

Delphi Summary Paper

The study employed a Delphi process in order to gauge the degrees of consensus and disagreement amongst various stakeholders around the issues of recovery and care coordination e.g. service users, carers, professionals and national policy makers. Delphi techniques are part of a larger group of 'consensus methods' which aim to gather expert opinion from appropriate individuals with experience of the research topics in question. The focus was the potential organisation and delivery of recovery led care coordination packages across a range of mental health settings. The same questionnaire is administered multiple times and respondents are invited to reconsider or modify their responses in light of others' opinions at the end of each round. The Delphi process was administered over two rounds. The first round used purposive sampling through an open-ended questionnaire to send out to people either by post or email and returned the completed copy to an administrator. At this first stage of the Delphi, 19 professionals, 9 policy makers, 29 service users and 25 carers took part. The insights from this phase of the research were used to inform the development of the questions for stage 2 of the Delphi. A common problem with the Delphi technique concerns withdrawals from the study. By the end of the final 'round' of Delphi, the following groups and numbers of respondents remained:

- Service users (9);
- Carers (10);
- Mental Health professionals (2) ; and,
- Mental Health Policy Makers (9).

Because of the low number of 'front-line' professionals remaining with the study until completion, their responses were combined with those of policy makers for the purposes of statistical analysis.

In addition, the richness of the qualitative data in the questionnaires was recognised and further analysis in keeping with the emancipatory and participatory nature of the project was undertaken.

Analysis

SPSS was used to analyse the quantitative data and NVivo 9 used as a data management package to assist in the analysis of the qualitative data.

Kruskal-Wallis tests were used to determine statistically significant differences ($p < 0.05$) in response to the Delphi statements between service users / carers / professional groups. The Kruskal–Wallis test is a statistical method for testing whether differences exist between the median (average) Delphi scores of more than 2 sub-groups from the same sample: this is the test of choice when analysing ordinal data such as that generated by the Delphi instrument. Because no consistent patterns of opinion emerged in relation to group membership (service user / carer / professional), a hierarchical cluster analyses were performed in order to identify patterns of similarity of response within the data. Hierarchical cluster analysis is a statistical procedure that identifies relatively homogenous groups of respondents (cases) based upon selected characteristics – in this case similarity in the way they scored the Delphi statements. NVivo 9 was used as the data management package to assist with qualitative data analysis.

[1] Care Coordination

There were statistically significant differences of opinions expressed by various groups in 14 out of 40 statements. Once again, in some instances, service users and carers disagreed with professionals e.g. Statement: 'Promoting recovery and working with service users towards mutually agreed goals is central to care coordination.' (Service users and carers 'strongly agreed' whilst professionals' collectively expressed much less agreement with this statement).

Similarly, in other instances, service users and professionals disagreed with carers e.g. statement: 'Service users should be active partners in their own mental health care during care coordination' (Service users and professionals 'strongly agreed' with this statement, whilst carers expressed only 'mild agreement').

In other instances, professionals and carers disagreed with service users e.g. statement: 'Care coordination can be more recovery focussed if service users have the opportunity to choose their care coordinators' (carers and professional groups both 'disagreed' with this statement whilst service users tended to 'strongly agree').

The following differences were found to be statistically significant:

DELPHI STATEMENTS RELATING TO CARE COORDINATION *	SERVICE USERS	CARERS	PROFESSIONALS
Service users should be active participants in care coordination	Strong agreement	Weak agreement	Strong agreement
Promoting recovery / mutually agreed goals is central to care coordination	Strong agreement	Strong agreement	Weak agreement
Promoting recovery / mutually agreed goals is central to care coordination	Strong agreement	Strong agreement	Weak agreement
Repeating Assessments is a negative experience for everybody	Strong agreement	Weak agreement	Weak agreement
Carers / families voices are not heard in the process of care coordination	Weak agreement	Weak agreement	Disagreement
Lack of time care coordinators are able to spend in face to face contact inhibits good care coordination	Strong agreement	Strong agreement	Disagreement
Lack of continuity among staff inhibits good care coordination	Strong agreement	Strong agreement	Neither Agree / Disagree

Care coordination can be more recovery focussed if the goals are defined by the service user	Strong agreement	Moderate agreement	Moderate agreement
All meetings with service users should be held in less formal settings	Moderate agreement	Moderate agreement	Disagreement
Service users should have the opportunity to choose their care coordinators	Moderate agreement	Disagreement	Disagreement

*Differences between groups highlighted in **bold**.

