MAJOR RESEARCH PROJECT

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How do clients experience the alliance when working with the Mental Health Recovery Star in Rehabilitation Settings?

Section A:
Literature Review of the Nature of the Working Alliance in Case Management Mental Health Services

Word Count: 7,975 (279)

Section B:

How do clients experience the alliance when working with the Mental Health Recovery Star in Rehabilitation Settings? A Grounded Theory

Word Count: 7,990 (243)

Overall Word Count: 15,965 (522)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

APRIL 2016

SALOMONS
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Acknowledgments

I would like to extend my sincere thanks to the clients and workers who were involved in this study. I am very grateful for their willingness to share their time and thoughts with me. I would also like to thank the service managers who provided access for me to carry out this research in a variety of settings. Your assistance has been greatly appreciated. A big thank you to my external supervisor, Joy MacKeith, for the inspiration of this project, and to my internal supervisor, Dr Sue Holttum for your guidance, patience, and support. It has been invaluable.

On a personal note I would like to thank my wonderful husband, who has walked this journey with me, with all its highs and lows, supporting me on every level. Thanks Nath, I love you more than words could say. To George and Maddy, thank you for your patience and always bringing a smile to my face, I love you both very much. To my parents whose belief in me and love exceeds that which any child could hope for, thank you. Dad, your gracious support has been a constant reminder of that of our Heavenly Father, to whom I owe the biggest thanks.

Summary of MRP Portfolio

Section A: Section A is a literature review, including research that has explored the nature of the alliance between clients and case managers in mental health services. A systematic approach was used to search for quantitative and qualitative studies as well as theoretical analysis addressing this subject.

This review identifies factors associated with a positive alliance by both clients and workers. It also highlights challenges arising from difficulties inherent in relationship building among this client group and systemic pressures within services. Theoretical and ethical arguments, offering insight into the complexities involved, are also are reviewed. It is concluded that further research is required, particularly qualitative studies of client perspectives to provide better understanding of the alliance within case management.

Section B: Section B presents a study using Grounded Theory Methods (GTM) that explored client experiences of the alliance within the context of using the Mental Health Recovery Star (MHRS) in rehabilitation mental health services. Ten clients and four workers from three different services were interviewed. A theoretical model is provided, summarising the results, which highlight three key overlapping processes seen within the alliance and use of the MHRS. Overall these reflected a core category of 'being engaged in working together towards improved wellbeing'. The results are discussed alongside existing theory and research. Attention is drawn to ways in which these processes appear to be enhanced or hindered whilst using the MHRS, calling for improvements in negotiation practices and support for workers in this setting. Further clinical and research implications are presented.

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MAJOR RESEARCH PROJECT

SECTION A: LITERATURE REVIEW

Literature Review of the Nature of the Working Alliance in Case Management Mental Health Services

Word Count: 7,975 (279)

APRIL 2016

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Abstract

Increasingly the evidence base for mental health treatment points to common factors across models and approaches that are seen to account for positive clinical outcomes, in particular the working alliance between a provider and client. Whilst the alliance, or therapeutic relationship, has been explored extensively in psychotherapy, far less is known about this in case management mental health services. Here workers have a broader remit of helping to provide a full range of long-term health and social care needs for those with severe and complex difficulties. This literature review used a systematic approach to examine the available empirical research that has explored the nature of the alliance between case managers and clients in this context, including factors that might assist or hinder a positive alliance. In addition, theoretical and ethical arguments that offer further understanding of the complexities involved are discussed. The limited research in this area suggests leading influences underpinning the alliance often stem from service-related practices. In particular this includes power imbalances and conflicting demands of the worker's role affected by the needs of the client and systemic pressures. Clinical implications and future research considerations are presented, including the need for qualitative studies that capture client experiences.

Keywords: Working/helping alliance, therapeutic/helping relationship, case management, case work, keywork, mental health

1. Introduction

1.1. Context

National policy stipulates a Recovery-based approach to mental health services, directed at providing person-centred care characterised by collaborative working with professionals, service users and carers (Department of Health [DoH], 2011).

The Recovery movement has gathered momentum internationally in recent years, marked by a shift away from medicalising mental health problems towards understanding individual experiences within social contexts, with an emphasis on hope, meaning and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Perkins & Slade, 2012). How this translates to services remains open to debate, especially where services are often informed by the available evidence-base, despite limitations to what has been researched, and by clinical governance that prioritises symptom-reduction over personal expressions of recovery (Denham-Vaughan and Clark, 2012; Perkins & Slade, 2012).

Case management is a service directed at providing those with long term mental health difficulties a co-ordinated provision of health and social care in the community, that incorporates assessing and addressing a wide range of needs, such as housing, welfare benefits, medical treatment, psychosocial and emotional support, and assistance with everyday matters (Mueser, Bond, Drake, & Resnick, 1998; Ross, Curry, & Goodwin, 2011).

1.2. Evidenced-based practice (EBP)

EBP in mental health focuses on specific treatment interventions; however a considerable strand of research suggests that it is the non-specific factors of treatment, in particular the relationship between professionals and clients, that clients value most and that has a greater influence on outcomes (Priebe & McCabe, 2008; Stanhope & Solomon, 2008; Thomas, Bracken & Timmimi, 2012).

As such there has been a move towards transtheoretical models of treatment (Dudley, Kuyken, &Padesky, 2011) and a call for further research into process-related variables of treatment, particularly pertaining to the relationship between providers and clients (Kondrat, 2012).

1.3. Defining the Alliance

There are varied definitions of the relationship between a provider and client receiving treatment for mental health difficulties. Terms often used interchangeably include the Therapeutic Relationship/Alliance, Working Alliance, Helping Alliance/Relationship (McCabe & Priebe, 2004) and more recently within the Recovery movement, Recovery Alliance, or just Alliance (Stanhope & Solomon, 2008).

The therapeutic relationship has its roots in Freud's psychodynamic model that was further developed by Greenson (1967), which made distinctions between the 'real relationship', transference, and a collaborative working alliance. Subsequently, Rogers' (1961) person-centred approach reframed the alliance by identifying three core conditions clinicians should implement to facilitate therapeutic change - empathy, unconditional positive regard, and congruency.

