, K. (2005) 'Possible selves of individuals with Alzheimer's disease', *Psychology and Aging*, 20(2), 285.
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. and Petticrew, M. (2008) 'Developing and evaluating complex interventions: the new Medical Research Council guidance', *BMJ*, 337.
- Craig, P. and Petticrew, M. (2013) 'Developing and evaluating complex interventions: Reflections on the 2008 MRC guidance', *International Journal of Nursing Studies*, 50(5), 585-587.
- Cresswell, J. and Plano Clark, V. (2011) *Designing and Conducting Mixed Methods Research*, Thousand Oaks, CA: Sage.
- Crowe, T., Deane, F., Oades, L. and (2012) 'Individual recovery planning: aligning values, strengths and goals' in King, R., Lloyd, C., Meehan, C., Deane, P. and Kavanagh, D., eds., *Manual of psychosocial rehabilitation*, United Kingdom: : Wiley-Blackwell.
- Crowe, T., Deane, F., Oades, L., Caputi, P. and Morland, K. (2006) 'Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery', *Psychiatric Services*, 57(10), 1497-1500.
- Daley, S., Newton, D., Slade, M., Murray, J. and Banerjee, S. (2013) 'Development of a framework for recovery in older people with mental disorder', *International Journal of Geriatric Psychiatry*, 28(5), 522-529.
- Dallaire, B., McCubbin, M., Carpentier, N. and Clément, M. (2008) 'Representations of Elderly with Mental Health Problems Held By Psychosocial Practitioners from Community and Institutional Settings', *Social Work in Mental Health*, 7(1-3), 139-152.
- Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R. and Sells, D. (2005) 'Processes of recovery in serious mental illness: Findings from a multinational study', *American Journal of Psychiatric Rehabilitation*, 8(3), 177-201.
- Davidson, L. and Guy, K. (2012) 'Peer support among persons with severe mental illnesses: a review of evidence and experience', *World Psychiatry*, 11(2), 123-128.

- Davidson, L., O'Connell, M., Tondora, J., Styron, T. and Kangas, K. (2006) 'The top ten concerns about recovery encountered in mental health system transformation', *Psychiatric Services*, 57(5), 640-645.
- Davidson, L., Schmutte, T., Dinzeo, T. and Andres-Hyman, R. (2008) 'Remission and recovery in schizophrenia: practitioner and patient perspectives', *Schizophrenia Bulletin*, 34(1), 5-8.
- Davidson, L., Tondora, J., Staeheli Lawless, M., O'Connell, M. and Rowe, M. (2009) *A practical guide to recovery-oriented practice : tools for transforming mental health care*, Oxford: Oxford University Press.
- De Boer, M. E., Hertogh, C. M., Dröes, R.-M., Riphagen, I. I., Jonker, C. and Eefsting, J. A. (2007) 'Suffering from dementia—the patient's perspective: A review of the literature', *International Psychogeriatrics*, 19(06), 1021-1039.
- Deal, T. and Kennedy, A. (2000) *Corporate cultures : the rites and rituals of corporate life*, New ed., Cambridge, Mass.: Perseus Publishing.
- Deegan, P. (1996) *Recovery as a journey of the heart*, National Empowerment Center.
- Deegan, P. E. (1993) 'Recovering our sense of value after being labeled mentally ill', *Journal of Psychosocial Nursing and Mental Health Services*, 31(4), 7-11.
- Department of Health (1999) *Effective care co-ordination in mental health services*, London: HMSO.
- Department of Health (2006) *From Values to Action: The Chief Nursing Officer's review of mental health nursing*, London: HMSO.
- Department of Health (2009) *Living Well with Dementia: A National Dementia Strategy*, London:
- Department of Health (2011) *No Health without mental health: A cross-government mental health outcomes strategy for people of all ages*, London: HMSO.
- Desisto, M., Harding, C., McCormick, R., Ashikage, T. and Brooks, G. (1995) 'The Maine and Vermont three-decade studies of serious mental illness. I. Matched comparison of cross-sectional outcome', *British Journal of Psychiatry*, 167, 338-342.
- Dunn, G. (2013) 'Pragmatic trials of complex psychosocial interventions: methodological challenges', *Epidemiology and Psychiatric Sciences*, 22(02), 105-109.
- Färdig, R., Lewander, T., Melin, L., Folke, F. and Fredriksson, A. (2011) 'A randomized controlled trial of the illness management and recovery program for persons with schizophrenia', *Psychiatric Services*, 62(6), 606-612.