General thematic qualitative findings relating to the issue of care coordination included:

- All groups acknowledge the assessment, planning and monitoring components of care coordination.
- For service users and some carers care coordination has or should have a strong link with recovery, policy makers and staff generally do not make this clear link.
- Service users make the strong link with the need for the process to be about them and be at the heart of the process rather than be on the receiving end of the delivery of the process.
- The importance of the relationship between service user/ carer and care coordinator is emphasised, though not clearly articulated by all staff. The nature of this relationship is recognised as impacting upon the effective delivery of care coordination.
- All groups make reference to the bureaucratic processes of care coordination and there is some cynicism that care coordination is primarily about ticking boxes rather than the effective delivery of appropriate care and support.
- There is a difference in how people talk about care coordination service users and carers clearly draw upon their experience and discuss their understanding from a 'real life' perspective. Staff have a tendency to provide a utopian answer about what the text book says that care coordination should be, we are unsure from the staff perspective about 'what is'. Both policy makers and staff generally provide a dispassionate perspective of care coordination.

Because no consistent patterns of opinion emerged in relation to group membership (service user / carer / professional), a cluster analysis was performed in order to identify patterns of similarity of response within the data (whilst ignoring whether responses were made by service users, carers or professionals). Three distinctive clusters were identified:

DELPHI STATEMENTS RELATING TO CARE COORDINATION	CLUSTER 1	CLUSTER 2	CLUSTER 3
	STATUS QUO ORIENTATION	ORTHODOX SERVICE-IMPROVEMENT ORIENTATION	SOCIAL -REVISIONIST ORIENTATION
	6 Professionals 2 Service Users 1 Carer	5 Service Users 3 Carers 2 Professionals	5 Carers 2 Service Users 0 Professionals
Having knowledge of mental health issues is not essential to effective care coordination.	Disagree	Disagree	Agree
The amount of paperwork (often repeated) the care coordinator has to complete leads to less effective care coordination.	Disagree	Strongly Agree	Neither Agree / Disagree
The care coordination process does not provide an opportunity for the carers/family member's voice to be heard.	Disagree	Neither Agree / Disagree	Strongly Agree
The least helpful part of care coordination is the lack of time coordinators are able to spend in face to face contact with service users.	Strongly Disagree	Strongly Agree	Strongly Agree
The least helpful part of care coordination is the lack of continuity among staff.	Neither Agree / Disagree	Agree	Strongly Agree
Care coordinators are there to support the service users' goals whether they agree with them or not.	Agree	Disagree	Strongly Agree

All differences were statistically significant at the $p \leq 0.05$ level (meaning that there was a less than 1 in 20 chance that these differences being due to random error). However, in this instance clusters were less clear cut and more difficult to characterise given that statements asked respondents to express an opinion on a number of different dimensions e.g. levels of satisfaction with current service provision, opinion in regard to the need for status quo versus radical revision,

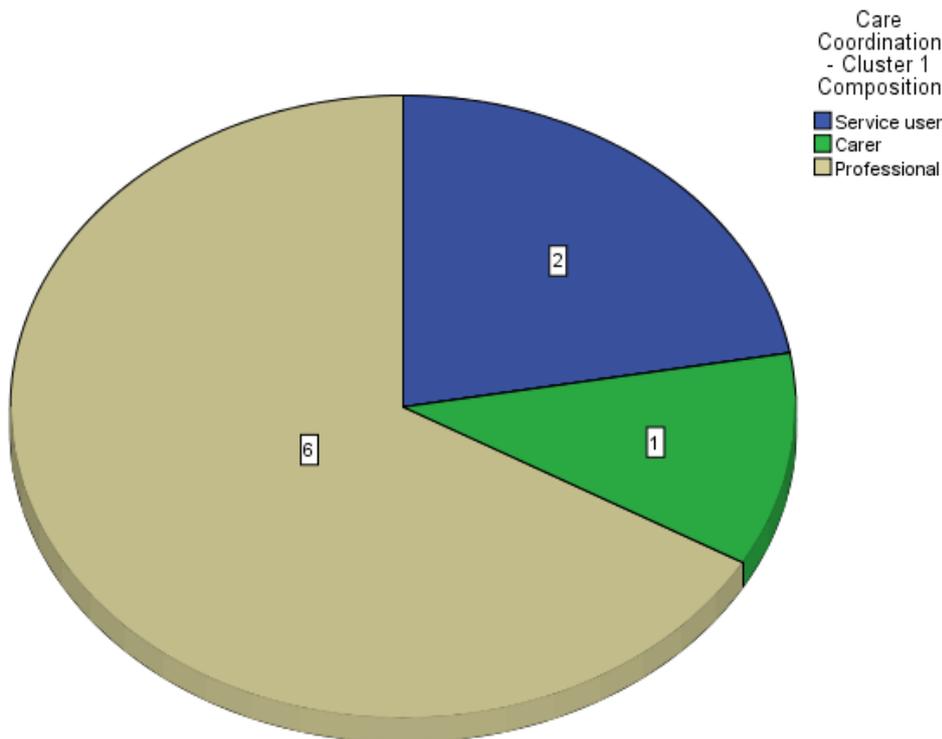
broadly medical versus social orientation towards mental health problems and their treatment. Broadly, we characterised the clusters as demonstrating:

- **Status Quo orientation** – in favour maintaining the current orthodoxy and practices in relation to care coordination;
- **Orthodox service-Improvement orientation** – in favour of the current orthodoxy in care coordination provision, whilst at the same time recognising the need for service improvement;
- **Social - Revisionist orientation** – dissatisfied with current service provision and in favour of radical revision of care coordination to align more with the principals of a 'social-model' of care provision.