Bordin's (1979) integrative model of the working alliance is a further development, seen to extend across disciplines, theoretical models and contexts (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003). Here three core components are seen to facilitate positive change - agreed goals, tasks of therapy, and a positive bond (Bordin, 1979). Horvath and Horvath and Greenberg (1989) operationalised Bordin's model in the Working Alliance Inventory (WAI), which is the dominant measure used in case management settings (Kondrat 2012; Solomon, Draine & Delaney, 1995).

1.4. Alliance and recovery outcomes

Traditionally, research on the alliance was carried out within the context of psychotherapy, where a strong alliance has consistently been shown to be related to positive outcomes (Lambert & Barley, 2011; Martin, Garske, & Davis, 2000).

Research among clients receiving treatment in mental health services not limited to psychotherapy similarly report a positive association between strength of alliance and recovery outcomes across diagnosis and settings (Del Re, Flückiger, Horvath, Symonds , & Wampold, 2012; Moran et al., 2014).

One such setting receiving focus in more recent times is case management, where the interpersonal dynamics between client and worker is distinct from psychotherapy because of the diverse range of responsibilities expected from the case manager (Angell & Mahoney, 2007). The evidence regarding the alliance specifically within the context of case management is relatively limited; however that which is available suggests the alliance is a promising predictor of positive therapeutic outcomes (Chinman, Rosenbeck & Lam, 2000; Hicks, Deane & Crowe 2012; Priebe & Guyters, 1993; Howgego et al., 2003; Kondrat, 2012).

1.5. Case management

There is no standard definition of case management or case-manager, also referred to as 'key worker' and 'care-coordinator' (Farrelley & Lester, 2014). Hereon in 'worker' will be used for ease of reference. Workers' training and experience is highly variable – ranging from an absence of graduate training (Buck & Alexander, 2006) to diverse professional backgrounds (most commonly nursing and occupational therapy) (Solomon et al., 1995). Similarly there is variability with regards to a worker's role; however common responsibilities include assessing and monitoring a client's needs, advocacy, psychosocial

support, practical support, and co-ordinating health and social care provision in community settings (Angell & Mahoney, 2007; Mueser et al., 1998).

Mueser et al., (1998) have provided a summary of the dominant case management models as follows:

i) Broker service model – workers primarily advocate for and co-ordinate access to services with minimal clinical input.

ii) Clinical case management model – workers additionally employ clinical skills (assessment, psycho-education and psychotherapeutic input).

iii) Assertive Community Treatment (ACT) model – delivered by a multidisciplinary team of which case managers are a part. Clients may be assigned a primary worker or caseloads may be more evenly spread across the team.

iv) Intensive Case Management (ICM) – low client to worker ratio where caseloads are not shared by the team.

v) Strengths model – specific focus on client and community resources, working towards client self-determination, growth and change.

vi) Rehabilitation model – emphasis is placed on independent living skills and community integration.

Regardless of the case management model used, building an effective working alliance with the client is fundamental to the worker's role, yet training in this area is sparse (Ross et al., 2011).

1.6. Rationale and aims of review

In sum there is a fair body of research that has explored the nature of the alliance and its association with outcomes, mostly within the context of psychotherapy and more recently in other mental health service settings (Del Re et al., 2012; McCabe & Priebe,

2004); however that which has focused on the relationship between workers and clients remains limited. These tend to focus on clinical outcomes, with promising links between a strong alliance and positive change (Howgego et al., 2003); however no systematic review of the literature exploring the nature of the alliance within case management has yet been carried out. The aim of this paper is to address this gap. This literature review is directed at answering the following question:

What is the nature and /or components of the alliance between case managers and clients receiving treatment in mental health services?

In order to review the literature on this subject, systematic methods were used, based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) model (Moher, Liberati, Tetzlaff & Altman, 2009), a summary of which is provided in Figure 1 below.

Electronic searches were carried out using the following databases which cover academic literature in medicine, health care, psychology, social sciences and related disciplines: PsycInfo, Medline, Applied Social Sciences Index and Abstracts (ASSIA), Cinahl, and Web of Science.

The following search terms were used: [therapeutic relationship OR therapeutic alliance OR working alliance OR working relationship OR helping relationship OR helping alliance] AND case management OR casework OR casework relationship OR keywork* OR care coordinat* OR care co-ordinat*] AND mental health.

The inclusion criteria used for the selected papers were as follows:

- Empirical papers that stated clear aims of investigating the factors of the alliance between adult clients with primarily mental health difficulties and clinicians identified as case managers within mental health services.

- Theoretical papers that specifically address alliance processes between case managers and clients.

- Peer-reviewed articles.

- Papers in English.

In order to narrow the focus of this review the following exclusion criteria were applied:

- Papers that do not differentiate between case managers and other members of a community mental health team.

- Research among "consumer-providers" or limited to those receiving forensic services or involuntary treatment because these contexts reflect idiosyncratic interpersonal dynamics (including power differentials) that could be a specialist area to be researched in their own right (Solomon et al., 1995; Stanhhope & Solomon, 2008; Sweeney et al. 2014).