- Farkas, M. (2007) 'The vision of recovery today: what it is and what it means for services', *World Psychiatry*, 6(2), 68.
- Farkas, M., Gagne, C., Anthony, W. and Chamberlain, J. (2006) 'Implementing Recovery Orientated Based Programs: Identifying the Critical Dimensions', *Community Mental Health Journal*, 41(2), 141-157.
- Finch, H., Lewis, J. and Turley, C. (2014) 'Focus Groups' in Ritchie J, Lewis, J., McNaughton Nicholls, C. and Ormston, R., eds., *Qualitative Research Practice*, London: Sage.
- Flick, U. (2009) *An Introduction to Qualitative Research*, London: Sage.
- Folstein, M. F., Folstein, S. E. and McHugh, P. R. (1975) "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician', *Journal of Psychiatric Research*, 12(3), 189-198.
- Forchuk, C., MARTIN, M. L., Chan, Y. and Jensen, E. (2005) 'Therapeutic relationships: From psychiatric hospital to community', *Journal of Psychiatric and Mental Health Nursing*, 12(5), 556-564.
- Fraser, S. and Plsek, P. (2003) 'Translating evidence into practice: a process of externally driven spread or personal adoption?', *Education for Primary Care*, 14(2), 129-138.
- Friedli, L. (2009) *Mental health, resilience and inequalities*, Copenhagen: World Health Organisational (WHO) Regional Office for Europe
- Friesen, B. J. (2007) 'Recovery and resilience in children's mental health: Views from the field', *Psychiatric Rehabilitation Journal*, 31(1), 38-48.
- Fuh, J.-L. and Wang, S.-J. (2006) 'Assessing quality of life in Taiwanese patients with Alzheimer's disease', *International Journal of Geriatric Psychiatry*, 21(2), 103-107.
- Fukui, S., Goscha, R., Rapp, C. A., Mabry, A., Liddy, P. and Marty, D. (2012) 'Strengths model case management fidelity scores and client outcomes', *Psychiatric Services*, 63(7), 708-710.
- Fulford, K. B. and Williams, R. (2003) 'Values-based child and adolescent mental health services?', *Current Opinion in Psychiatry*, 16(4), 369-376.
- Fulford, K. W. B. (2004) 'Ten principles of values-based medicine (VBM)' in Schramme, T. and Thome, J., eds., *Philosophy and Psychiatry*, Berlin: de Gruyter, 50-80.
- Fullerton, J. and West, M. A. (1996) 'Consultant and client-working together?', *Journal of Managerial Psychology*, 11(6), 40-49.
- Fyrand, L. (2010) 'Reciprocity: A Predictor of Mental Health and Continuity in Elderly People's Relationships? A Review', *Current gerontology and geriatrics research*, 2010.

- Gavan, J. (2011) 'Exploring the usefulness of a recovery-based approach to dementia care nursing', *Contemporary Nurse*, 39(2), 140-146.
- Geller, J. L. (2000) 'Personal accounts: first-person accounts in the Journal's second 25 years', *Psychiatric Services*, 51(6), 713-716.
- Genoe, R., Dupuis, S. L., Keller, H. H., Martin, L. S., Cassolato, C. and Edward, H. G. (2010) 'Honouring identity through mealtimes in families living with dementia', *Journal of Aging Studies*, 24(3), 181-193.
- Gilbody, S. and Whitty, P. (2002) 'Improving the delivery and organisation of mental health services: beyond the conventional randomised controlled trial', *The British Journal of Psychiatry*, 180(1), 13-18.
- Gilburt, H., Slade, M., Bird, V., Oduola, S. and Craig, T. K. (2013) 'Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study', *BMC Psychiatry*, 13, 167.
- Glaser, B. and Strauss, A. (1967) *The discovery of grounded theory: Strategies for qualitative research*, Chicago: Aldine.
- Glaser, B. G. (1992) *Emergence vs forcing : basics of grounded theory analysis*, Mill Valley, CA: Sociology Press.
- Grant, A., Treweek, S., Dreischulte, T., Foy, R. and Guthrie, B. (2013) 'Process evaluations for cluster-randomised trials of complex interventions: a proposed framework for design and reporting', *Trials*, 14(1), 15.
- Grant, M. J. and Booth, A. (2009) 'A typology of reviews: an analysis of 14 review types and associated methodologies', *Health Information & Libraries Journal*, 26(2), 91-108.
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P. and Kyriakidou, O. (2004) 'Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations', *Milbank Quarterly*, 82(4), 581-629.
- Grey, B. (2010) *Evaluation of the Use of Internal Consultancy in Mental Health*, unpublished thesis King's College London.
- Grey, B. and Bailey, S. (2010) *Coaching programme for clinical staff*, London: SLaM Partners, South London and Maudsley NHS Foundation Trust,.
- Grimshaw, J. M., Shirran, L., Thomas, R., Mowatt, G., Fraser, C., Bero, L., Grilli, R., Harvey, E., Oxman, A. and O'Brien, M. A. (2001) 'Changing provider behavior: an overview of systematic reviews of interventions', *Medical Care*, 112-II45.
- Grol, R. (1997) 'Beliefs and evidence in changing clinical practice', *BMJ*, 315(7105), 418-21.