The composition of each cluster in terms of group membership (professional / service user / carer) is noteworthy in this respect and will be subject to further analysis / debate in the final reporting of this research.

[1.1] Status Quo orientation

The majority population of this cluster occupied roles as Mental Health Professionals.



There was general consensus from professionals that care coordination is a method or process of *'understanding, organising, implementing and coordinating various aspects of a care plan to achieve the goals of treatment and recovery'*. (207)

For many reviewing progress and reformulating goals is an integral part of this process with a view to ensuring that the most appropriate intervention is coordinated and delivered. Staff generally presented a text book view of care coordination which reflected a person centred approach with the aim of coordinating and managing

care. The majority of staff suggested that care coordination has a role in facilitating the *'continuity of care across a number of potential service interfaces'* (242) and care being coordinated through a *'primary point of contact'*; (222).

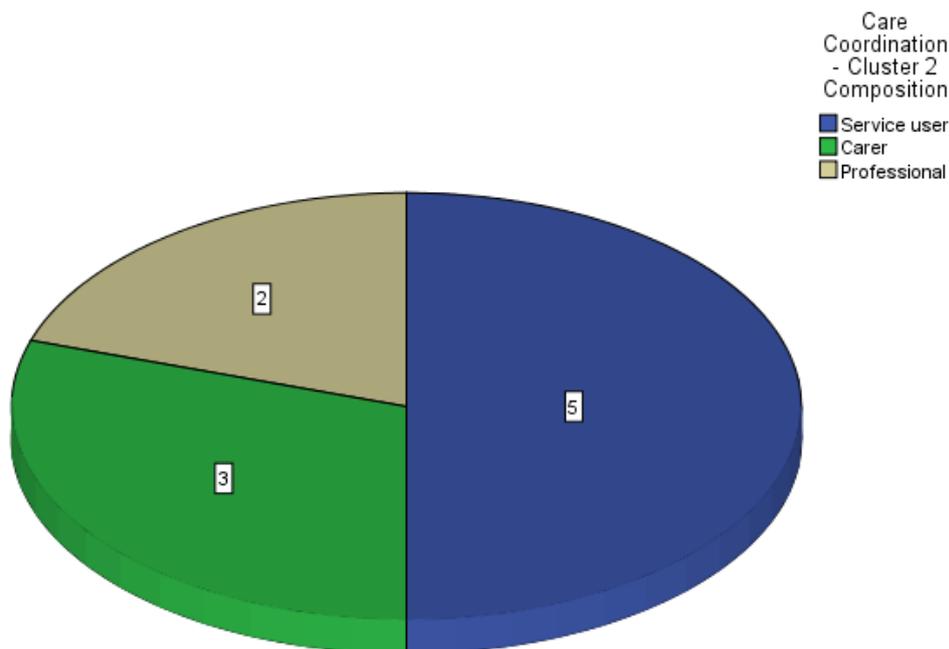
When talking about care coordination some policy makers made reference to the importance of the relational basis of care coordination. It *'involves establishing a trusting reliable relationship with the user of mental health services'* (407).

For one policy maker there is awareness that this approach affects the depth of involvement a care coordinator is able to have with the person. *'...in the current system care coordination has changed so it is more about referrals to other professionals and overseeing the care package- not discussing things too deeply, not getting involved'* (423)

Policy makers and staff generally did not make any clear link between care coordination and recovery.

[1.2] Orthodox service-Improvement orientation

The majority population of this cluster were mental health service users.



Some service users stated that they either did not understand the care coordination process of they had not received good care coordination: One person particularly commented on this in relation to having a dual diagnosis: *'poor in regard to dual diagnosis'* (514) *'Service users not involved and doesn't know what it is or means. Never seen it in action'* (521) Service users generally placed themselves in the centre of the care coordination process working in collaboratively with their care

coordinator and other key people in the team that supports their care: *'care coordination for me is having a team of people who work with me to help me deal with my mental health issues. This is an equal partnership with a shared goal and vision'* (516)

Service users in this cluster suggested that care coordination has a number of functions:

- **To coordinate and monitor support:**

'Someone taking responsibility for coordinating support (the appropriate care) for the individual in need' (520)

- **Relevant Information sharing:**

'Someone who can signpost to the most appropriate service intervention. Someone who shares appropriate up to date information'