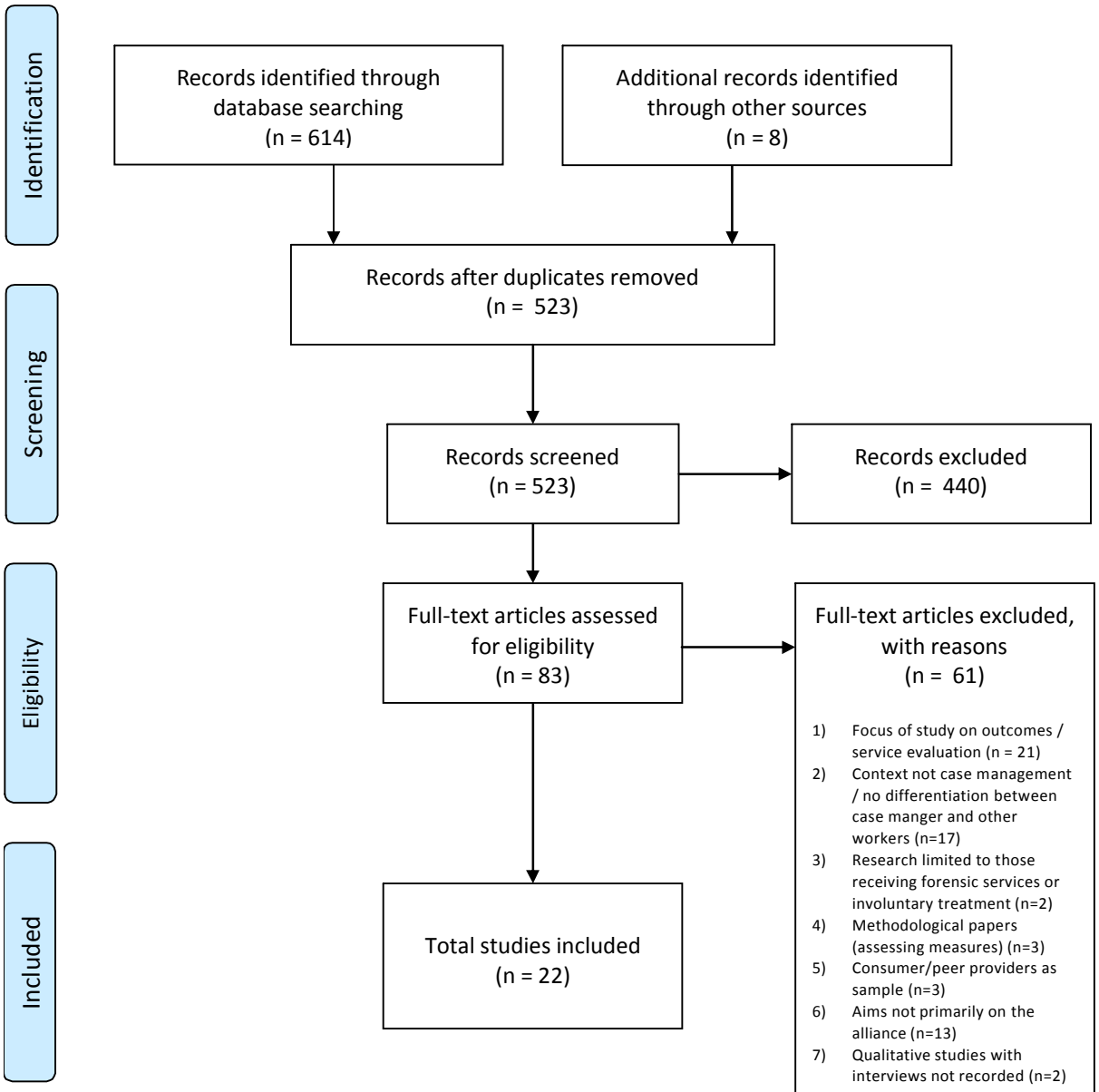
- Research which primarily focuses on service evaluation or outcomes. Where papers aimed to assess both predictors of the alliance and the association between alliance and outcomes, only data pertaining to the former was included (Hopkins & Ramsundar, 2006; Klinkenberg, Calsyn & Morse, 1998; Priebe & Guyters, 1993).

- Qualitative studies where interviews were not recorded because such methods fall short of capturing an in-depth understanding of the subject for which qualitative research is designed (Buck & Alexander 2006; Nath, Alexander & Solomon, 2012).

1.7. Summary of literature search

A flow diagram summarising the process involved in the literature search for this review has been provided below.

Figure 1: Summary of literature search



In total, 614 articles resulted from the database searches and eight articles sourced from references. After removing 99 duplicates, a review of titles and abstracts, applying the inclusion and exclusion criteria, resulted in the exclusion of 440 articles. This resulted in 83 full text articles, of which 22 were accepted. A summary table of the empirical studies has been provided in Appendix 1.

It should be noted that this review did not include systematic citation and ancestry searches, which may have resulted in the exclusion of relevant papers from the broader field of adult mental health – for example research that may have looked at the alliance in the context of case management without specifically using the terminology covered by the keywords used in the search for this review.

The quality of papers has been critiqued using Vandenbroucke et al.'s (2007) framework for quantitative papers and the Critical Appraisal Skills Programme (CASP) framework for qualitative studies (http://www.casp-uk.net) (summaries provided in Appendices 2 - 3).

This literature review will commence with a recent review concerning the alliance within case management among clients with a psychotic disorder (Farrelly & Lester, 2013). Empirical research will then be reviewed by looking at client and worker perspectives of the alliance respectively, followed by theoretical papers that offer insights into this subject. Finally, the findings will be discussed with conclusions drawn, highlighting implications for further research.

2. Review paper

Farrelly and Lester (2013) carried out a critical interpretative synthesis of literature that explored the alliance within case management among clients diagnosed with a

psychotic disorder. From the 13 papers reviewed, three overlapping components to an effective alliance were identified: mutual trust, mutual respect, and shared decision making.

The synthesising argument generated from this review was that the alliance is polarised around these three key constructs, with the polar opposites being mistrust, disrespect and decision-making fraught with competing agendas. In particular, there is disagreement between clients and workers as to whether the aim of their relationship is primarily engagement (equating to treatment compliance) or improvement (recovery-related benefits for clients). A tension exists between client autonomy and risk management because of workers' accountability to social and political stakeholders, such as the health service and national policy. This is said to result in role conflict and ambiguity of needs and expectations within the relationship. The authors conclude that clearer expectations of treatment and the alliance should be provided.

It should be noted that this synthesis was not a systematic review and included only 13 papers, restricted to clients with a diagnosis of a psychotic disorder, it is therefore not designed to be representative of the evidence in this field.

3. Empirical studies

3.1. Client perspectives - Quantitative studies

Clients have been shown to rate the alliance with their workers as relatively positive (Priebe & Guyters, 1993). This was assessed among 72 clients in a case management service in Germany using a five item questionnaire developed by the authors that assessed clients' ratings of the following: workers' understanding, involvement, criticism, adequacy of treatment, and whether or not they felt better after their sessions. Most of these items were significantly positively correlated except for client perception of criticism which had a negative correlation with the other factors.

