Collaborative Recovery Project

The following is a list of abstracts from various articles and chapters that relate to research conducted into recovery from mental illness conducted by researchers affiliated with the Illawarra Institute for Mental Health, University of Wollongong. This was initiated with work related to the Collaborative Recovery Project. The Collaborative Recovery project was conducted as part of the Australian Integrated Mental Health Initiative (AIMhi), and was jointly funded by an NHMRC Strategic Mental Health Partnership Grant (# 219327) and by partner organisations (2000-2005). Development and evaluation of a peer-led self development program to support recovery was funded by Australian Rotary Health (2007-2008). An Australian Research Council grant (LP0990708) has funded a randomised controlled trial evaluating two forms of coaching support to increase the transfer of Collaborative Recovery training into clinical practice amongst mental health workers (2009-2012).

Copies of the published articles can be obtained by emailing mjohnson@uow.edu.au. You can also go to the following website to view additional resources used in the Collaborative Recovery project: http://socialsciences.uow.edu.au/iimh/collaborativerecoverymodel/index.html

Peer reviewed journal articles


Objective: The consumer movement is advocating that rehabilitation services become recovery-orientated. The objectives of this study are to gain a better understanding of the concept of recovery by: (i) identifying a definition of recovery that reflects consumer accounts; and (ii) developing a conceptual model of recovery to guide research, training and inform clinical practice.

Method: A review was conducted of published experiential accounts of recovery by people with schizophrenia or other serious mental illness, consumer articles on the concept of recovery, and qualitative research and theoretical literature on recovery. Meanings of recovery used by consumers were sought to identify a definition of recovery. Common themes identified in this literature were used to construct a conceptual model reflecting the personal experiences of consumers.

Results: The definition of recovery used by consumers was identified as psychological recovery from the consequences of the illness. Four key processes of recovery were identified: (i) finding hope; (ii) re-establishment of identity; (iii) finding meaning in life; and (iv) taking responsibility for recovery. Five stages were identified: (i) moratorium; (ii) awareness; (iii) preparation; (iv) rebuilding; and (v) growth.

Conclusion: A five-stage model compatible with psychological recovery is proposed, which offers a way forward for attaining recovery-orientated outcomes. After further
empirical investigation, a version of this model could be utilized in quantitative research, clinical training and consumer education.


**Objectives:** Recovery is an emerging movement in mental health. Evidence for recovery-based approaches is not well developed and approaches to implement recovery-oriented services are not well articulated. The collaborative recovery model (CRM) is presented as a model that assists clinicians to use evidence-based skills with consumers, in a manner consistent with the recovery movement. A current 5 year multi-site Australian study to evaluate the effectiveness of CRM is briefly described.

**Conclusion:** The collaborative recovery model puts into practice several aspects of policy regarding recovery-oriented services, using evidence-based practices to assist individuals who have chronic or recurring mental disorders (CRMD). It is argued that this model provides an integrative framework combining (i) evidence-based practice; (ii) manageable and modularized competencies relevant to case management and psychosocial rehabilitation contexts; and (iii) recognition of the subjective experiences of consumers.


**Background:** Homework refers to between-session activities that are tied to therapeutic goals. Homework has been suggested as being an important clinical adjunct to case management practices, however, to date, research has not examined case managers’ use of homework. Aims: To identify the degree that case managers use homework within their clinical practice and explore the way it is administered with people diagnosed with a persistent and recurring psychiatric illness.

**Method:** A survey was completed by 122 case managers (63% of those approached) comprising nurses, psychologists, social workers, occupational therapists and welfare/support workers.

**Results:** Ninety-three percent of case managers implement homework, but only 15% regularly use a systematic approach to homework administration. Seventy-six percent of case managers reported people in recovery had a positive attitude towards the use of homework, yet 72% felt that homework completed was of a low quality.

**Conclusions:** Suggestions are made for improving the systematic use of homework by case managers.

The study examined mental health case managers’ attitudes towards the use of homework and explored the relationship between clinician attitudes and systematic homework administration practices. One hundred and twenty two Australian mental health case managers completed a survey examining attitudes towards the use of homework. Case managers who held more positive attitudes reported better client responses to homework. Systematic homework administration was predicted by the degree case managers felt homework enhanced client outcomes and the importance case managers placed on the use of homework for severe psychiatric disabilities. The use of training and supervision programs to promote systematic homework administration practice is discussed.


Goal striving promotes hope and enhances motivation, which is important for psychosocial rehabilitation and recovery. The Collaborative Goal Technology (CGT) is a new goal striving intervention that is used to support the autonomy and recovery processes of the person with a psychiatric disability. The CGT protocol and its utility are outlined. Theory and research from goal striving, motivation and mental health recovery domains that informed the development of CGT are described. A case example is also provided.


**Objective:** This study examined the impact of a two-day, recovery-based training program for mental health workers on knowledge, attitudes, and hopefulness related to the recovery prospects of people with enduring mental illness.

**Methods:** A self-report pre-post training repeated-measures design was used with 248 mental health workers from the community-based government health sector (N=147) and nongovernment organizations (N=101) in eastern Australia.

**Results:** Staff attitudes and hopefulness improved after training. Trainees significantly increased their knowledge regarding principles of recovery and belief in the effectiveness of collaboration and consumer autonomy support, motivation enhancement, needs assessment, goal striving, and homework use.

**Conclusions:** This is preliminary evidence indicates that staff recovery orientation can improve with minimal training.


This paper highlights challenges in implementing mental health policy at a service delivery level. It describes an attempt to foster greater application of recovery-orientated principles and practices within mental health services. Notwithstanding a highly supportive policy environment, strong support from service administrators and
enthusiastic staff response to training, application of the training and support tools was weaker than anticipated. This paper evaluates the dissemination trial against key elements to promote sustained adoption of innovations. Organisational and procedural changes are required before mental health policies are systematically implemented in practice.


**Objective:** In order to realize the vision of recovery-orientated mental health services, there is a need for a model and a method of measuring recovery as the concept is described by mental health consumers. A preliminary five-stage model based on consumer accounts was developed in an earlier study by the authors. This next stage of the research program describes the development and initial testing of a stage measure which, when validated, can be used in testing that model.

**Method:** Existing measures of recovery were reviewed to assess their concordance with the model, and a new measure, the Stages of Recovery Instrument (STORI) was subsequently developed. A postal survey was conducted of 94 volunteers from the NISAD Schizophrenia Research Register. Participants completed the STORI and measures of mental health, psychological wellbeing, hope, resilience and recovery.

**Results:** The STORI correlated with all of the psychological health variables, and the five stage subscales were found to be internally consistent. An ordinal relationship between the stage subscales was demonstrated by the intercorrelations of the subscale scores and the pattern of correlations between the subscales and the other measures. However, a cluster analysis of items revealed an overlap in measurement of adjacent stages, with only three clear clusters emerging.