- **Facilitating interagency communication:**

'In theory care coordination should improve communication between agencies and the service user' (526)

- **support along the pathway to recovery and keeping people well:**

'The purpose of offering a seamless journey to recovery' (526)

'Joined up thinking working towards keeping someone well and taking part in life and being part of the world...' (511)

- **Some service user respondents reflected a less utopian view of care coordination:**

Care coordination is *'a corporate word that works well for organisations'* (521)

'The statutory coordination of extremely limited opportunities to raise self-esteem that is not outcome focussed enough and is severely limited by the fear and capacity of the care coordinators.' (534)

The written accounts of some carers in this cluster reflected their understanding of care coordination as a positive experience: *'Recognising and encouraging the person and their families and carers to draw upon strengths whilst supporting and giving good knowledge and information about the steps to recovery...build effective working relationships with a range of external organisations and groups that can help all who care and are cared for'* (701).

For Service users and some carers care coordination has or should have a strong link with recovery. 'Recovery' was not always mentioned as one of the aims of care coordination, reference was generally made to people receiving the *'right care in the right place at the right time by the right people.'* (204)

For policy makers the relational basis of care coordination forms the context for the assessment, planning and coordination of services i.e. the care coordination process. They identified that having a service that is responsive to the needs of the individual during their mental health journey is a characteristic of good care coordination. Similar to staff, their accounts were characterised by an idealised view of care coordination. However, policy makers also commented on the current political context for care coordination at a time of austerity: involves a *'process of allocating scarce resources and fitting the person to what's available'* (419).

One staff member felt that it was a 'paper exercise' that was about 'bureaucratic box ticking', whereas other staff suggested that care coordination was strongly person centred and is a dynamic process to facilitate positive change for the person. Service users make the strong link with the need for the process to be about them rather than just the delivery of a process. All groups make reference to the bureaucratic processes of care coordination and there is some cynicism that care coordination is primarily about ticking boxes rather than the effective delivery of appropriate care and support. There is a difference in how people talk about care coordination service users and carers clearly draw upon their experience and discuss their understanding from a 'real life' perspective. Staff have a tendency to provide a utopian answer about what the text book says that care coordination should be, we are unsure from the staff perspective about 'what is'. Both policy makers and staff generally provide a dispassionate perspective of care coordination. Effectiveness of the support network available was seen to either constrain or facilitate effective outcomes from care coordination.

Several consistent themes emerged within the qualitative analysis of data provided by members of this cluster.

- **Care Plan:**

Whilst having a care plan is one of the technical outputs of care coordination, again it is the quality of participation in how it is produced and written that makes it meaningful for this service user.

'when I am unwell there is a plan to follow which is meaningful because I took part in writing it' (515)

Service users and carers identified that it is important to have an approach to care coordination where there is clarity and a positive direction of travel:

'having a constructive plan of care...being able to see progress made' (526)

- **Peer support:**

Some carers receive support from external organisations that provide them with knowledge and support that has not been forthcoming from the traditional care coordination system. Both carers and service users acknowledged the value of the support they received from their peers. *'Peer support from other people who are recovering and have true empathy'*. (525) Some of this support took place within an organised system of carer support e.g. named carer organisation.

- **Bureaucratic processes:**

For one member of staff the most helpful part of care coordination would be *'that we all know and use the same forms'* (215)

This is reflected by a service user who suggests that there is a benefit in *'the fact that I don't have to keep repeating my story to various people'* (515)

- **Trusted Relationships:**

For this member for staff it is the relationship with the service user that is the most important attribute of the process of care coordination. The centrality of relationships

moves care coordination from a technical to a relational process. *'I think it's about relationships rather than function of care coordination that matters, the service user being able to know this professional over a longer time and feel supported.'* (423)

Establishing trusting relationships were also very important to service users: *"...its having someone to talk to in more depth about you, your difficulties and your life in general, who you see more frequently and for longer lasting appointments than your psychiatrist..."* (504)

'one to one, when you have time with that person you feel cares' (554).