A cross-sectional study among 86 participants from an ACT service in the US found that older clients (45 or older) reported significantly stronger alliances with workers (measured two years into treatment) than younger clients when demographic and clinical characteristics were controlled for - namely criminal arrests, homelessness, number of hospitalisations and ethnicity (Draine & Solomon, 1996). The authors propose that workers may offer continuity of care that supports clients through physical, mental, and social difficulties associated with ageing. However this explanation remains speculative and would require further empirical research. The authors acknowledge that a longitudinal study may have been preferable.

Klinkenberg et al. (1998) similarly sought to assess predictors of the alliance as measured by the client, looking at both client characteristics and service variables. Data were obtained from a parent study among clients in an assertive service in the US, taken at two months and fourteen months.

At month two only four out of 22 variables were significant predictors of the alliance - low hostility, greater perceived needs, greater service contacts, and ethnicity. Being Caucasian was associated with a weaker alliance; however the authors do not provide a full description of the ethnicity of participants. Among the client variables shown not to be significant predictors were age, gender, diagnosis, denial of illness, and number of conflictual relationships. At month fourteen the only significant predictor of the alliance was strength of alliance at month two.

Whilst the authors use a range of measures to assess many variables in this study, the psychometric properties of most of these remain unclear. Importantly this includes the self-report measure of the alliance developed by the authors that was based on a measure used in counselling. The validity of the findings therefore may be questionable. Further

limitations include the small sample size (74-93), which varied because of missing data that are unaccounted for.

Kondrat and Early (2010) completed a cross-sectional study among 160 clients from case management services in the US, looking at whether client ratings of the alliance correlated with client perceptions of stigma (beliefs that those with a serious mental illness (SMI) are devalued in society and discriminated against). They also sought to assess whether specific case managers formed better alliances with clients (47 workers were involved).

After controlling for numerous client demographic variables (age, gender, amount of treatment), the worker accounted for 11% of variance in alliance ratings. The findings suggest some workers form better alliances than others; however, unfortunately no other details regarding worker characteristics (such as experience, training or personal attributes) were obtained so it is not clear what specific qualities of the worker may account for this influence.

The analysis also suggested client perceptions of stigma did not predict working alliance; however when combined with the variable of worker, this relationship was significant – that is workers may reduce the effect of perceived stigma on the alliance. Of the variables controlled for, a significant inverse association was found between length of treatment and alliance ratings. The authors suggest this may be due to a high turnover rate of workers, which creates inconsistencies in the alliance; however this was not formally assessed.

Other research has looked at whether the nature and extent of a client's interpersonal relationships and social contexts predicts the quality of their therapeutic relationships (Catty et al., 2012). In a study that assessed this among 93 clients in a UK case management service, ratings of the alliance were not shown to be associated with the size of a client's

social network or number of confidants (Catty et al., 2012). Similarly, social network variables were not associated with a client's attachment to the community team. Attachment style was not associated with a client's rating of their alliance with their worker and only one attachment style (preoccupied) was shown to be associated with attachment to the team. These results demonstrated a distinction between a client's experience of personal and professional relationships. Furthermore, team attachment was associated with having poorer global functioning, suggesting clients with greater difficulties may have greater dependency on team support. The authors acknowledge numerous limitations to their study, including potential bias arising from purposive sampling and choice of a less traditional measure of attachment style, which perhaps did not capture important constructs related to developmental or unconscious attachment factors.

3.2. Worker perspectives - Quantitative studies

Using data from the same parent study as that used in the Klinkenberg et al. (1998) study, Klinkenberg, Calsyn and Morse (2002) subsequently examined predictors of the alliance as rated by the worker. They found that worker ratings of the alliance remained moderately stable over 18 months. Most client variables did not predict alliance (including gender, conflictual relationships, and diagnoses) although the alliance was stronger at 18 months for clients who were African American (in comparison to clients who were Caucasian) and without a substance misuse disorder. A stronger alliance was associated with greater acknowledgement from clients about their need for mental health treatment. In terms of case management variables, number of contacts did not predict alliance; however providing a wider range of services to the client predicted a stronger alliance at six months but not 18 months. This suggests that concrete assistance addressing a range of needs (housing, transport, and other treatments) are more important early on in the case

management relationship. Unfortunately the analysis did not provide further detail to compare which types of services were possibly valued the most.

One study which has looked at service factors in more detail, found that a worker's initial impression of the alliance may impact on the extent and type of service they provide (Hopkins & Ramsundar, 2006). This study among 30 adults with a SMI in Canada sought to identify factors that predicted case management interventions. Workers completed measures of the alliance and of clients' functioning in the community (behavioural problems, community adjustment and social competence) during the first two months of engaging with a client and a year later. Logs of time spent with the client, phonecalls to other stakeholders, community visits and types of support were also obtained.

The working alliance (as rated by the worker) was shown to be a stronger predictor of the extent and type of intervention provided than a client's community functioning. A stronger alliance predicted more worker support, community visits, and sessions focused on activities of daily living (ADL) and social skills.

Key limitations of this study include the small sample size and absence of psychometric properties of measures used or means to validate the data collected. In addition, clients' community functioning was measured using the workers' subjective perspectives only.

3.3. Client and worker perspectives ' Quantitative studies

Clients and provider's have been shown to view their relationship rather differently (Calsyn, Klinkenberg, Morse, & Lemming, 2006); therefore studies that incorporate both parties' views may better elucidate our understanding of the alliance.

Calsyn et al., (2006) assessed both worker and client ratings of the alliance at numerous time points - baseline, three months and 15 months among 115 clients with a

SMI, substance misuse, and homelessness in ACT services in the US. They sought to identify a range of predictors of the alliance, including client variables (age, gender, race, readiness to change substance misuse (RTC) and willingness to seek help); treatment variables (transportation, counselling, and assistance with ADL); and changes in client outcomes (days in stable housing, symptomology, RTC and conflictual relationships).