**Conclusions:** The results provide preliminary empirical validation of the STORI as a measure of the consumer definition of recovery. However, refinement of the measure is needed to improve its capacity to discriminate between the stages of the model. The model could then be comprehensively tested using longitudinal methods and the inclusion of objective measures.


The following review examines research on case management that draws on consumer perspectives. It clarifies the extent of their involvement and whether evaluations were informed by recovery perspectives. Searches of Ovid Medline(R) (1966-2006), Psychinfo (1967-2006) and Cinahl (1982-2006) were conducted using combinations of: assertive community treatment/case management/ assertive outreach/strengths model/rehabilitation model/ICM/Intensive case management; and client/participant (perspectives)/service users/consumer priorities/client attitudes. Thirteen studies that sought to investigate consumer perspectives were identified. Only one study asked consumers about experiences of recovery. Most evaluations did not adequately assess consumers’ views, and active consumer participation in research was
rare. Supporting an individual’s recovery requires commitment to a recovery paradigm that incorporates traditional symptom reduction and improved functioning, with broader recovery principles, shifting its focus from illness to wellbeing. It also requires greater involvement of consumers in the implementation of case management and ownership of their own recovery process, not just in research that evaluates the practice.


**Objective:** Mental health services in Australia are increasingly becoming ‘recovery-orientated’. However, there are varying meanings for recovery and few measures that specifically target recovery outcomes. The current study aimed to assess the construct and concurrent validity of a patient self-report measure, the Recovery Assessment Scale.

**Method:** Participants were 168 individuals with severe and persistent psychiatric disability who were participants in the Australian Integrated Mental Health Initiative (AIMhi) project. They completed self-report recovery and other mental health measures and their case workers completed the Health of the Nation Outcome Scales. Exploratory and confirmatory factor analyses were carried out to examine the factor structure of the RAS.

**Results:** Exploratory factor analysis of the RAS revealed five factors which were replicated using confirmatory techniques. Each factor has satisfactory internal reliability (Cronbach alpha range = .73 to .91). The factors displayed convergent validity with positive and significant correlations with other recovery measures. Concurrent validity was demonstrated with significant but lower correlations with symptoms and clinician rated measures of psychiatric functioning.

**Conclusion:** The factors of the RAS are consistent with the consumer literature on recovery. Correlations with other variables suggest the RAS is measuring something different from traditional symptom or functional mental health measures. Further research is needed to clarify the extent to which the RAS is able to capture the range of recovery experiences that have been described by consumers.


A survey was completed by 122 case managers describing the types of homework assignments commonly used with individuals diagnosed with severe mental illness (SMI). Homework types were categorized using a 12-item homework description taxonomy and in relation to the 22 domains of the Camberwell Assessment of Need (CAN). Case managers predominately reported using behaviourally based homework tasks such as scheduling activities and the development of personal hygiene skills. Homework focused on CAN areas of need in relation to Company, Psychological Distress, Psychotic Symptoms and Daytime Activities.

Abstract

AIMS:
To review developments in recovery-focused mental health services internationally.

METHODS:
Two forms of 'recovery' which have been used in the literature are considered, and international examples of recovery-focused initiatives reviews. A 'litmus test' for a recovery-focused service is proposed.

RESULTS:
'Clinical recovery' has emerged from professional literature, focuses on sustained remission and restoration of functioning, is invariant across individuals, and has been used to establish rates of recovery. 'Personal recovery' has emerged from consumer narratives, focuses on living a satisfying, hopeful and contributing life even with limitations caused by the illness, varies across individuals, and the empirical evidence base relates to stages of change more than overall prevalence rates. Clinical and personal recovery are different. Two innovative, generalisable and empirically investigated examples are given of implementing a focus on personal recovery: the Collaborative Recovery Model in Australia, and Trialogues in German-speaking Europe. The role of medication is an indicator: services in which all service users are prescribed medication, in which the term 'compliance' is used, in which the reasoning bias is present of attributing improvement to medication and deterioration to the person, and in which contact with and discussion about the service user revolves around medication issues, are not personal recovery-focused services.

CONCLUSIONS:
The term 'Recovery' has been used in different ways, so conceptual clarity is important. Developing a focus on personal recovery is more than a cosmetic change--it will entail fundamental shifts in the values of mental health services.


The use of evidence-based goal-setting principles is thought to improve goal attainment of people with psychiatric disability. Little is known about the frequency or quality of goal setting, and whether training and formalised goal-setting interventions improve goal setting practice. The Goal Instrument for Quality (Goal-IQ) was used to review 122 goal records in several eastern Australian mental health services. Seventy four percent of people in recovery had a documented goal record and these had 54% of the evidence-based goal setting principles measured by the Goal-IQ. Staff trained in goal setting showed significant improvements in the frequency and quality of documenting goals.
Rationale, aims and objectives: This study examines the experiences of mental health service consumers engaged in various recovery-focused support practices as well as examining consumer valuing of these activities.

Method: A self-report questionnaire was developed drawing on key aspects of the Collaborative Recovery Model (CRM) (responsibility, collaboration, autonomy, motivation, needs, goals, homework). Ninety-two adult consumers from metropolitan, regional and rural non-government organizations and public mental health services in eastern Australian states completed the questionnaire.

Results: Consumers using services provided by CRM-trained workers identified significant changes to service delivery in relation to frequency with which they were encouraged to take responsibility for their recovery, degree to which they collaborated with staff and the extent to which they were encouraged to complete homework activities to assist them to achieve their goals, when compared with consumers using traditional services. The key aspects of the CRM were valued by consumers. No differences were found in terms of overall ratings of clinician helpfulness in assisting recovery between the two groups.

Conclusions: Consumers are able to perceive recovery-focused service changes. Although preliminary, this is a significant step towards assessing the operationalization of recovery principles from the consumer’s perspective.

**Background:** Conceptualisations of recovery involve more than just symptom amelioration and include the development of hope, meaning and self identity. Goal attainment promotes wellbeing within non-clinical samples and mental health consumers report that it facilitates their psychological recovery. Research is yet to investigate the impact of baseline symptom distress on goal progress/attainment and subsequent wellbeing amongst service users with enduring mental illness.

**Aims:** 1) To examine whether baseline measures of symptoms, functioning and recovery are associated with greater goal progress, and 2) to examine the association between improvements in mental health outcome and goal attainment.

**Method:** Seventy one consumers with enduring mental illness who were receiving case-management support from both government and non-government mental health services participated in the study. Case-management goal attainment was examined against mental health outcome measures (functional and recovery measures) for the same goal setting period.