- Handley, E., Southwell, O. and Steel, J. (2012) 'Recovery and intellectual disabilities: a review', *Advances in Mental Health and Intellectual Disabilities*, 6(4), 192-198.
- Handley, M. A., Schillinger, D. and Shiboski, S. (2011) 'Quasi-experimental designs in practice-based research settings: design and implementation considerations', *Journal of the American Board of Family Medicine*, 24(5), 589-96.
- Harding, C., Brooks, G., Ashikagat, Strauss, J. and Brier, A. (1987) 'The Vermont Longitudinal study of persons with severe mental illness, I. Methodology, study sample, and overall status 32 years later', *American Journal of Psychiatry*, 144, 717-726.
- Harding, C. M. and Zahniser, J. H. (1994) 'Empirical correction of seven myths about schizophrenia with implications for treatment', *Acta Psychiatrica Scandinavica*, 90(s384), 140-146.
- Hardy, M. and Bryman, A. (2004) *Handbook of Data Analysis*, London: Sage.
- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., Dube, K., Ganev, K., Giel, R. and Der Heiden, W. (2001) 'Recovery from psychotic illness: a 15-and 25-year international follow-up study', *The British Journal of Psychiatry*, 178(6), 506-517.
- Hasson-Ohayon, I., Roe, D. and Kravetz, S. (2007) 'A randomized controlled trial of the effectiveness of the illness management and recovery program', *Psychiatric Services*, 58(11), 1461-1466.
- Haywood, K., Garratt, A. and Fitzpatrick, R. (2005) 'Quality of life in older people: a structured review of generic self-assessed health instruments', *Quality of Life Research*, 14(7), 1651-1668.
- Helfrich, C. D., Li, Y. F., Sharp, N. D. and Sales, A. E. (2009) 'Organizational readiness to change assessment (ORCA): development of an instrument based on the Promoting Action on Research in Health Services (PARIHS) framework', *Implement Science*, 4, 38.
- Henderson, A. R. (2011) 'A substantive theory of recovery from the effects of severe persistent mental illness', *International Journal of Social Psychiatry*, 57(6), 564-73.
- Heun, R., Bonsignore, M., Barkow, K. and Jessen, F. (2001) 'Validity of the five-item WHO Well-Being Index (WHO-5) in an elderly population', *European Archives of Psychiatry and Clinical Neuroscience*, 251(2), 27-31.
- Hill, L., Roberts, G., Wildgoose, J., Perkins, R. and Hahn, S. (2010) 'Recovery and person-centred care in dementia: common purpose, common practice?', *Advances in Psychiatric Treatment*, 16(4), 288-298.
- Hopper, K. (2007) 'Rethinking social recovery in schizophrenia: What a capabilities approach might offer', *Social Science and Medicine*, 65(5), 868-879.

- Huber, G., Gross, G. and Schüttler, R. (1975) 'A long-term follow-up study of schizophrenia: psychiatric course and prognosis', *Acta Psychiatrica Scandinavica*, 52(1), 49-57.
- Hulscher, M., Laurant, M. and Grol, R. (2003) 'Process evaluation on quality improvement interventions', *Quality and Safety in Health Care*, 12(1), 40-46.
- International Dementia Advocacy and Support Network (2014) 'International Dementia Advocacy and Support Network', [online], available: <http://www.dasninternational.org/> [accessed
- Irving, K. and Lakeman, R. (2010) 'Reconciling mental health recovery with screening and early intervention in dementia care', *International Journal of Mental Health Nursing*, 19(6), 402-8.
- Jabareen, Y. (2009) 'Building a Conceptual Framework: Philosophy, Definitions, and Procedure', *International Journal of Qualitative Methods*, 8(4).
- Jacobson, N. and Greenley, D. (2001) 'What is recovery? A conceptual model and explication', *Psychiatric Services*, 52(4), 482-485.
- James, B. D., Xie, S. X. and Karlawish, J. H. T. (2005) 'How Do Patients With Alzheimer Disease Rate Their Overall Quality of Life?', *The American Journal of Geriatric Psychiatry*, 13(6), 484-490.
- Jenkinson, C., Layte, R., Jenkinson, D., Lawrence, K., Petersen, S., Paice, C. and Stradling, J. (1997) 'A shorter form health survey: can the SF-12 replicate results from the SF-36 in longitudinal studies?', *Journal of Public Health*, 19(2), 179-186.
- Jeste, D. V. and Palmer, B. W. (2013) 'A call for a new positive psychiatry of ageing', *British Journal of Psychiatry*, 202, 81-3.
- Jha, A., Jan, F., Gale, T. and Newman, C. (2013) 'Effectiveness of a recovery-orientated psychiatric intervention package on the wellbeing of people with early dementia: a preliminary randomised controlled trial', *Int J Geriatr Psychiatry*, 28(6), 589-96.
- Joint Commissioning Panel for Mental Health (2013) *Guidance for commissioners of older people's mental health services*, London.
- Kielhofner, G. (2008) *Model of human occupation theory and application*, Baltimore: Lippincott Williams & Wilkins.
- Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S. and Stall, R. (2007) 'Implementing evidence-based interventions in health care: application of the replicating effective programs framework', *Implement Science*, 2, 42.
- Killaspy, H., White, S., Taylor, T. L. and King, M. (2012) 'Psychometric properties of the Mental Health Recovery Star', *The British Journal of Psychiatry*, 201(1), 65-70.