Overall, ratings of the alliance were not strongly correlated between time intervals and between clients and case managers, suggesting views of the alliance differ and do not remain stable over time.

With regards to the independent variables that were assessed, the variance in alliance was accounted for by independent variables only to a moderate degree whereby client age, race and diagnosis were not shown to predict the alliance but client RTC was a strong predictor for both parties' ratings. Male clients rated the alliance slightly higher than women but gender did not predict alliance ratings for workers. Treatment variables (transportation, contacts, and ADL assistance) predicted alliance ratings for workers more than for clients, although transportation also predicted client's rating of alliance at 15 months.

The authors specifically sought to assess the 'marker hypothesis' – that is whether clinical outcomes (positive changes for the client) predict a more positive alliance. To this end only a modest correlation was shown (less than 10% of the variance in alliance ratings for both parties at 15 months was accounted for by changes in client outcomes). For client ratings these included increased RTC substance use and reduced conflictual relationships. For worker ratings, these included reduced symptomology, increased housing stability, and increased income. This offers some support for the 'marker hypothesis' but as the correlation was modest, further research is required.

Despite the alliance ratings in this study being shown to vary over time, this analysis unfortunately did not assess client variables as predictors of the alliance at 15 months, only at three months, so it is not clear how such factors may influence the alliance longer term.

In addition, the measure developed to assess treatment factors was restricted to four variables. A more extensive or open-ended questionnaire may have identified other predictors, including worker characteristics. Despite these limitations, the methods used are relatively robust in comparison to the other studies thus far – especially in terms of seeking both parties' ratings of the alliance, assessing these over time, and using a wide range of predictors that pertain to client, treatment and client change.

3.4. Client and worker perspectives of limit setting

A particular area of focus within the case management alliance concerns "therapeutic limit setting" (TLS) – that is restrictions or pressure workers place on the client to encourage a change in behaviour or compliance with treatment (Neale & Rosenheck, 2000).

Neale and Rosenheck explored this within a US ACT service among 1564 veterans with diverse mental health difficulties, looking at the association between a range of limit setting behaviours and client and worker perceptions of the alliance.

The main limit setting behaviours employed by workers were verbal confrontations, such as highlighting consequences of destructive behaviours. The other main forms of limit setting in descending order of frequency were: money management (payeeship arrangements where workers help manage a client's benefit funds); contingent withholding (restricting access to resources); enforced hospitalisation, and invoking external authorities (such as probation officers). Workers were more likely to use limit setting with clients with greater difficulties (such as symptom severity, substance misuse, and longer hospitalisations).

Overall TLS was negatively associated with perceptions of the alliance, especially for workers. For clients, a negative association was found between money management and the alliance whereas workers showed the alliance to be negatively associated with all TLS except for money management. Furthermore the variable most negatively associated with the alliance for workers was contingency withdrawal. The authors do not offer possible explanations for these differences. It should also be noted that the correlational design does not make it possible to ascertain the direction of the association found – that is whether TLS results in a weaker alliance or visa versa.

Elsewhere, clients and workers have reported perceiving such "payeeship arrangements" to be positive and beneficial (in terms of improved housing, budgeting and substance misuse) and not to interfere with a positive alliance (Dixon, Turner, Krauss, Scott & McNary, 1999). This study focused on the impact of payeeship on the alliance using a structured questionnaire, completed during interviews with 54 worker-client pairs from a US ACT service for those experiencing homelessness and mental health difficulties. Workers in this study did however report verbal abuse from 44% of the clients in relation to their payeeship responsibilities. Discrepancies between client and worker perceptions were found in terms of whether the client agreed to the payeeship, whereby workers overestimated client agreement at the start.

Duration of the payeeship was associated with fewer difficulties and greater client satisfaction, suggesting a client's experience of such arrangements may become more positive over time. The association between a range of client characteristics and alliance were also explored, including gender, race or diagnosis. These were not seen to be associated with either party's perceptions of the alliance.

Unlike the sample in the study by Neale and Rosenheck, the sample used by Dixon and colleagues was small with no evidenced validity or reliability for the questionnaire used. Furthermore, neither study used control groups as a means of comparison. A further study which addressed this shortcoming was that carried out by Angell, Martinez, Mahoney and Corrigan, (2007) who similarly explored the impact of payeeship arrangements on the alliance, using a control group design.

This study compared the alliance between workers and clients who had "clinician payees" (case managers who also took on payeeship responsibilities) with two different control groups - those whose payeeship responsibilities were carried out by non-clinicians (such as family members) and those who did not have a payeeship arrangement in place.

A unique strength of this study is that the measure of the alliance used, namely the Working Relationship Scales (WRS) (Yamaguchi, 1999), was specifically developed for case management. It covers both the 'bond' and 'conflict' dimensions, with sound psychometric properties reported.

Their findings showed that when compared to the control groups, those with 'clinician payees' were more likely to have greater difficulties (comorbid diagnoses, poorer functioning, less insight, and less schooling). In addition they were more likely to perceive financial leverage (that resources would be withheld unless they complied with treatment). This was found especially for younger clients and those with more severe symptoms. Those with clinician payees also reported more conflict in the alliance, which was shown to be mediated by perceived financial leverage. Despite this, there was no significant difference in the bond element of the alliance, suggesting that even though they reported higher levels of conflict they formed just as strong emotional attachments to their workers.

It should be noted that financial leverage was not measured objectively; nevertheless the findings highlight that well-intentioned interventions, perceived to be coercive by the client, may create conflict in the alliance. Interestingly this appears not to necessarily interfere with the client's view of the emotional bond with the worker.

3.5. Qualitative studies

Quantitative approaches of assessing the alliance, which tend to use measures developed in the context of psychotherapy, have been criticised for not generalising to case management where the alliance has its own unique dynamics *(*Nath et al., 2012).

Furthermore they may not capture an in-depth understanding of the alliance, calling for more qualitative approaches (Buck & Alexander 2006). Unfortunately there is a paucity of such studies. Two of these have been excluded from this review for their poor quality because of the aforementioned misfit between research aims and data collection methods, in that interviews were not recorded (Buck & Alexander 2006; Nath et al., 2012). Three remaining studies will be discussed below.