**Results:** Path modelling indicated that goal attainment mediates the relationship between baseline (pre-goal setting) levels of symptom distress and progress on recovery constructs such as hope, self confidence, a greater sense of meaning and identity.

**Conclusions:** When symptoms are less distressing consumers are better able to make progress on their case-management goals, which in turn enables consumers to progress in aspects of their psychological recovery. Therefore, assisting consumers in the alleviation of these symptoms is important within a recovery framework particularly when this is done in service of promoting self determined recovery for mental health consumers.


**Objective:** Therapeutic homework has been recommended for use by mental health case managers to help clients with severe mental illness (SMI). The current research examined the actual use of homework by case managers working in clinical practice.

**Method:** Case managers were trained in a systematic approach to homework administration and were provided with carbonized Homework Administration Pads to assist with homework implementation. Hierarchical Linear Modeling (HLM) was used to examine the relationship between homework and outcome for participants in the study (N = 129).

**Results:** The total number of homework assignments administered to each client predicted improvement on the Health of Nation Outcome Scale (HoNOS) and Kessler 10 (K10). How Well the homework was completed also predicted improvements on the HoNOS. The relationship between homework and recovery-orientated outcome measures was not significant. **Conclusion:** The study provides preliminary support for the use of a systematic approach to homework administration procedures when working with SMI.
Future research should examine strategies to promote the regular use of systematic homework administration procedures by mental health case managers.


**Abstract**
Therapeutic homework refers to activities that clients complete between their visits with mental health workers. The aim of such homework is to facilitate progress toward treatment goals. There is an increasing body of research indicating that homework completion is associated with improved outcomes of psychotherapy across a wide range of clinical disorders (such as depression and anxiety). However, there is limited research into the role of homework in mental health case management for people with severe mental illnesses such as schizophrenia.


Mental health service provision is being transformed by a call for ‘recovery oriented care’. Rather than the traditional medical meaning of cure, the term ‘recovery’ refers to the personal and transformational process of patients living with mental illness, moving towards a preferred identity and a life of meaning – a framework where growth is possible, and the fixed mindsets around diagnoses such as schizophrenia are challenged. At an organisational level, however, organisations and their service providers have typically operated on a framework that is fixed in terms of the potentialities of the mental health patients. This paper describes the ongoing transformation of a large tertiary inpatient mental health unit in Ontario, Canada, through a parallel staff and patient implementation of a person-centred strengths based coaching framework, known as the Collaborative Recovery Model (CRM). Consistent with developments in positive psychology, the model focuses on strengths and values, goals and actions, within a coaching framework, with an emphasis on the alliance between staff and patient, and the growth potential of the patient. By using the principles of coaching psychology, mental health staff members are leading change in the organisation by personal use of the principles and practices that they are also using to coach patients. The leadership and organisational change challenges are described and future directions are discussed.


**Objective:** To examine self-identity within the recovery processes of people with serious mental illnesses using a repertory grid methodology.
Method: Cross-sectional study involving 40 mental health service consumers. Participants rated different “self” and “other” elements on the repertory grid against constructs related to recovery, as well as other recovery focused measures.

Results: Perceptions of one’s “ideal self” represented more advanced recovery in contrast to perceptions of “a person mentally unwell.” Current perceptions of self were most similar to perceptions of “usual self” and least similar to “a person who is mentally unwell.” Increased identification with one’s “ideal self” reflected increased hopefulness in terms of recovery.

Conclusions: The recovery repertory grid shows promise in clinical practice, in terms of exploring identity as a key variable within mental health recovery processes. Distance measures of similarity between various self-elements, including perceptions of others, maps logically against the recovery process of hope.


Transfer of training (ToT) is defined as the application of competencies acquired during training into the workplace. Poor ToT to clinical practice in mental health settings has negative implications for evidence based service provision. The study aimed to explore the variables influencing differences in ToT across mental health settings. Variables of interest included organization type, caseload, and several variables related to the opportunity to use training. One hundred and seventy-three mental health clinicians from community based government and non-government mental health services in eastern Australia were trained in recovery oriented interventions. Measures of ToT included time taken until implementation of intervention protocols, assessed using a clinical audit and a questionnaire survey completed by clinicians to identify barriers to implementation 6 months after training. Approximately 37% of the trained clinicians participating in the study were found to be implementing training protocols in clinical practice. In addition, the average time taken to implement the protocols was 5.6 months following training. The most frequently cited barriers were institutional constraints. Higher caseloads and more frequent client contact were related to a higher level of ToT. ToT can be difficult to achieve in clinical practice. Greater facilitation of ToT may be achieved through better integration of the new ideology and protocols, regular monitoring of progress, staff incentives and examination of external attributions by clinicians of their responsibility to transfer training.


Self-identified stage of recovery (SISR) is a two-part scale assessing both the stage of recovery (SISR-A) and the component processes of recovery (SISR-B) for people with mental illness. This study aimed to develop a Japanese version of SISR and to examine
its reliability and validity. The Japanese versions of SISR-A and SISR-B were developed through focus group cognitive interviews and the translation-back-translation procedure. A cross-sectional questionnaire survey was conducted of 223 participants who had chronic mental illness, aged 20 or older, currently living in communities and inpatient ward settings; 59.2% were males and the average age was 47.6 years. The questionnaire also included the 24-item Recovery Assessment Scale, Herth Hope Index, Empowerment scale, and Resilience scale. Cronbach’s alpha coefficient, intraclass correlation coefficient and weighted kappas were generally fair to high. And SISR-A and SISR-B scores positively correlated with other relevant scales. This study supported the reliability and validity of the Japanese version of SISR-A and SISR-B among people with chronic mental illness in Japan.


**Background:** Service providers’ attitudes towards recovery can improve with formal training. However, it is unclear whether improvements depend on dispositional hope.

**Aims:** To determine whether attitudinal improvements following formal recovery training vary depending on participants’ dispositional hope.

**Method:** One hundred and three providers attended formal recovery training and completed measures of recovery knowledge, attitudes, hopefulness and optimism.

**Results:** Training improved providers’ recovery knowledge, attitudes, hopefulness and optimism. Providers with both high and low dispositional hope achieved similar gains.

**Conclusions:** Attitudinal improvements following formal recovery training were not dependent on baseline levels of dispositional hope. Institutions committed to recovery-oriented care should consider utilising formal training.