- Kiresuk, T. J. and Sherman, M. R. E. (1968) 'Goal attainment scaling: A general method for evaluating comprehensive community mental health programs', *Community Mental Health Journal*, 4(6), 443-453.
- Kitwood, T. M. (1997) *Dementia reconsidered : the person comes first, Rethinking ageing series*, Buckingham: Open University Press.
- Knapp, M., Prince, M., Albanese, E., Banerjee, S., Dhanasiri, S., Fernandez, J., Ferri, C., McCrone, P., Snell, T. and Stewart, R. (2007) 'Dementia UK: A report to the Alzheimer's Society on the prevalence and economic cost of dementia in the UK produced by King's College London and London School of Economics', *Alzheimer's Society: London*.
- Krupa, T., Fossey, E., Anthony, W. A., Brown, C. and Pitts, D. B. (2009) 'Doing daily life: how occupational therapy can inform psychiatric rehabilitation practice', *Psychiatric Rehabilitation Journal*, 32(3), 155-161.
- Lacson, E., Xu, J., Lin, S.-F., Dean, S. G., Lazarus, J. M. and Hakim, R. M. (2010) 'A comparison of SF-36 and SF-12 composite scores and subsequent hospitalization and mortality risks in long-term dialysis patients', *Clinical Journal of the American Society of Nephrology*, 5(2), 252-260.
- Lakeman, R. (2010) 'Mental health recovery competencies for mental health workers: a delphi study', *Journal of Mental Health*, 19(1), 62-74.
- Lal, S. (2010) 'Prescribing recovery as the new mantra for mental health: does one prescription serve all?', *Canadian journal of occupational therapy, Revue canadienne d'ergotherapie*. 77(2), 82-89.
- Lancaster, G. A., Dodd, S. and Williamson, P. R. (2004) 'Design and analysis of pilot studies: recommendations for good practice', *Journal of Evaluation in Clinical Practice*, 10(2), 307-312.
- Laudet, A. B. (2007) 'What does recovery mean to you? Lessons from the recovery experience for research and practice', *Journal of Substance Abuse Treatment*, 33(3), 243-56.
- Le Boutillier, C., Leamy, M., Bird, V., Lawrence, V., Williams, J. and Slade, M. (2014a) 'Competing priorities: Staff perspectives on supporting recovery',
- Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J. and Slade, M. (2011) 'What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance', *Psychiatric Services*, 62(12), 1470-1476.
- Le Boutillier, C., Slade, M., Lawrence, V., Bird, V. J., Chandler, R., Farkas, M., Harding, C., Larsen, J., Oades, L. G. and Roberts, G. (2014b) 'Competing Priorities: Staff Perspectives on Supporting Recovery', *Administration and Policy in Mental Health and Mental Health Services Research*, 1-10.
- Le Couteur, D. G., Doust, J., Creasey, H. and Brayne, C. (2013) 'Political drive to screen for pre-dementia: not evidence based and ignores the harms of diagnosis', *BMJ: British Medical Journal*, 347.

- Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011) 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', *The British Journal of Psychiatry*, 199(6), 445-452.
- Leathard, A. (2013) *Interprofessional collaboration: from policy to practice in health and social care*, Routledge.
- Lette, E. (1989) 'How I perceive and Manage My Illness', *Schizophrenia Bulletin*, 15(2), 197-200.
- Levitt, A., Mueser, K., DeGenova, J., Lorenzo, J., Bradford-Watt, D., Barbosa, A., Karlin, M. and Chernick, M. (2009) 'Randomized controlled trial of illness management and recovery in multiple-unit supportive housing', *Psychiatric Services*, 60(12), 1629-1636.
- Liberman, R. P. and Kopelowicz, A. (2005) 'Recovery from schizophrenia: a concept in search of research', *Psychiatric Services*, 56(6), 735-742.
- Liberman, R. P., Kopelowicz, A., Ventura, J. and Gutkind, D. (2002) 'Operational criteria and factors related to recovery from schizophrenia', *International Review of Psychiatry*, 14(4), 256-272.
- Lim, L.-Y. and Fisher, J. (1999) 'Use of the 12-item short-form (SF-12) Health Survey in an Australian heart and stroke population', *Quality of Life Research*, 8(1-2), 1-8.
- Livingston, G., Cooper, C., Woods, J., Milne, A. and Katona, C. (2008) 'Successful ageing in adversity: the LASER-AD longitudinal study', *Journal of Neurology, Neurosurgery & Psychiatry*, 79(6), 641-645.
- Lloyd, C., Waghorn, G. and Williams, P. L. (2008) 'Conceptualising recovery in mental health rehabilitation', *The British Journal of Occupational Therapy*, 71(8), 321-328.
- Lyons, R. A., PERRY, I. M. and LITTLEPAGE, B. N. (1994) 'Evidence for the validity of the Short-form 36 Questionnaire (SF-36) in an elderly population', *Age and Ageing*, 23(3), 182-184.
- MacKeith, J. and Burns, S. (2008) *Mental Health Recovery Star*, London: Mental Health Providers Forum and Triangle Consulting
- Mackenzie, M., O'Donnell, C., Halliday, E., Sridharan, S. and Platt, S. (2010) 'Do health improvement programmes fit with MRC guidance on evaluating complex interventions?', *British Medical Journal*, 340, c185.
- MacRae, H. (2011) 'Self and other: The importance of social interaction and social relationships in shaping the experience of early-stage Alzheimer's disease', *Journal of Aging Studies*, 25(4), 445-456.