- **Communication:**

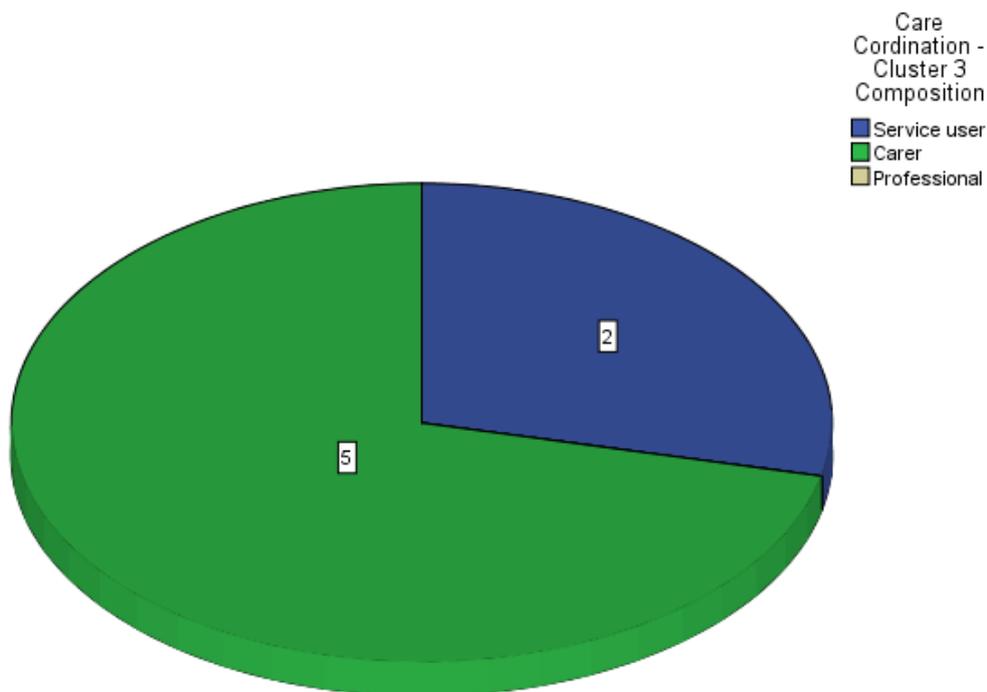
There is considerable consensus between service users, carers, staff and policy makers that to be able to *'communicate effectively'* (207) is central to the process of good care coordination.

Service users and carers *'Communication'* was often stated in the data as a *'catch all'* phrase, however, effective communication was seen to have *"A good listener, someone who may not be able to give/ get you what you want but listens, tries and treats you with dignity and respect..."*---

Good communication was also seen as being about clarity of purpose.

[1.3] Social - Revisionist orientation

The majority population of this cluster were carers.



The patient should always be at the heart of any care decisions and /or goals whenever possible. The majority of carers described it simply as a support system that aims to ensure that professionals work together. This contrasts with a poor experience of care coordination where there is a breakdown in dialogue and communication which results in ineffective service provision for the service user and support for the carer: Care coordination is *'patch and sometimes makes things worse by meeting with big teams where the patient is discussed as if they are not there. The system that is there to help them needs to change – it is having a negative impact and most service users do not want to go to care coordination meetings.'* (702)

One person again refers to care coordination as *'lip service, box ticking'*. All groups acknowledge the assessment, planning and monitoring components of care coordination. Several consistent themes emerged within the qualitative analysis of data provided by members of this cluster.

- **Seeing the person:**

The nature of the relationship recognises the person at the centre of the process and seeks to create a plan around the issues that are important to the individual: *'joined up thinking where you are the centre from which the professional world comes round/ from/ to and that they listen to you and things keep you well supported'* (508) The person is more than a number of a diagnosis, but is viewed as a valued individual:

'having a team of people who see me for me and not a diagnosis' (516)

- **Active engagement:**

Part of being focussed on the individual is that it is not a passive process but an active process that involves the service user in the active decision making around their care and support:

'Having the service users input regarding the decisions being made...' (519)

'Being encouraged to express your views. Ideas being taken into account, being respected in a non-stigmatised way...' (512)

'when they involve you in shared care, when they involve you in writing your own care plan and ask you to sign it and if you would like a copy' (542)

- **The role of 'overseer':**

Having a single point of contact to act as an overseer was seen as helpful to the process of care coordination. Staff particularly identified the importance of having a single point of contact:

' an identifiable individual who is 1 contact with all involved in a person's care/ treatment / care package' (242)

This person is seen as having the role of an overseer and negotiator across different sectors and services:

'having a single person with overarching responsibility. The opportunity to negotiate bespoke care rather than impose blanket solutions' (205)

Some service users identified the importance of having one person to talk to, however many service users did not talk about having a named individual but that the strength of care coordination was in having access to a team of people:

'having a team of people who see me for me and not a diagnosis' (516)

Whilst having a single point of contact to undertake the coordination was important to people – the most important element was the positive trusting relationship between the key individuals, effective communication and a way of working that was person centred and collaborative

[2] Recovery

General thematic qualitative findings relating to the issue of recovery included:

- Recovery is seen as a personal journey which may be lifelong with setbacks along the way.
- There is some focus on the removal of symptoms, but there is also a trend to move beyond the traditional medical model approach into wellness.
- Recovery affects how the person sees themselves (identity) and it is influenced by peer and family support and the degree to which they are able to take personal responsibility and actively participate in their own recovery.
- Some of the obstacles to recovery include, prejudice, societies acceptance of difference and stigma and peoples housing and financial status. Where the medical model approach is still practiced this has a disempowering effect on service users.