There is an international call for mental health services to become recovery-oriented, and also to use evidence-based practices. Addressing this call requires recovery-oriented measurement of outcomes and service evaluation. Mental health consumers view recovery as leading as meaningful life, and have criticised traditional clinical measures for being too disability-oriented. This study compares three measures of consumer-defined recovery from enduring mental illness: the Recovery Assessment Scale, the Mental Health Recovery Measure and the Self-Identified Stage of Recovery, with four conventional clinical measures. Correlational analyses supported the convergent validity of the recovery measures, although certain subscales were unrelated to each other. More importantly, little relationship was found between consumer-defined recovery and the clinical measures. Analyses of variance revealed that scores on the recovery measures increased across self-identified stage of recovery, but scores on most clinical measures did not improve consistently across stage of recovery. The findings demonstrate the qualitative difference between the two types of measures, supporting the claim by consumers that clinical measures do not assess important aspects of recovery.
need for further research and refinement of recovery measurement, including assessment of stages of recovery, with the aim of including such measures as an adjunct in routine clinical assessment, service evaluation and research.


**Background:** Subjective experiences of psychotic disorders are often not communicated because of the difficulty in articulating them. Metaphor is a valuable way of describing these experiences to others. Recovery in psychotic disorders involves consolidation and transitioning processes. The ontological and orientational types of metaphor seem to form the linguistic basis of these processes.

**Aims:** The aim of this paper is to review and describe how metaphor may be used both as a strategy for people with psychotic disorders to articulate their subjective experiences of self, and also as an approach to support recovery.

**Method:** A systematic review of 28 studies was conducted, to examine the nature and function of metaphor used in studies involving an intervention or therapeutic method for psychosis.

**Results:** Sixteen studies contained first-person experiences, 24 studies used metaphor to consolidate the self of the person with psychotic disorder, and 19 studies used metaphor to transition the self of the person, although applied use of metaphor in this way was limited.

**Conclusions:** The use of metaphor as a strategy is a potentially valuable way for both people with psychotic disorders to express their experiences, and for promotion of recovery within this population.


**Objective:** To develop a brief interview-based assessment tool, feasible for routine use in mental health service settings to measure an individual’s stage of psychological recovery from an enduring mental illness.

**Method:** Key indicators for each stage of psychological recovery were formulated according to the stages of psychological conceptual framework and an analysis of transcribed data wherein seventeen consumer participants described their illness and recovery experiences. Upon development of the measure, Short Interview to assess Stages of Recovery (SIST-R), the instrument was evaluated by practitioners and consumers to examine its feasibility for use in mental health service settings. A pilot test with eighteen mental health consumer participants compared results obtained by the SIST-R with those from an existing self-report stages of psychological recovery measure (STORI), a measure of psychological distress (K-10), and a measure of recovery (RAS).

**Results:** Concordance between the SIST-R and the STORI was substantial (Somers’ $D = .61$, $p = .004$). The mean scores from other recovery measures correspond with what
could be theoretically expected across individual stages of recovery. Conclusion: This study contributes towards the strengthening of a recovery-oriented approach within clinical/mental health service settings with the development of an assessment tool that demonstrates potential clinical utility. There is a need to validate further the preliminary findings of this study.


Objective Most mental health outcome and satisfaction measures have been developed by academic researchers or service providers. Consumers have been limited to the role of participant or advisor. The validity and reliability of these satisfaction measures have been challenged. This paper reports the development of a consumer satisfaction questionnaire in which consumers work as collaborative researchers to increase its face validity and relevance.

Method Eleven themes from a previous participatory study were used by consumer researchers and university-based researchers to generate questionnaire items, with four items reflecting each theme. The internal consistency and factor structure were examined in public and non-government mental health service centres based on data of 202 mental health consumers.

Results Principal Components Analysis with oblique rotation yielded a two-factor structure: Empowerment and Dehumanization. The two factors together explained 36.7% of the total variance. The scale demonstrated high internal consistency, with Cronbach’s alpha for the total scale at 0.92, and for the two factors at 0.92 and 0.80.

Conclusions The questionnaire was developed in accordance with an evaluation framework of consumer directed evaluation of mental health services. The final questionnaire consists of 26 items. It has satisfactory internal consistency and appeared to be useful with inpatients and outpatients. Further research will be performed to establish its test–retest reliability and criterion validity.


Background: One key component of recovery-oriented mental health services, typically overlooked, involves genuine collaboration between researchers and consumers to evaluate and improve services delivered within a recovery framework.

Method: Eighteen mental health consumers working with staff who had received training in the Collaborative Recovery Model (CRM) took part in in-depth focus group meetings, of approximately 2.5 hours each, to generate feedback to guide improvement of the CRM and its use in mental health services.

Results: Consumers identified clear avenues for improvement for the CRM both specific to the model and broadly applicable to recovery-oriented service provision. Findings suggest consumers want to be more engaged and empowered in the use of the CRM from the outset.
Limitations: Improved sampling procedures may have led to the identification of additional dissatisfied consumers.

Conclusions: Collaboration with mental health consumers in the evaluation and improvement of recovery-oriented practice is crucial with an emphasis on rebuilding mental health services that are genuinely oriented to support recovery.


The current study explores the types of homework assignments used in a recovery orientated case management approach. It also examines the relationship between the types of homework used and the clients’ area of need as rated on the CANSAS. There were 129 client and mental health case manager dyads that participated in the study. Written copies of all homework assignments administered during the 12-month research period were collected (N = 1054). The homework assignments were categorised according to the ‘type’ and the ‘need domain addressed by the task’. The majority of these tasks were behavioural in nature. On a group level homework tended to broadly address areas of need for clients in the study. Only 2 of the 1054 homework assignments administered directly addressed areas of Intimate Relationships or Sexual Expression. The importance of addressing Intimate Relationship and Sexual Expression within case management is discussed.


Objective: This study explored the relationship between employment and recovery in individuals with psychiatric disabilities and proposed that participants who were employed would have higher levels of recovery than participants who were not employed.

Methods: Data were analysed from a pre-existing data-set produced in a large scale NHMRC project conducted as part of the Australian Integrated Mental Health Initiative (AIMhi), High Support Stream. Participants were 244 people with a range if psychiatric illnesses who received support from 11 public sector and non-government mental health organisations in Queensland and New South Wales, Australia. Scores on the Recovery Assessment Scale (RAS) were compared between those participants who were engaged in paid employment and those who were not.

Results: The results revealed that there was no difference in total recovery scores between those who worked and those who did not work. This finding indicated that higher recovery scores were not associated with participants who were employed. Also contrary to expectations, the results showed that workers scored lower than non-workers on the RAS factor described as “reliance on others” and there was a trend towards significance in the same direction on the factor “willingness to ask for help.”

Conclusions and Implications for Practice: Further research needs to be conducted to determine if the differences between workers and non-workers on the above factors
represent a personal variable such as independence or self-determination that is associated with individuals with psychiatric disabilities that are engaged in employment. Rehabilitation interventions aimed at increasing levels of employment in people with psychiatric disabilities could improve recovery and employment outcomes through focusing on these personal variables.