- Martin, F., Turner, A., Wallace, L. M. and Bradbury, N. (2013) 'Conceptualisation of self-management intervention for people with early stage dementia', *European Journal of Ageing*, 10(2), 75-87.
- Martin, G. (2009) 'Recovery approach to the care of people with dementia: decision making and 'best interests' concerns', *Journal of Psychiatric and Mental Health Nursing*, 16(7), 654-660.
- McCleary, N., Duncan, E., Stewart, F. and Francis, J. (2013) 'Active ingredients are reported more often for pharmacologic than non-pharmacologic interventions: an illustrative review of reporting practices in titles and abstracts', *Trials*, 14(1), 146.
- McGhee, G., Marland, G. R. and Atkinson, J. (2007) 'Grounded theory research: literature reviewing and reflexivity', *Journal of Advanced Nursing*, 60(3), 334-342.
- McKay, R., McDonald, R., Lie, D. and McGowan, H. (2012) 'Reclaiming the best of the biopsychosocial model of mental health care and 'recovery' for older people through a 'person-centred' approach', *Australas Psychiatry*, 20(6), 492-5.
- Mead, S., Hilton, D. and Curtis, L. (2001) 'Peer Support: A theoretical perspective', *Psychiatric Rehabilitation Journal*, 25(2), 134-141.
- Mental Health Commission (2005) *A Vision for a Recovery Model in Irish Mental Health Services*, Dublin, Ireland: Mental Health Commission.
- Mental Health Commission (2012) *Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be*, Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission of Canada (2012) *Changing directions, changing lives: The mental health strategy for Canada*, Calgary: Mental Health Commission of Canada.
- Mind (2012) *The Recovery Paradigm for Mental Health: Life and times of a supermodel* London: Mind.
- Moos, R. H. (1986) *Work environment scale manual*, Consulting Psychologists Press Palo Alto, CA.
- Morse, J. M., Stern, P. N. and Corbin, J. M. (2008) *Developing grounded theory: The second generation*.
- Mountain, G. A. (2006) 'Self-management for people with early dementia An exploration of concepts and supporting evidence', *Dementia*, 5(3), 429-446.
- Mountain, G. A. and Craig, C. L. (2012) 'What should be in a self-management programme for people with early dementia?', *Aging & mental health*, 16(5), 576-583.

- Mueser, K., Gingerrich, S., Salyers, M., McGuire, A., Reyes, R. and Cunningham, H. (2004) *The Illness Management and Recovery (IMR) Scales (Client and Clinician Versions)*, Concord, New Hampshire: New Hampshire-Dartmouth Psychiatric Research Center.
- Mueser, K. T., Bartels, S. J., Santos, M., Pratt, S. I. and Riera, E. G. (2012) 'Integrated Illness Management and Recovery: a program for integrating physical and psychiatric illness self-management in older persons with severe mental illness', *American Journal of Psychiatric Rehabilitation*, 15(2), 131-156.
- Mueser, K. T., Meyer, P. S., Penn, D. L., Clancy, R., Clancy, D. M. and Salyers, M. P. (2006) 'The illness management and recovery program: rationale, development, and preliminary findings', *Schizophrenia Bulletin*, 32(suppl 1), S32-S43.
- National Development Team for Inclusion (2011) *A Long Time Coming – achieving age equality in mental health services. Part 2*, Bath: National Development Team for Inclusion.
- National Institute for Health and Clinical Excellence (2008) *Occupational therapy interventions and physical interventions to promote the mental wellbeing for older people in primary care and residential care.*, London: Department of Health.
- National Institute for Mental Health Excellence (2005) *Guiding statement on recovery*, London: HMSO.
- National Institute of Mental Health Excellence, T. S. C. f. M. H. T. N. (2004) *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*, London: NIMHE, The Sainsbury Centre for Mental Health & The NHSU,.
- Neil, S. (2006) 'Grounded Theory Sampling: ' *Journal of Research in Nursing*, 1(3), 253-260.
- New Freedom Commission on Mental Health (2005) *Achieving the Promise: Transforming Mental Health Care in America*, Rockville MD, USA: US Department of Health and Human Services.
- NHS Confederation and Centre for Mental Health (2012) *Supporting recovery in mental health*, London: NHS Confederation.
- NHS Education for Scotland and Scottish Recovery Network (2008) *Realising Recovery Learning Materials*, Edinburgh: NES.
- NHS Institute for Innovation (2006) *Productive Community Services*, London: HMSO.
- O'Connell, M., Tondora, J., Croog, G., Evans, A. and Davidson, L. (2005) ' From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system', *Psychiatric Rehabilitation Journal*, 28(4), 378-8386.