3.5.1. Worker perspectives - Qualitative studies

Yamashita and colleagues (2005) sought to explore the processes of care that are involved in the alliance between nurse case managers across three different contexts in Canadian mental health services – inpatient, transition and community settings. Sixteen workers were interviewed using grounded theory methods.

A core category identified across these settings was negotiating care together in a trusting relationship. This involves eliciting the support required to meet the client's needs and goals based on an ongoing holistic understanding of the client. To this end, workers provide support directly as well as liaise with staff, community providers, and carers or family members.

In the inpatient setting, focus is placed on negotiations involving medical staff and bureaucracy. In transition units, focus is on securing resources in both settings. In community care, focus is on advocating for services from a range of agencies.

The methods in this study are well-described; however there is no acknowledgment of its limitations. In particular there is a lack of reflexivity, despite this being a vital element of grounded theory methods (Mruck & May, 2007)

In a more robust qualitative study of workers' views of the alliance, Sullivan and Floyd (2012) analysed 40 semi-structured interviews with case managers in the US, using ethnographic interviewing and thematic analysis, validated by two researchers coding data independently that informed subsequent data collection.

They noted key components to the alliance as well as challenges that make these difficult to implement in practice, highlighting the complexities involved in the alliance. The themes that arose were centred on traditional phases of the helping process, facilitated by the long-term nature of the alliance in case management, namely:

Engagement– overcoming barriers to trust, which are seen to stem from past personal and professional relationships frequently marked by trauma and mistrust (including high staff turnover).

Goal planning- facilitating client self-determination and hope towards recovery.

Pushing, pulling and letting go – providing guidance whilst allowing for client self-determinism and managing barriers that disrupt progression towards goals.

Moving forward – remaining goal-oriented despite setbacks, which requires workers managing their own feelings of discouragement.

Building on the relationship – remaining a consistent presence for the client and investing emotionally in the relationship alongside managing professional boundaries. Here

there is seen to be scope for greater flexibility than that of more traditional professional roles, in terms of less rigid working schedules, informal interactions and meeting in a range of contexts. This is seen as a challenge but also desirable by both parties.

The authors conclude that overcoming these difficulties, inherent in the worker's role, requires careful recruitment and supervision.

3.5.2. Client and worker perspectives ' Qualitative study

Repper, Ford, and Cooke (1994) sought to identify, describe, and understand case managers' relationships and interventions with clients using qualitative interviews with both parties. Participants were obtained from four case management services in the UK (16 workers discussing two clients each, one worker discussing one client, 13 of these clients, and three other clients recommended by workers). Thematic analysis yielded a coding framework that was subsequently further analysed, producing key interrelated principles and processes, similar to those reported by Sullivan and Floyd (2012). The principles identified were as follows:

Realism – expectations that working together will be a long-term process, progress is likely to be slow.

Long-term perspective - workers needing to be consistent and persistent.

Positive, empathic understanding of the client as well as *client-centred flexibility* - workers employing a wide range of skills and flexibility with times and locations to meet with clients.

The key processes identified were seen to reflect the following strategies:

A trusting relationship – requires addressing the challenge of clients historically disengaging from services.

Engagement - being dependable early in the relationship to meet clients' urgent and practical needs.

Assessment - ongoing assessment of a full range of client needs.

Communicating with clients - expressing understanding and being non-judgemental.

Use of various therapeutic and educational interventions, adapted to clients' individual needs (for example ADL, behavioural programmes, and counselling).

Monitoring - offering long-term support and monitoring clients' compliance with treatment.

To be able to deliver these, workers are seen to require support, including supervision and information-sharing among teams.

A major limitation of this study is the possible selection bias of the sample – 20 of the 33 clients discussed were not interviewed because their workers had advised they were too vulnerable or occupied with other research. The findings reported therefore may not capture more varied perspectives.

4. Theoretical papers

4.1. Power dynamics

The alliance needs to be understood within relevant social and political contexts, where power dynamics are at play throughout the system (Timms & Borrell, 2001). To this end, theoretical frameworks drawn from disciplines such as psychotherapy and social work help to elucidate our understanding of the alliance (Kondrat & Teater, 2012; Thurston, 2003).

The tension between facilitating client self-determinism and risk management, as highlighted in Ferrelley and Lester's (2013) review and empirical studies related to

"therapeutic limit setting" (Angell et al., 2007; Dixon et al., 1999; Neale & Rosenheck, 2000), is a longstanding challenge in case management (Gaitskell, 1998).

Timms and Borrell (2001) question whether assertive outreach, particularly among those who are homeless, who are known not to engage with statutory services, may be seen as unethical in pathologising their experiences and choices. They argue that case management is fraught with such ethical dilemmas, where providers hold important decision-making powers, such as access to housing, sharing of client information, and legislative powers to detain people. Lunt (2004) similarly questions the ethics of professionals overriding clients' judgment, even on the basis of managing risk of harm to the client, because such is seen to foster disempowerment and learned helplessness, which impedes recovery.

On the other hand, Gaitskell (1998) maintains that those working in case management are often disempowered themselves. Workers are said to be expected to assume a broad range of often conflicting responsibilities (such as advocacy, psychosocial support, and client empowerment), within a context of social and political agendas that prioritise risk management and efficiencies above therapeutic care. She advises that workers need clearer expectations regarding their job role, better training, and confidence to meet these expectations. Sabin (1993) similarly highlights the constraints that broader systemic factors place on the alliance, including limited availability of resources. He points out common conflicts that arise in case management (including conflicting views regarding the client's problem, treatment goals, methods and conditions), arguing that not only should workers negotiate these conflicts with clients in a collaborative alliance but may need to engage in political advocacy in challenging structures and practices within the health care systems to support the provision of care for clients.