This paper outlines the potential of parallel processes to enhance experiential learning opportunities in coaching for mental health practitioners. Traditional views of parallel processes in clinical supervision are examined in relation to how they can be applied to enhance coaching mental health practitioners. For example, parallel relationship patterns refer to repetitive interpersonal relationship patterns that are transferred from client interactions with mental health practitioners into the coaching sessions for these mental health practitioners. In addition, experiential learning strategies that utilize parallel process concepts might include the use of equivalent protocols for staff development coaching as are used by mental health practitioners in their work with clients experiencing mental health problems. Two coaching approaches (skills acquisition and transformational coaching) to support the implementation and use of a practice model for mental health staff and clients are presented to exemplify the potential advantages of purposeful use of parallel processing in coaching mental health practitioners.


**Background:** The majority of mental health case managers report the use of homework to support their clinical work, but practitioner surveys indicate that it is not routinely used at each session.

**Aims:** The current study aimed to examine barriers that mental health case managers’ experience in implementing homework, and to also identify strategies used by case managers to promote successful homework administration.

**Method:** Mental health case managers (N = 134) completed a survey that examined their use of homework for individuals diagnosed with a severe mental health problem. It also asked them to identify barriers to regular implementing homework and to describe strategies to promote more regular homework use.

**Results:** On average, homework was used at 50% of clinical contacts. The primary reasons for not using homework included: allocating insufficient time at appointments, perceived client resistance to using homework and concerns that the client was too unwell. Strategies used to overcome these difficulties included, prioritising the use of homework, and ensuring that homework assignments were achievable.

**Conclusions:** Clinicians are able to identify a range of practical strategies to promote homework use. Discussion focuses on the application of the suggested strategies to promote more regular use of homework.

Recovery-oriented services are being increasingly called for around the world. These services do not just consider recovery from mental illness as symptom remission, but the person’s ability to redefine his/her self and to “live well” even with enduring symptoms. However, little is known about the views of Thai nurses regarding the conceptualisations of recovery. This paper presents the findings of a qualitative study that explored the perspectives of 24 Thai nurses regarding schizophrenia and recovery. Semi-structured interviews were conducted with nurses who were providing care for people living with schizophrenia in both hospital and community settings. A thematic analysis identified personal and environmental factors were related to recovery. Illness acceptance, hope, and adherence to treatment were viewed as facilitators of recovery, while low levels of self-responsibility and illness-related factors were barriers. Environmental factors such as presence of a supportive environment and accessibility to mental health services were described as facilitators, while stigma towards mental health illness and fragmented health services were barriers. The implications of these findings to promote recovery-oriented mental health services in Thailand are discussed.


**Background:** Goal setting within recovery in psychiatric disability can enhance meaning, hope and self-identity. Little is known about the types of goals being set and whether goal type differs across different stages of recovery.

**Objective:** 1) describe the types of goals set within Australian mental health services, 2) determine whether certain types of goal domains are more likely to be set within different stages of recovery, 3) determine whether there is a difference in the frequency of *approach* and *avoidance* goals set at different stages of psychological recovery.

**Method:** Goal records of 144 individuals accessing mental health services within Australia were reviewed to examine content of goals, the ratio of approach and avoidance oriented goals and changes across stages of psychological recovery.

**Results:** Individuals further along in their recovery process set significantly more *approach* oriented goals and the types of goals set appeared more diverse, reflecting broader life roles. **Conclusions:** This lends support to the definition of psychological recovery as ‘the movement towards’ greater meaning and enhanced sense of self.


**Background:** Consumer-defined recovery from schizophrenia spectrum disorders and other recurring psychotic illnesses (“serious mental illness”, “SMI”) emphasise re-


establishment of a personally meaningful life. The working alliance (“the alliance”) is highlighted as important in facilitating recovery however there is little empirical evidence concerning the relationship between the alliance and recovery in populations with SMI. **Aims:** The aim is to explore the relationship between the alliance and recovery over time in a sample with SMI.

**Method:** Sixty-one individuals with SMI receiving case management support from mental health services in Australia were recruited by their mental health workers and completed measures of working alliance and recovery. Measures were collected by the workers during regular counselling sessions on two separate occasions. The average time between measurement times was 6 months apart.

**Results:** Multiple regression analyses indicated that changes in the alliance predicted recovery, but changes in recovery also predicted the alliance. No definitive conclusions regarding the causal direction of the relationship between the alliance and recovery could be drawn.

**Conclusions:** The results provide preliminary evidence that improvement in the alliance positively influences gains in recovery and that gains in recovery also facilitate stronger alliance in SMI. These findings support an emphasis on the alliance.


**Abstract**

**Objective:** This study reports on the relationship between stage of recovery and hope, meaning and responsibility for individuals diagnosed with severe mental illness.

**Methods:** Seventy seven people with a diagnosis of a psychotic disorder of at least 6 months duration participated in the study. Participants completed the Self-identified Stage of Recovery (SISR), measures of component processes of recovery (Hope Scale; Positive Interpretation of Disease, SpREUK; Active Involvement, PHMQ) and the Recovery Assessment Scale-short (RAS).

**Results:** Hope, meaning, *Personal Confidence and Hope* and *Not being dominated by symptoms* varied significantly across stages of recovery, however neither in a parallel nor linear fashion.

**Conclusions and implications for practice:** Hopefulness and sense of meaning in relation to the experience of mental illness increase before personal confidence and resilience in the face of setbacks. Symptoms appear to take less prominence in individuals’ lives in later stages of recovery. Greater insight into the relationship between stage of recovery and component processes may allow for more targeted recovery oriented support for individuals at different stages of recovery.
Abstract
Clear national policy now exists in Australia regarding recovery. Personal accounts of
recovery often include reference to meaning, purpose and issues regarding identity.
Personal strengths and expression of personal values are closely related to the
development of meaning, purpose and a stable sense of self, resulting in a sense of
wellbeing. These constructs fall under the research umbrella of positive psychology. By
combining aspects of the recovery policy with evidence from the science of positive
psychology there are increasing attempts to include strengths and values work with
mental health staff and consumers. This paper describes how the collaborative recovery
model (CRM) with its emphasis on strengths and values, draws on the emerging evidence
based on positive psychology. CRM has now been implemented in non-government
community services in each mainland state of Australia. Implementation issues of the
CRM as one example of recovery-orientated service provision are then described.
Potential barriers and facilitators of growth-based approaches such as CRM moving to
government clinical services is then discussed. Recent national reviews of recovery
measurement instruments are also summarized. Specific recommendations are then
provided to further national implementation of recovery-orientated service provision in
Australia.