- Ochocka, J., Nelson, G., Janzen, R. and Trainor, J. (2006) 'A longitudinal study of mental health consumer/survivor initiatives: Part 3—A qualitative study of impacts of participation on new members', *Journal of Community Psychology*, 34(3), 273-283.
- Office for National Statistics (2011) *Census: Digitised Boundary Data (England and Wales)* London: HMSO.
- Ogawa, K., Miya, M., Watarai, A., Nakazawa, M., Yuasa, S. and Utena, H. (1987) 'A long-term follow-up study of schizophrenia in Japan--with special reference to the course of social adjustment', *The British Journal of Psychiatry*, 151(6), 758-765.
- Patton, M. (2002) *Qualitative researcher and evaluation methods* London: Sage.
- Perkins, R. (2008) *Introduction to Recovery training programme*, London: SWLStG.
- Perkins, R., Repper, J., Rinaldi, M. and Brown, H. (2012) *Recovery Colleges*, London: Mental Health Network NHS Confederation.
- Perneger, T. V. (1999) 'Adjusting for multiple testing in studies is less important than other concerns', *BMJ: British Medical Journal*, 318(7193), 1288.
- Perneger, T. V. and Burnand, B. (2005) 'A simple imputation algorithm reduced missing data in SF-12 health surveys', *Journal of Clinical Epidemiology*, 58(2), 142-149.
- Phinney, A. (2006) 'Family strategies for supporting involvement in meaningful activity by persons with dementia', *Journal of Family Nursing*, 12(1), 80-101.
- Piat, M. and Lal, S. (2012) 'Service providers' experiences and perspectives on recovery-oriented mental health system reform', *Psychiatric Rehabilitation Journal*, 35(4), 289.
- Pratt, S. I., Bartels, S. J., Mueser, K. T. and Forester, B. (2008) 'Helping older people experience success: an integrated model of psychosocial rehabilitation and health care management for older adults with serious mental illness', *American Journal of Psychiatric Rehabilitation*, 11(1), 41-60.
- Protheroe, J., Rogers, A., Kennedy, A. P., Macdonald, W. and Lee, V. (2008) 'Promoting patient engagement with self-management support information: a qualitative meta-synthesis of processes influencing uptake', *Implementation Science*, 3(1), 44.
- Ralph, R. O. (2000) 'Recovery', *Psychiatric rehabilitation skills*, 4(3), 480-517.
- Ramsay, C. R., Matowe, L., Grilli, R., Grimshaw, J. M. and Thomas, R. E. (2003) 'Interrupted time series designs in health technology assessment: lessons from two systematic reviews of behavior change strategies', *International Journal of Technology Assessment in Health Care*, 19(04), 613-623.
- Rapp, C. and Goscha, R. (2006) *The strengths model: Case management with people suffering from psychiatric disabilities* New York: Oxford University Press.

- Ready, R. E., Ott, B. R. and Grace, J. (2004) 'Patient versus informant perspectives of Quality of Life in Mild Cognitive Impairment and Alzheimer's disease', *International Journal of Geriatric Psychiatry*, 19(3), 256-265.
- Repper, J. and Carter, T. (2011) 'A review of the literature on peer support in mental health services', *Journal of Mental Health*, 20(4), 392-411.
- Repper, J. and Perkins, R. (2003) *Social inclusion and recovery : a model for mental health practice*, Edinburgh ; New York: Baillière Tindall.
- Repper, J. and Perkins, R. (2013) *Implementing recovery through organisational change: briefing paper 6*, London: NHS Confederation.
- Resnick, S. and Rosenheck, R. (2008) 'Integrating peer-provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment', *Psychiatric Services*, 59(11), 1307-1314.
- Ridgway, P. (2001) 'Restorying psychiatric disability: learning from first person recovery narratives', *Psychiatric Rehabilitation Journal*, 24(4), 335.
- Ridgway, P. and Press, A. (2004) *Assessing the recovery commitment of our mental health service: a user's guide to the Development of Recovery Enhancing Environments Measure (DREEM): UK Pilot version 1*, UK:
- Rinaldi, M., Perkins, R., Glynn, E., Montibeller, T., Clenaghan, M. and Rutherford, J. (2008) 'Individual placement and support: from research to practice', *Advances in Psychiatric Treatment*, 14(1), 50-60.
- Roberts, G. (2011) "Forensic service user": transitional identity or life sentence?: Commentary of recovery and working with offenders', *Advances in Psychiatric Treatment*, 17(3), 188-190.
- Roberts, G. and Boardman, J. (2014) 'Becoming a recovery-oriented practitioner', *Advances in Psychiatric Treatment*, 20(1), 37-47.
- Roberts, G. and Wolfson, P. (2004) 'The rediscovery of recovery: open to all', *Advances in Psychiatric Treatment*, 10(1), 37-48.
- Robson, D. and Gray, R. (2007) 'Serious mental illness and physical health problems: A discussion paper', *International Journal of Nursing Studies*, 44(3), 457-466.
- Rockwood, K., Graham, J. and Fay, S. (2002) 'Goal setting and attainment in Alzheimer's disease patients treated with donepezil', *Journal of Neurology, Neurosurgery & Psychiatry*, 73(5), 500-507.
- Rockwood, K., Joyce, B. and Stolee, P. (1997) 'Use of goal attainment scaling in measuring clinically important change in cognitive rehabilitation patients', *Journal of Clinical Epidemiology*, 50(5), 581-588.