There were statistically significant differences of opinions expressed by various groups in 7 out of 32 statements. In some instances, service users and carers disagreed with professionals e.g. Statement: 'Taking part in activities and feeling part of things is important in increasing recovery.' (Service users and carers 'strongly agreed' whilst professionals' neither agreed / disagreed').

In other instances, service users and professionals disagreed with carers e.g. statement: 'Recovery is a return to functioning at a level experienced before the 'disorder'.' (Service users and professionals 'strongly disagreed' with this statement, whilst carers 'strongly agreed').

In one instance, professionals and carers disagreed with service users e.g. statement: 'Recovery can only be defined by the person, so they would tell you if they were in recovery' (carers and professional groups both expressed 'neutral' opinions about this statement whilst service users tended to 'strongly agree'). The following differences were found to be statistically significant:

DELPHI STATEMENTS RELATING TO RECOVERY *	SERVICE USERS	CARERS	PROFESSIONALS
Recovery is self-defined hope and personal meaning	Strong agreement	Strong agreement	Weak agreement
Strong support networks including family and friends increases recovery	Moderate agreement	Strong agreement	Moderate agreement
Participation in activities / feeling included increases recovery	Strong agreement	Strong agreement	Neither Agree / Disagree
Recovery can only be defined by the person experiencing mental health problems	Moderate agreement	Disagreement	Moderate agreement
Recovery is a return to functioning at a level experienced before the 'disorder'	Disagreement	Strong agreement	Disagreement

*Differences between groups highlighted in **bold**.

Because no consistent patterns of opinion emerged in relation to group membership (service user / carer / professional), a cluster analysis was performed in order to identify patterns of similarity of response within the data (whilst ignoring whether responses were made by service users, carers or professionals). Two distinctive clusters were identified.

DELPHI STATEMENTS RELATING TO RECOVERY	CLUSTER 1	CLUSTER 2
	MEDICAL – CURATIVE ORIENTATION	PERSONAL – SOCIAL ORIENTATION
	<ul style="list-style-type: none"> • 4 professionals • 4 service users • 10 (all) carers 	<ul style="list-style-type: none"> • 7 professionals • 5 service users
Recovery is a return to functioning at a level experienced before the ‘disorder’.	Agree / Strongly Agree	Disagree
Recovery is increased personal control of your life.	Tend to agree	Strongly Agree
Recovery can only be defined by the person, so they would tell you if they were in recovery.	Disagree	Strongly Agree
Socialising with other people shows that someone is in recovery.	Tend to Disagree	Tend to Agree
Being in recovery would mean freedom from symptoms.	Tend to Agree	Tend to Disagree

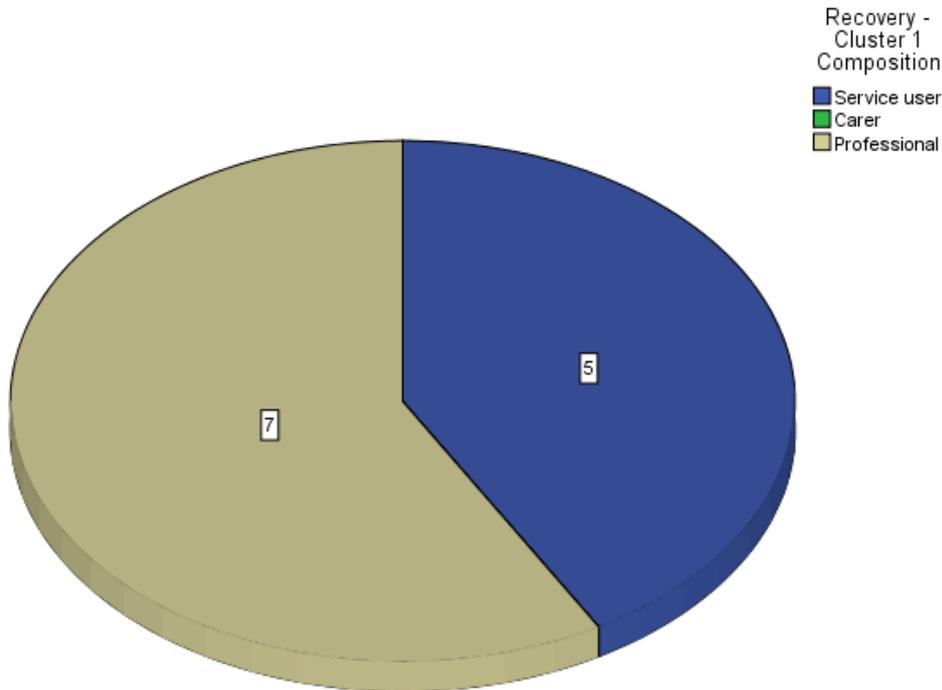
All differences were statistically significant at the $p \leq 0.05$ level (meaning that there was a less than 1 in 20 chance that these differences being due to random error). We described one cluster as displaying a ‘medical – curative orientation’, whilst the other displayed a ‘personal – social orientation’ to recovery.