Bird, V. J., Le Boutillier, C., Leamy, M., Larsen, J., Oades, L. G., Williams, J., & Slade,
Review. Psychological Assessment. Advance online publication. doi: 10.1037/a0028983

Abstract
Strengths assessments focus on the individual's talents, abilities, resources, and strengths.
No systematic review of strengths assessments for use within mental health populations
has been published. The aims of this study were to describe and evaluate strengths
assessments for use within mental health services. A systematic review identified 12
strengths assessments (5 quantitative, 7 qualitative). The Strengths Assessment
Worksheet (SAW) was the most widely utilized and evaluated qualitative assessment.
Psychometric properties of the assessments were assessed against set quality criteria.
Data on psychometric properties were available for 4 measures. The Client Assessment of
Strengths, Interests and Goals (CASIG) had the strongest psychometric evidence. The
SAW and CASIG assessments can be tentatively recommended within clinical practice,
although the evidence for all strengths assessments is currently limited. To describe the
content of the strengths assessment, the items used to operationalize the concept of
strengths in each assessment were extracted and themed. Twenty-four themes were
identified and organized into 3 overarching categories: individual factors, environmental
factors, and interpersonal factors. These categories form the basis of an empirically based
definition of strengths that could be used as a conceptual foundation for new clinical
assessments. (PsycINFO Database Record (c) 2012 APA, all rights reserved)
Abstract
Purpose: The review aimed to (1) identify measures that assess the recovery orientation of services; (2) discuss how these measures have conceptualised recovery, and (3) characterise their psychometric properties.
Methods: A systematic review was undertaken using seven sources. The conceptualisation of recovery within each measure was investigated by rating items against a conceptual framework of recovery comprising five recovery processes: connectedness; hope and optimism; identity; meaning and purpose; and empowerment. Psychometric properties of measures were evaluated using quality criteria.
Results: Thirteen recovery orientation measures were identified, of which six met eligibility criteria. No measure was a good fit with the conceptual framework. No measure had undergone extensive psychometric testing and none had data on test-retest reliability or sensitivity to change.
Conclusion: Many measures have been developed to assess the recovery orientation of services. Comparisons between the measures were hampered by the different conceptualisations of recovery used and by the lack of uniformity on the level of organisation at which services were assessed. This situation makes it a challenge for services and researchers to make an informed choice on which measure to use. Further work is needed to produce measures with a transparent conceptual underpinning and demonstrated psychometric properties.


Abstract
Objective: To develop a brief measure of stage of psychological recovery from mental illness by identifying the best-performing items of the 50-item Stages of Recovery Instrument (STORI).
Method: Item response modelling was used to identify a short form of the full-length STORI. The resulting items were subjected to factor analysis to further refine the subscales. A second data set was used to confirm the construct validity of the new measure. A correlational analysis was conducted to examine relationships among the five subscale scores.
Results: Analyses identified 30 items that represented the five stages of the full STORI. The five stage subscale scores of the shorter measure, the STORI-30, showed a pattern of correlations that demonstrated an ordinal relationship between the stages.
Conclusions: There is a need for recovery-oriented measures to augment established clinical assessment tools. The shorter version of the STORI, the STORI-30, shows promise as a brief measure of stage of recovery, more feasible for routine clinical use.
Further psychometric and longitudinal testing is recommended. Qualitative research would be valuable in establishing acceptability to consumers and the clinical usefulness of the STORI-30.


**Abstract**

Living according to one's personal values has implications for wellbeing, and incongruence between personal and workplace values has been associated with burnout. Using the SGP Card Sorting Task (Ciarrochi & Bailey, 2008), this study explored mental health practitioners' personal life values and personal work-related values, and their relationships with wellbeing and burnout. Congruence between life and work-related values was related to wellbeing and perceived accomplishment at work. Those whose personal values were consistent with the commonly-shared values of a caring profession experienced lower burnout and higher personal wellbeing. Successfully pursuing one's work values predicted lower burnout and greater wellbeing. Honesty, clearly defined work, competence and meeting obligations were associated with lower burnout and higher wellbeing. Acceptance of others and helping others were associated with lower burnout. The implications for recovery-oriented practice are noted. Values clarification exercises may invigorate the sense of meaning in practitioners' work, increasing wellbeing and reducing staff burnout.


**Abstract**

Moving to recovery-oriented service provision in mental health may entail retraining existing staff, as well as training new staff. This represents a substantial burden on organisations, particularly since transfer of training into practice is often poor. Follow-up supervision and/or coaching have been found to improve the implementation and sustainment of new approaches. We compared the effect of two coaching conditions, skills-based and transformational coaching, on the implementation of a recovery-oriented model following training. Training followed by coaching led to significant sustained improvements in the quality of care planning in accordance with the new model over the 12-month study period. No interaction effect was observed between the two conditions. However, post hoc analyses suggest that transformational coaching warrants further exploration. The results support the provision of supervision in the form of coaching in the implementation of a recovery-oriented service model, and suggest the need to better elucidate the mechanisms within different coaching approaches that might contribute to improved care.

Abstract

**Background:** Values guide and potentially motivate people in their lives. Aligning personal values with organisational values has the potential to improve job satisfaction, reduce burnout and lower Intentions To Leave (ITL).

**Aims:** To determine whether changes in Value Motivation (VM) predict burnout and ITL following training.

**Method:** Participants were staff from a Mental Health (MH) organisation in Australia. They participated in the Collaborative Recovery Training Programme (CRTP) and completed pre- and post-measures of values, general health, burnout and ITL.

**Results:** Increasingly holding work values due to guilt and shame predicted higher burnout after training. Increases in intrinsically held values predicted less ITL after training.

**Conclusions:** Attending to and clarifying VM's has the potential to decrease burnout and ITL. Training programmes should focus on understanding the importance of values in reducing burnout and turnover rates among MH professionals.

Abstract

**Background:** There is growing acceptance that optimal service provision for individuals with severe and recurrent mental illness requires a complementary focus on medical recovery (i.e., symptom management and general functioning) and personal recovery (i.e., having a 'life worth living'). Despite significant research attention and policy-level support, the translation of this vision of healthcare into changed workplace practice continues to elude. Over the past decade, evidence-based training interventions that seek to enhance the knowledge, attitudes, and skills of staff working in the mental health field have been implemented as a primary redress strategy. However, a large body of multidisciplinary research indicates disappointing rates of training transfer. There is an absence of empirical research that investigates the importance of worker-motivation in the uptake of desired workplace change initiatives. 'Autonomy' is acknowledged as important to human effectiveness and as a correlate of workplace variables like productivity, and wellbeing. To our knowledge, there have been no studies that investigate purposeful and structured use of values-based interventions to facilitate increased autonomy as a means of promoting enhanced implementation of workplace change.