Thurston (2003) also addresses systemic factors, criticising healthcare systems for embodying a culture of prioritising risk management over therapeutic treatment with inadequate training and supervision for staff. Drawing on psychodynamic theory, he proposes that the "management" side of case management is de-skilling for clinicians and untherapeutic for clients because it focuses on providing a list of social and health needs instead of addressing fundamental interpersonal forces underlying psychopathology. Clients are seen to project anger and fear from past personal and professional relationships into their current working alliances. This often includes traumatic or harmful attachment histories as well as inconsistent and 'uncontained' relationships with workers because of the high staff turnover in this field. This in turn may result in countertransference – workers' feelings of hate and rejection towards the client that had been projected into the worker.

It is argued that workers are particularly vulnerable towards such forces because they are required to fulfil often conflicting roles alongside additional demands of being non-judgmental and empathic, without being supported to recognise or address the destructive nature of these interpersonal dynamics.

Thurston proposes an alternative model that has been implemented within an Acute Day Hospital based on group-oriented treatment. The key practices that he advocates for are: care plans jointly developed by the client and multidisciplinary team; a high level of reflection and skilled supervision within staff teams; and training to go beyond basic counselling or interpersonal skills towards understanding the more destructive psychopathological dynamics commonplace in clients with severe mental difficulties.

Kondrat and Teater (2012) similarly argue for interpersonal dynamics to be reflected on in case management. They propose a conceptual model of the alliance, drawing on Cooley's (1967) concept of the *looking glass self* - that is reflexivity processes between client

and worker whereby the worker reflects on their own assumptions and views about the client and their recovery and then reflects to the client the possibility of recovery. This involves seeing the client with a multi-faceted identity, beyond their diagnosis, with numerous positive possibilities. This enables a client to alter their own views of themselves, away from diagnostic labels and associated self-stigma.

Again, this is said to require skilled supervision to enable workers to have an awareness of their own and clients' internal worlds and how these inform interpersonal processes in the alliance.

4.2. Strength-based approach

Greene et al. (2006) have proposed a strengths-based framework to be used with clients in case management services, drawn from solution-focused therapy (De Jong & Miller, 1995). This model aims to translate the core principles of recovery (such as hope, empowerment, and coping), into the everyday interactions between workers and clients. Here workers are advised to focus on their interpersonal communication with clients, using interviewing techniques that elicit client strengths and future-oriented goals (such as seeking to identify exceptions to problems and coping strategies).

They suggest guidelines be developed from this model, whilst also arguing that these should not be applied in a formulaic way, which will require training and supervision. This approach has yet to be empirically evaluated.

5. Critique and limitations

Before providing a summary and discussion of the findings reported in the papers in this review it is important to draw attention to numerous key limitations seen across these:

Firstly, samples in the quantitative studies reviewed were mostly small and homogenous, limiting the generalisability of the findings to different services and populations (Calsyn et al., 2006).

Secondly, perspectives of the alliance were mostly obtained by subjective measures, commonly the WAI (Calsyn et al., 2006; Draine & Solomon, 1996; Kondrat & Early, 2010; Neale & Rosenheck 2000) or adapted versions thereof (Calsyn et al., 2006; Hopkins & Ramsundar (2006) as well as measures developed by the authors, without established psychometric properties (Dixon et al., 1999; Klinkenberg 1998; Klinkenberg, 2002; Priebe & Guyters, 1993). Despite the WAI having well-established psychometric properties and extensive use across diverse settings, it arguably does not capture the complexities of the alliance within a case management context (Angell & Mahoney 2007; Calsyn et al., 2006). The use of alternative measures specifically developed in such a context can be seen as a relative strength – namely the Working Relationship Scales (WRS) (Yamaguchi, 1999) in Angell et al., (2007); and the Scale to Assess the Therapeutic Relationship in Community Mental Health Care (STAR) (McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007) used in Catty et al., (2012).

Thirdly, the paucity of qualitative research, particularly that which elucidates client views, restricts a fuller understanding of the interpersonal complexities that are vital in mental health treatment (Hewitt & Coffey, 2005) and falls short of the recovery movement's call for greater client involvement and perspectives in research used to inform clinical practice (Harding, Pettinari, Brown, Hayward, & Taylor, 2011).

A fourth key limitation is the lack of longitudinal studies because of the variance in the alliance that has been shown over time from both workers and clients (Calsyn et al., 2006; Kondrat & Early, 2010).

Finally, the theoretical papers only shed some understanding of the difficulties associated with the conflicting roles of the worker as well as power imbalances with social and political systems, which is reflected in the empirical studies of limit-setting in particular (Angell et al., 2007; Dixon et al. 1999;). There is an agreement that there is a need for better training and supervision; however such advice remains vague.

6. Discussion

The findings from the quantitative and qualitative research can be summarised according to client factors and case managements variables respectively.

6.1. Client factors

In terms of client factors, despite the numerous sociodemographic variables that have been assessed (commonly age, gender, ethnicity, and diagnoses), no clear, consistent predictors of a strong alliance have emerged.

Client factors that have received particular focus concern those related to social functioning. There is no strong evidence to suggest the number of client conflictual relationships is associated with strength of alliance (Calsyn et al., 2006; Klinkenberg et al., 1998; Klinkenberg et al., 2002). Rather, conflict in the alliance has more clearly been shown to be associated with the practice of limit setting (Dixon et al., 1999), as will be discussed.

Catty et al., (2012) found that clients' ratings of the alliance were not significantly associated with the extent of their social network or attachment style. This appears somewhat inconsistent with psychodynamic theory that would argue that one's personal relationships, including attachment histories, inevitably impact on one's therapeutic alliance with professionals through dynamic processes such as transference and

countertransference (Thurston, 2003). Perhaps this is demonstrated in the commonplace challenge of engagement among this population (Repper et al., 1994) and the hostility identified from both parties in the alliance, seen to be compounded by high staff turnover rates (Sullivan & Floyd, 2012).

Another focal area pertaining to client factors is client functioning. The level of difficulties in terms of clients' global functioning and clients' perception of their need for assistance have been shown to have a positive correlation with strength of alliance as rated by clients and case managers (Catty et al., 2012; Klinkenberg et al., 1998; Klinkenberg et al., 2002). This possibly highlights the importance of concrete assistance being provided to meet clients' practical needs, especially during the engagement phase of the alliance (Klinkenberg et al., 1998; Repper et al., 1994), discussed further below.