- Rogers, J., Vergare, M., Baron, R. and Salzer, M. (2007) 'Barriers to recovery and recommendations for change: The pennsylvania consensus conference on psychiatry's role', *Psychiatric Services*, 58(8), 1119-1123.
- Royal College of Psychiatrists (2008) *Fair Deal Manifesto*, London.
- Royal College of Psychiatrists, C. f. Q. I. (2009) 'Memory Services National Accreditation Programme',
- Salyers, M. P., Godfrey, J. L., Mueser, K. T. and Labriola, S. (2007) 'Measuring illness management outcomes: a psychometric study of clinician and consumer rating scales for illness self management and recovery', *Community Mental Health Journal*, 43(5), 459-80.
- Sass, B., Moffat, J., McKenzie, K. and Bhui, K. (2009) 'A learning and action manual to improve care pathways for mental health and recovery among BME groups', *Int Rev Psychiatry*, 21(5), 472-81.
- Schein, E. H. (1999) *Process consultation revisited: Building the helping relationship*, Addison-Wesley Reading, MA.
- Schein, E. H. (2004) *Organizational culture and leadership*, Jossey-Bass business & management series, 3rd ed., San Francisco, CA: Jossey-Bass.
- Scottish Recovery Network (2009) *Carers and Supporting Recovery*.
- Shepherd, G., Boardman, J. and Burns, M. (2010) *Implementing Recovery: A methodology for organisational change* London: Centre for Mental Health.
- Shepherd, G., Boardman, J. and Slade, M. (2008) *Making recovery a reality*, Sainsbury Centre for Mental Health London.
- Slade, M. (2009) *Personal recovery and mental illness : a guide for mental health professionals*, *Cambridge medicine*, Cambridge: Cambridge University Press.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. and Whitley, R. (2014) 'Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems', *World Psychiatry*, 13(1), 12-20.
- Slade, M., Amering, M. and Oades, L. (2008) 'Recovery: an international perspective', *Epidemiologia e Psichiatria Sociale*, 17(2), 128.
- Slade, M., Luke, G. and Knowles, L. (2009) 'Methodologies for evaluating recovery training', *Clinical Psychology Forum*, 193, 10-15.

- Sloane, P. D., Zimmerman, S., Williams, C. S., Reed, P. S., Gill, K. S. and Preisser, J. S. (2005) 'Evaluating the quality of life of long-term care residents with dementia', *The gerontologist*, 45(suppl 1), 37-49.
- Smith, S., Lamping, D., Banerjee, S., Harwood, R., Foley, B., Smith, P., Cook, J., Murray, J., Prince, M. and Levin, E. (2005) 'Measurement of health-related quality of life for people with dementia: development of a new instrument (DEMQOL) and an evaluation of current methodology', *Health Technology Assessment (Winchester, England)*, 9(10), 1-93, iii-iv.
- Smith, S., Lamping, D., Banerjee, S., Harwood, R., Foley, B., Smith, P., Cook, J., Murray, J., Prince, M. and Levin, E. (2007) 'Development of a new measure of health-related quality of life for people with dementia: DEMQOL', *Psychological Medicine*, 37(5), 737-746.
- Social Care Institute for Excellence (2006) *Assessing the mental health needs of older people: SCIE guide 3*, London: HMSO.
- Sole, K. and Read, L. (2009) 'Person-centred care and recovery' in Foundation, M. H., ed. *Older People's Mental Health Today: A handbook*, London: OLM-Pavilion.
- Song, L. Y. and Shih, C. Y. (2009) 'Factors, process and outcomes of recovery from psychiatric disability: the unity model', *International Journal of Social Psychiatry*, 55(4), 348-60.
- South London & Maudsley NHS Foundation Trust (2014) *Consent for Contact*, London: SLAM:
- South London and Maudsley NHS Foundation Trust and South West London and St George's NHS Trust (2010) *Recovery is for All: Hope, Agency and Opportunity in Psychiatry: A Position Statement by Consultant Psychiatrists*, London: SLAM/SWLSTG:
- Spencer, L., Ritchie, J., O'connor, W., Morrell, G. and Ormston, R. (2014) 'Analysis in Practice' in Ritchie J, Lewis, J., McNaughton Nicholls, C. and Ormston, R., eds., *Qualitative Research Practice*, London: Sage.
- Steckler, A. B., Linnan, L. and Israel, B. (2002) *Process evaluation for public health interventions and research*, Jossey-Bass San Francisco.
- Steeman, E., Casterlé, D., Dierckx, B., Godderis, J. and Grypdonck, M. (2006) 'Living with early stage dementia: a review of qualitative studies', *Journal of Advanced Nursing*, 54(6), 722-738.
- Stewart, R., Soremekun, M., Perera, G., Broadbent, M., Callard, F., Denis, M., Hotopf, M., Thornicroft, G. and Lovestone, S. (2009) 'The South London and Maudsley NH'S foundation trust biomedical research centre (SLAM BRC) case register: development and descriptive data', *BMC Psychiatry*, 9(1), 51.
- Strauss, A. L. and Corbin, J. M. (1990) *Basics of qualitative research : grounded theory procedures and techniques*, Newbury Park ; London: Sage.