There is some/considerable consensus among all four groups, professionals, policy-makers, service users and carers, that recovery involves a process or a journey which may be life-long and involve setbacks along the way: *‘Recovery to me is a journey, which never ends. I am on my journey and learning all the time about aspects of my journey. At times the journey is easier than at others’.* (515)

There is some emphasis on learning/teaching coping skills, identifying triggers etc. There is also evidence that some think care coordination is less effective as it is time-consuming involving too much paper work and so on.

[2.1] Medical – Curative Orientation

The interesting feature of this cluster was that it was exclusively composed of mental health service users and mental health professionals, with no carers.



Several consistent themes emerged within the qualitative analysis of data provided by members of this cluster.

- **Journey or destination:**

However, some also see recovery more as an achievable goal or end-point, defining it as a return to health after the acute stages of an illness: *'A person being well again, back to the way they were, having quality of life'* (705) Such a view applies not only to carers and service users who can remember better times before ill health set in but also to care coordinators and policy makers who aim presumably to move clients forward from diagnoses that necessitated care coordination in the first place towards a point where they can manage their own lives more successfully: *[The acute stages of illness are past and there is a coming to terms with what has happened] The restoration of health, personal meaning and quality of life following a period of ill health* (407)

For many recovery is an issue that affects identity as a whole. For some it may mean learning to manage continuing impairment/ illness: *'The acute stages of illness are past and there is a coming to terms with what has happened'* (205)

- **Stigma:**

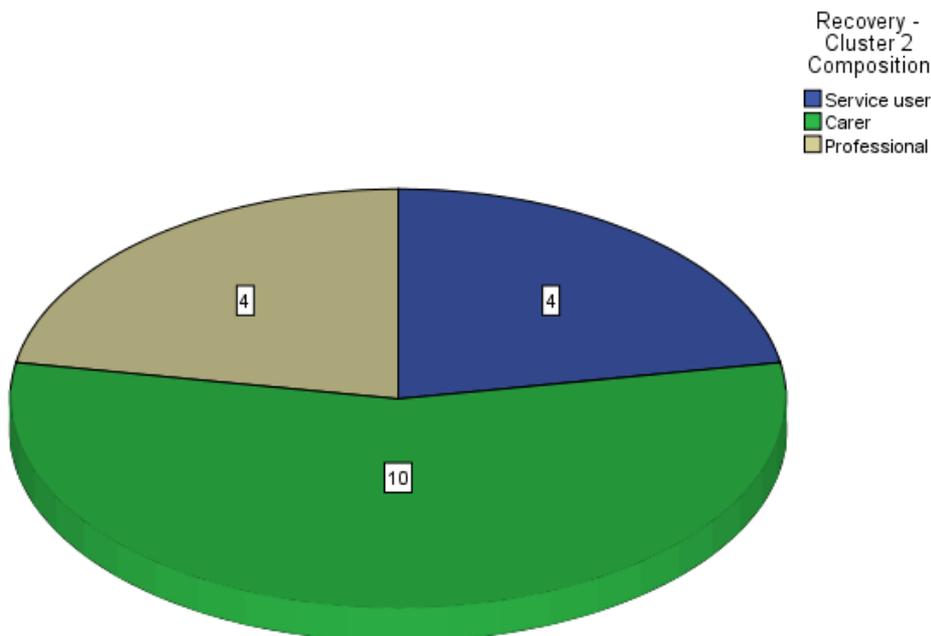
Unfortunately this view is not held universally and all four groups of respondents acknowledge the many obstacles to recovery in the world outside including *'Prejudice, stereotyping, stigma'* (426), *'housing conditions and financial status'* (505) *'Society's negativity and incapacity for the acceptance of people who differ from the norm'* (512), *STIGMA* in capital letters (757). Notably stigmatisation is not only experienced on the part of strangers: *'Stigma and discrimination in the work place, or*

you may get employed as a token mad person in a mad organisation' (521). *'Family and friends discriminate against mental health conditions'* (521) More worryingly some service users report perceived stigmatisation from health professionals. One service user on requesting that her GP refer her to an art group reports being told she was *'a good looking intelligent girl and not like those people.'* (548)

While such an unprofessional attitude is hopefully rare merely perceiving professionals' lack of belief that *'recovery or at least partial recovery is achievable'* (540) must have a negative impact. This disempowering effect may be explained in part by some professionals' adherence to the medical model of recovery: *'Professionals, despite words to the contrary, still stuck in reality to a predominantly medical model approach'*. (218). One policy maker identifies the disempowering effect of *'A focus on symptoms and problems rather than building on strengths'* (416). This in turn may result in the impression that recovery may mean being *'symptom free'* and therefore recovery being unattainable (222).