**Methods:** This study involves 200 mental health workers across 22 worksites within five community-managed organisations in three Australian states. It involves cluster-randomisation of participants within organisation, by work site, to the experimental (values) condition, or the control (implementation). Both conditions receive two days of training focusing on an evidence-based framework of mental health service delivery. The experimental group receives a third day of values-focused intervention and 12 months of values-focused coaching. Well-validated self-report measures are used to explore variables related to values concordance, autonomy, and self-reported implementation success. Audits of work files and staff work samples are reviewed for each condition to determine the impact of implementation. Self-determination theory and theories of organisational change are used to interpret the data.

**Discussion:** The research adds to the current knowledge base related to worker motivation and uptake of workplace practice. It describes a structured protocol that aims to enhance worker autonomy for imposed workplace practices. The research will inform how best to measure and conceptualise transfer. These findings will apply particularly to contexts where individuals are not 'volunteers' in requisite change processes.

Abstract
Recovery has come to mean living a life beyond mental illness, and recovery orientation is policy in many countries. The aims of this study were to investigate what staff say they do to support recovery and to identify what they perceive as barriers and facilitators associated with providing recovery-oriented support. Data collection included ten focus groups with multidisciplinary clinicians (n = 34) and team leaders (n = 31), and individual interviews with clinicians (n = 18), team leaders (n = 6) and senior managers (n = 8). The identified core category was Competing Priorities, with staff identifying conflicting system priorities that influence how recovery-oriented practice is implemented. Three sub-categories were: Health Process Priorities, Business Priorities, and Staff Role Perception. Efforts to transform services towards a recovery orientation require a whole-systems approach.


Abstract
Objectives: The coaching relationship has been described as the catalyst for change. This study explores the coaching relationship by comparing the working alliance and the ‘real relationship’- the undistorted and authentic experience of the other- in participants in skills coaching and transformational coaching.

Design: A 2 (coaching condition) x 2 (time) factorial design was used.

Method: Staff from community psychiatric recovery services were trained in a new service delivery approach (Collaborative Recovery Model), followed by coaching from internal coaches once per month to enhance implementation of the training. All trained staff were invited to participate in the research. Forty coachees met the requirements for inclusion in the study (>=3 coaching sessions in six months). Coaches completed a coaching alliance measure after each session. Coachees completed measures of working alliance and real relationship after six months of coaching.

Results: Analyses indicated that the coaching relationship is stronger after receiving transformational coaching, from both coachees' and coaches' perspectives. Relationships developed over time in transformational coaching, but not with skills coaching.

Conclusions: The results provide preliminary evidence that transformational coaching encourages the development of stronger coaching relationships. Future research should examine the effect of coaching approach on the outcomes of coaching.

**Abstract**

Carers are important to the recovery of their relatives with serious mental disorder however, it is unclear whether they are aware of, or endorse recent conceptualisations of recovery. This study compared carers’ and mental health workers’ recovery attitudes, and undertook multivariate predictions of carers’ wellbeing, hopefulness and recovery attitudes. Participants were 82 Australian family members caring for a relative with psychosis. Carers’ average recovery attitudes were less optimistic than for previously surveyed staff. Carers’ recovery attitudes were predicted by perceptions that their relative’s negative symptoms were more severe. Hopefulness and wellbeing was predicted by more positive and less negative caregiving experiences. Hopefulness was also predicted by less frequent contacts with their affected relative, and unexpectedly, by perceptions of more severe psychotic symptoms. Carers’ wellbeing was further predicted by having a partner and having no lifetime history of a mental disorder. Hope and wellbeing are affected by everyday challenges and positive experiences of caregiving.

**Book chapters and other related publications:**


This chapter provides the practitioner with a framework to understand and evaluate psychosocial rehabilitation in mental health. A key challenge in psychosocial rehabilitation is to clearly define, operationalise and measure what we mean by psychosocial rehabilitation. To address this, the current chapter provides a definition of psychosocial rehabilitation that is relevant to five areas of intervention foci. A framework of psychosocial rehabilitation is presented using the metaphor of a lens to assist clarification of the complexities of psychosocial rehabilitation. Within each lens, principles are presented and indicators of good practice are described and this yields a list of thirty-six criteria to evaluate psychosocial rehabilitation programs. Possible future directions of psychosocial rehabilitation are considered including the challenges from the recovery and positive psychology movements as well as opportunities from contemporary approaches in self-help and self-management of chronic health conditions.


In this chapter we review the evidence for the importance of therapeutic relationship and particularly therapeutic or working alliance in facilitating recovery processes for individuals with mental illness. Most of the existing empirical evidence comes from psychotherapy research related to the treatment of non-psychotic disorders. However,
there is growing evidence that therapeutic alliance may also be an important predictor of treatment outcome for people with serious mental illness including those diagnosed with psychotic disorders.


This chapter looks at how people with a mental illness are marginalised and often denied opportunities to participate fully in the community of their choice. The importance of adopting a recovery focus is discussed. This is followed by exploring the implications for service delivery and the role of rehabilitation practitioners in providing a recovery oriented service, which targets access to a range of community activities. Practical strategies for developing a community participation focus are outlined.


Although there has been a consistent call for recovery-focussed care, there are few examples of recovery training programs that clearly attempt to operationalise recovery principles. Furthermore, the research evidence regarding recovery-based approaches is in its infancy. The guiding principles and key components of the Collaborative Recovery Model (CRM) are outlined in this paper. The CRM was designed to be an integrative framework that is consistent with recovery-based principles to assist mental health workers to use evidence-based practices with consumers.


In this article we describe the implementation of the CRM and describe it in terms of how three non-government mental health organisations responded to the call to increase their recovery-focussed practices. Although located in three different Australian states, servicing metropolitan, regional, and rural populations, the three organisations independently introduced very similar protocols to transfer recovery-focussed training into routine practice. The introduction of these implementation protocols is discussed in terms of the organisations’ development journeys and its parallels with a model of consumer recovery journeys.


It has long been recognised, that an essential part of the body of evidence in recovery is the lived experience of those recovering. An important part of the overall picture is the lived experience of those delivering a recovery model. It is difficult to imagine how a team can instil hope, meaning, identity and responsibility in its clients, if it has none of these for itself. This is an examination of how the SNAP team embarked on its own journey.

Many people with severe mental illness (SMI) such as schizophrenia, whose psychotic symptoms are effectively managed, continue to experience significant functional problems. This chapter argues that low intensity (LI) cognitive behaviour therapy (CBT; e.g. for depression, anxiety, or other issues) is applicable to these clients, and that LI CBT can be consistent with long-term case management. However, adjustments to LI CBT strategies are often necessary and boundaries between LI CBT and high intensity (HI) CBT (with more extensive practitioner contact and complexity) may become blurred. Our focus is on LI CBT's self-management emphasis, its restricted content and segment length, and potential use after limited training. In addition to exploring these issues, it draws on the authors' Collaborative Recovery (CR; Oades et al. 2005) and 'Start Over and Survive' programs (Kavanagh et al. 2004) as examples. ----- -----

Evidence for the effectiveness of LI CBT with severe mental illness is often embedded within multicomponent programs. For example, goal setting and therapeutic homework are common components of such programs, but they can also be used as discrete LI CBT interventions. A review of 40 randomised controlled trials involving recipients with schizophrenia or other severe mental illnesses has identified key components of illness management programs (Mueser et al. 2002). However, it is relatively rare for specific components of these complex interventions to be assessed in isolation. Given these constraints, the evidence for specific LI CBT interventions with severe mental illness is relatively limited.