- Tansella, M. and Thornicroft, G. (2009) 'Implementation science: understanding the translation of evidence into practice', *The British Journal of Psychiatry*, 195(4), 283-285.
- Tepper, M., Berger, R., Byrne, S., Smiley, J., Mooney, M., Lindner, E., Hinde, J. L. and Korn, P. (2013) 'Older adults' perceptions of recovery from mental illness: Impact of psychiatric hospitalization prior to 1990', *Psychiatr Rehabil J*, 36(2), 93-8.
- Tew, J. (2013) 'Recovery capital: what enables a sustainable recovery from mental health difficulties?', *European Journal of Social Work*, 16(3), 360-374.
- Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I. and Davidson, L. (2006) 'Others: the role of family, friends, and professionals in the recovery process', *Archives of Andrology*, 9(1), 17-37.
- Trivedi, P. (2010) 'A Recovery Approach in Mental Health Services: Transformation, Tokenism or Tyranny' in Basset, T. and Stickley, T., eds., *Voices of experience : narratives of mental health survivors*, Chichester: Wiley Blackwell.
- Tsuang, M. T., Woolson, R. F. and Fleming, J. A. (1979) 'Long-term outcome of major psychoses: I. Schizophrenia and affective disorders compared with psychiatrically symptom-free surgical conditions', *Archives of General Psychiatry*, 36(12), 1295-1301.
- Turner-Strokes, L. (2009) 'Goal attainment scaling (GAS) in Rehabilitation: a practice guide', *Clinical Rehabilitation*, 23, 362-370.
- Turner, D. and Powell, T. (2010) *NHS Commissioning*, London: HMSO.
- Uppal, S., Oades, L. G., Crowe, T. P. and Deane, F. P. (2010) 'Barriers to transfer of collaborative recovery training into Australian mental health services: implications for the development of evidence-based services', *Journal of Evaluation in Clinical Practice*, 16(3), 451-455.
- Vogel, A., Mortensen, E. L., Hasselbalch, S. G., Andersen, B. B. and Waldemar, G. (2006) 'Patient versus informant reported quality of life in the earliest phases of Alzheimer's disease', *International Journal of Geriatric Psychiatry*, 21(12), 1132-1138.
- Walker, G. and Bryant, W. (2013) 'Peer support in adult mental health services: A metasynthesis of qualitative findings', *Psychiatric Rehabilitation Journal*, 36(1), 28.
- Warburton, J., Bartlett, H., Carroll, M. and Kendig, H. (2009) 'Involving older people in community-based research: Developing a guiding framework for researchers and community organisations', *Australasian journal on ageing*, 28(1), 41-45.
- Ware, J. (2000) 'SF-36 health survey update', *Spine*, 25(24), 3130-3139.
- Ware, J., Kosinski, M. and Keller, S. (1996) 'A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity', *Medical Care*, 34(3), 220-233.

- West, M. (1996) 'Reflexivity and work group effectiveness: A conceptual integration' in West, M., ed. *Handbook of Work Group Psychology*, Chichester: John Wiley & Sons.
- West, M., Markiewicz, L. and Dawson, J. (2005) 'Aston Team Performance Inventory', *Management Set*.
- Whitley, R. and Drake, R. (2010) 'Recovery: a dimensional approach', *Psychiatric Services*, 61(12), 1248-1250.
- Whitley, R., Gingerich, S., Lutz, W. and Mueser, K. (2009) 'Implementing the illness management and recovery program in community mental health settings: facilitators and barriers', *Psychiatric Services*, 60(2), 202-209.
- Williams, R. and Fulford, K. B. (2007) 'Evidence-based and values-based policy, management and practice in child and adolescent mental health services', *Clinical Child Psychology and Psychiatry*, 12(2), 223-242.
- Willig, C. (2013) *Introducing qualitative research in psychology*, McGraw-Hill International.
- Woodbridge, K. and Fulford, B. (2003) 'Good practice? Values-based practice in mental health', *Mental Health Practice*, 7(2), 30-34.
- Woods, R. (2007) 'Recovery—is it relevant to older people', *Signposts*, 12, 30-31.
- Zerwas, S., Lund, B. C., Von Holle, A., Thornton, L. M., Berrettini, W. H., Brandt, H., Crawford, S., Fichter, M. M., Halmi, K. A., Johnson, C., Kaplan, A. S., La Via, M., Mitchell, J., Rotondo, A., Strober, M., Woodside, D. B., Kaye, W. H. and Bulik, C. M. (2013) 'Factors associated with recovery from anorexia nervosa', *Journal of Psychiatric Research*, 47(7), 972-9.