[2.2] Personal – Social Orientation

The interesting feature of this cluster was that all carers were located within it.



Professionals and policy makers seem to support broader interpretation of recovery i.e. not just medical model. Is that because they know what model/policy they are supposed to support when answering questions. Possibly tellingly one refers to *'the current fashion'* (239) and another suggests staff may pay lip service to the recovery model/care coordination.

So while some focus on removing symptoms or dealing with crises, there is evidence of a trend to move beyond the medical model – *‘learning to move forward from a mental health diagnosis’* (525) with goals ranging from the realistic and practical, *‘being able to cope with the bad times and make the most of the good times’* (504) through the more optimistic such as *‘maximising potential’* (202) to the ambitious and potentially far-reaching *‘lifelong journey of discovery’* (534).

Several consistent themes emerged within the qualitative analysis of data provided by members of this cluster.

- **Personal meaning:**

While there is much agreement concerning factors promoting or hindering recovery there is also acknowledgement from all sides that recovery is personal and individual. For one staff member recovery implies *‘an overall adjustment or improvement that is valuable and meaningful to the patient’* (239) and one policy maker describes recovery as *‘An individual’s journey towards building or rebuilding a fulfilling life of their choice.’* (419)

Moreover one service user notes that another individual’s recovery is not always identifiable to an outsider: *‘I would not know unless they told me. Everyone’s recovery is there’s’*. This suggests that effective care coordination requires good communication, respect for individual meaning, awareness and a flexible approach. The carer who knows the individual concerned well and can offer appropriate support in response to changing needs by *‘Looking at the person for the spark of communication they show they are ready for a next step’ must be invaluable’* (701).

By the same token a lack of continuity in care coordination is perceived by some as harmful: *‘Their plight is made worse by having to explain their symptoms and circumstances time and time again as one professional succeeds another’* (553).

- **The bigger picture:**

Both service users and carers recognise that recovery involves seeing the bigger picture: *‘Trying not to define yourself by your condition’* (702). *‘My recovery began when I began to realise I was not the label’*. (526) That recovery depends not only on being supported by others but also on the service user’s personal effort, active participation and positive attitude is also acknowledged: *‘Recovery to me is the service user using all/any resources available to be able to make a positive change in the style/mind-set to enable self-determination on their road to well-being’*. (519)

Taking responsibility and beginning to self-manage not only helps improve the service user’s self-image but it also changes how others view them, in turn supporting a new sense of ‘recovered’ identity: *‘Recovery to me is about regaining control, having a purpose in life. Having dreams and hopes. Having people believe in me. People see beyond my diagnosis, they see me as a person.’* (542)

Recovery is seen to operate not only at an individual level but may also lead to more balanced identities within relationships: For one carer recovery meant: *‘Our relationship going back to normal. I am no longer a father figure. Things are equal.’* (707)

For one service user moving the focus away from illness to identify more broadly with humanity and its common challenges also seems to promote wellbeing: *'Recovery is not about a cure. Taking personal responsibility, allowing you to make mistakes and knowing it is OK to do so. We are all in recovery from something, not just specific to mental health.'* (542)

- **Person centring:**

However, there is also evidence that both professionals and policy makers embrace much broader, more flexible, person-centred approaches in theory if not always in practice: *'Putting the service user at the centre of the process and encouraging them to make decisions based on their own identified needs and aspirations'*. (201) And in a policy maker's positive words: *'Increase recovery? What does this mean? A person can be helped in their recovery journey by people who help them to believe in themselves and their own future, by building on their strengths, working towards their goals, experiencing and celebrating successes, learning to manage their own challenges in many different ways and learning when they would find support helpful ...'* (416) Such aims are also appreciated by many service users and their carers as supporting recovery: *Having hope that things can get better. 'Having people around you that genuinely care about you and support and encourage you, including professionals, family and friends. Having something to do with your time that you get something out of, whatever it is and however insignificant it may appear to be to others...'* (504)

'Increased care and support focused on 'recovery' where the goal is to increase care and support that focuses on service users' goals, interests, skills, preference and quality of life'. (757) 'Diplomatic care and a good understanding of the patient's needs. Plenty of TLC. Indeed it seems that a support network sensitive to your needs is most important for many service users. How would you know if someone was in recovery? (implies a discernible change in identity More on self-esteem – individual needs to have a valued role' (211), (708). 'Sometimes broader socio-political issues interfere/influence recovery (stigma, benefits, employment, social capital etc.), but there is wide agreement that recovery may ultimately depend on the individual becoming responsible for their own recovery achieving an internal locus of control (418, policy maker) and ultimately able to own their progress' (507b).