In a previous chapter (Dean and Kavanagh, Chapter 37), the authors made a case for applying low intensity (LI) cognitive behaviour therapy (CBT) to people with serious mental illness (SMI). As in other populations, LI CBT interventions typically deal with circumscribed problems or behaviours. LI CBT retains an emphasis on self-management, has restricted content and segment length, and does not necessarily require extensive CBT training. In applying these interventions to SMI, adjustments may be needed to address cognitive and symptomatic difficulties often faced by these groups. What may take a single session in a less affected population may require several sessions or a thematic application of the strategy within case management. In some cases, the LI CBT may begin to appear more like a high-intensity (HI) intervention, albeit simple and with many LI CBT characteristics still retained. So, if goal setting were introduced in one or two sessions, it could clearly be seen as an LI intervention. When applied to several different situations and across many sessions, it may be indistinguishable from a simple
HI treatment, even if it retains the same format and is effectively applied by a practitioner with limited CBT training. ----- ----- 

In some ways, LI CBT should be well suited to case management of patients with SMI. Treating staff typically have heavy workloads, and find it difficult to apply time-consuming treatments (Singh et al. 2003). LI CBT may allow provision of support to greater numbers of service users, and allow staff to spend more time on those who need intensive and sustained support. However, the introduction of any change in practice has to address significant challenges, and LI CBT is no exception. ----- ----- 

Many of the issues that we face in applying LI CBT to routine case management in a mental health service and their potential solutions are essentially the same as in a range of other problem domains (Turner and Sanders 2006) and, indeed, are similar to those in any adoption of innovation (Rogers 2003). Over the last 20 years, several commentators have described barriers to implementing evidence-based innovations in mental health services (Corrigan et al. 1992; Deane et al. 2006; Kavanagh et al. 1993). The aim of the current chapter is to present a cognitive behavioural conceptualisation of problems and potential solutions for dissemination of LI CBT.


The chapter begins by providing a brief description of the components thought to be important in the therapeutic relationship and in developing a strong therapeutic working alliance. Many decades of research have established that good therapeutic alliance is related to better treatment outcomes for people engaged in psychotherapy. However, there has been relatively little of this research which has focused on individuals with severe mental illnesses such as schizophrenia. A brief review of these studies indicates ‘promising’ findings with regard to the link between therapeutic alliance and more positive treatment outcomes, but it is argued that a strength-based emphasis in treatment may be particularly important for those with severe mental illnesses.


This chapter describes the emerging movement in mental health services, the consumer recovery movement, a grass roots movement which in many ways parallels the values of the professional and scientific movement of positive psychology. Unlike many discrete positive psychological interventions, The Collaborative Recovery Model (CRM), is a broader systemic framework guiding a range of interventions with consumers, carers, staff and organisational systems will then be described. The CRM has been developed to assist with recovery oriented service provision for people with enduring mental illness, and is informed significantly by the principles, evidence and practices of positive
psychology and positive organisational scholarship. A summary of research outcomes is provided before a case example of an organisational transformation is provided. The chapter concludes with description of current and future research and related practice directions.


This book addresses an international challenge in relation to recovery: how to bring empirical investigation to the consumer-developed understanding of recovery. The book presents a stage model of psychological recovery based on narrative accounts from consumers. A method to measure psychological recovery is also described.


**Abstract**

This chapter describes collaborative goal-setting steps and a protocol that is underpinned by goal-directed principles. It is important to recognise that goals have different sources of motivation and that a major strategy in our approach involves linking goals with underlying values and strengths to tap into those sources of motivation. As part of this process, we try to help the person shape a personal life vision. Thus, goal setting creates 'a concrete road map that mediates between where the person is and where he or she desires to go' (Ades, 2004, p.15). Whilst collaborative goal setting is important, the values underpinning the goal and the vision driving the goal are also very important. This chapter focuses particularly on helping the person with a mental illness clarify life values and a vision. This vision is a great source of motivation and is essential for identifying goals, particularly approach-oriented goals (i.e. goals moving towards something positive). Goal setting is most effective when it occurs within a working relationship where the practitioner is sensitive to the client's readiness, motivations and orientation to his/her recovery process. There is often a need to socialise the client to goal setting and to build hope. Most clients come with needs-based goals that tend to be driven by an 'avoidance' motivation (i.e. to move away from or change an undesirable experience) and while these should be attended to, the aim is to help the client move toward growth-based goals that tend to have an 'approach' motivation. Goal setting is a fundamental part of psychosocial rehabilitation and recovery support. The quality of goal setting is determined by: - the authenticity of collaboration - the degree to which the client 'owns' the goals - the number of goal-directed principles used - the effective balance of the meaning and manageability of goals - how well specific goals are integrated with the action steps to attain the goals. Clarke et al. (2009a) found that the goal attainment of people with enduring mental illness mediated the relationship between their ratings of symptom distress and their perception of personal recovery. That is, goals are central to the recovery process, particularly in relation to facilitating growth, empowerment and
wellbeing. The steps outlined below are designed to operationalise the goal-setting principles.


Abstract
This chapter will first summarise the range of definitions that have been provided for peer support, in a mental health context. Clarifications of the different aims of peer support initiatives and the potential psychological processes that underpin them are then provided. Three key forms that peer support groups may take are then described and we track Sam as he experiences peer support in the context of job seeking. A summary of existing empirical evidence for peer support groups is provided before examining some of the necessary tensions that may exist between the alternative views of those coming from inside the consumer/survivor/ex-patient (cslx) movement perspective, and the traditional discourses based on the medical approach. A series of recommendations is then offered for those who are working or about to work within a peer support framework in mental health. The recommendations include things to do and things to avoid.


Abstract
The movement towards recovery-oriented mental health service provision has emerged from growing consumer interest to define recovery in terms of personal experience, rather than symptom reduction. In many Western nations, this developing interest has helped to shape governmental health policy (Slade, Amering, & Oades, 2008). Slade, Amering and Oades (2008) state that policy in mental health recovery has become widespread in the English speaking world. They make a distinction between clinical recovery and the more consumer defined view of personal recovery, arguing that the term ‘recovery’ has become increasingly visible in mental health services, referring to personal recovery.