6.2. Case management factors

As has been highlighted in the research presented in this review, there are some key components of a positive alliance between clients and workers – in particular building mutual trust, respect, and shared decision making (Farrelly & Lester 2013; Repper et al., 1994; Sullivan & Floyd, 2012; Yamashita et al., 2005). The literature has also acknowledged that workers' clinical skills help build a positive alliance, with emphasis placed on adopting a client-centred approach in using a variety of interventions, applied in a flexible way (Greene et al, 2006; Repper, 1994).

The role of the worker extends well beyond therapeutic input with dominant focus placed on the provision of a full range of services to meet a client's social and health care needs (Hopkins & Ramsundar, 2006). In terms of case management variables, not only has the extent of service provision (such as number of services and contacts) been shown to positively influence the alliance, particularly during the early stages of treatment

(Klinkenberg et al., 1998; Klinkenberg et al., 2002), but this association may be bidirectional in that workers may provide more support to clients with whom they have a more positive alliance (Hopkins & Ramsundar, 2006). In addition, the value clients place on the level of assistance provided appears more meaningful during the early stages of treatment, diminishing over time (Klinkenberg et al., 1998).

The expected long-term nature of the alliance in case management does indeed highlight the relevance of timings in this context. In particular, workers are required to exercise persistence and adopt a long-term perspective, with realistic expectations regarding client rate of progress (Repper et al, 1994). This challenge is reflected in the high staff turnover rates, resulting in disappointments and inconsistency in client treatment, which reinforces the difficulties of clients building a positive alliance (Kondrat & Early 2010; Repper et al., 1994). This highlights the importance of systemic support in the form of training and supervision, commonly recommended in the literature (Repper et al., 1994; Thurston, 2003). Unfortunately, in reality systemic influences, such as lack of skilled supervision and competing demands, are often seen to create further pressure and challenges for workers in this field (Gaitskell, 1998; Thurston, 2003).

6.3. Challenges in case management ‘ clinical implications

There are indeed numerous challenges embedded in the role of the case manager that not only stem from the complexities of clients’ needs and difficulties with which they present, but also from the political and social contexts in which the alliance takes place (Farrelley & Lester, 2013; Gaitskell, 1998; Lunt, 2004). The main overarching challenges in these contexts are seen in role conflict for workers as well as tensions in managing risk alongside supporting client self-determinism (Farrelley & Lester, 2013; Timms & Borrell, 2001).

6.3.1. Role conflict

The broad remit of the worker's role appears to create conflicts and lack of clarity regarding where professional boundaries lie (Repper et al., 1994; Sullivan & Floyd, 2012). The more informal and flexible aspects of the worker's role (for example, social interactions and varied meeting times and places) are seen to be positive and rewarding for both clients and workers (Sullivan & Floyd, 2012); however this also presents ethical dilemmas that are an added tension for both parties to manage (Timms & Borrell, 2001).

The alliance therefore appears to be an ongoing negotiation between client and worker (Sabin, 1993; Sullivan & Floyd, 2012). Such negotiations tend to involve other stakeholders (such as providers, carers) and are context-specific, varying across in-patient and community settings (Yamashita, et al., 2005).

6.3.2. Client autonomy versus paternalism

Client choice, empowerment and self-determinism are fundamental elements to a positive alliance within case management services (Farrelly & Lester, 2013). However it has been frequently recognised that the role of the worker requires addressing this need alongside managing client risk and being accountable to political and social systems that inform healthcare services, often at the expense of client-centred therapeutic practice (Gaitskell, 1998; Thurston, 2003). This has been described as a tension between client autonomy and paternalism (Timms & Borrell, 2001).

Such tension comes to the fore in the practice of "limit setting", which has been shown to bring conflict into the alliance and be negatively associated with perception of the alliance, for both clients and workers (Neale &Rosenheck, 2000). However the findings reported by Dixon et al. (1999) and Angell et al. (2007) suggest that even where perceived coercion creates conflict in the alliance, this may not necessarily impact the 'bond' or overall

strength of the alliance. Furthermore, over time such limit setting practices may present with fewer difficulties as duration of such arrangements have been associated with greater client satisfaction (Dixon et al., 1999). Again this highlights the importance of adopting a long-term perspective and considering how best workers might be supported to provide the persistence and consistency required to build a positive working alliance over time (Repper et al., 1994).

To this end, the need for quality supervision and reflection for workers, within systems that are stretched for resources, is a common concern (Gaitskell., 1998; Repper et al., 1994; Sullivan & Floyd, 2012; Thurston, 2003).

6.3.3. Implications for clinical psychology

The challenges outlined above are particularly relevant for clinical psychology which can be seen to play an important role in addressing these challenges and tensions. In particular, the frequently highlighted need for skilled supervision for case managers (Gaitskell., 1998; Repper et al., 1994; Sullivan & Floyd, 2012; Thurston, 2003) arguably might best be provided by clinical psychologists because of their comprehensive and specialist training in biopsychosocial models of understanding behaviours, including complex interpersonal dynamics relevant to clients as well as staff teams (British Psychological Society [BPS], 2011; Kat, 2015). Furthermore, the BPS Clinical Psychology Leadership Development Framework outlines specific direct and non-direct clinical skills and responsibilities expected from clinical psychologists in multidisciplinary teams, which includes clinical, professional and strategic competencies (BPS, 2010). Key examples relevant to the complexities within case management highlighted in this review include direct clinical skills required in building an effective therapeutic alliance with clients

presenting with complex difficulties, as well as non-direct systemic input, such as consultancy, staff training and managerial responsibilities (BPS, 2010).

In terms of such systemic input, there is a growing expectation for clinical psychologists to take on leadership responsibilities in improving service development (Kat, 2015). This might also include playing an important role in addressing the need for further research in relation to case management services, discussed further below.

7. Research implications

Whilst the alliance has been explored in depth within psychotherapy, far less is known about this in the context of case management (Howgego et al., 2003). As has been discussed, studies which have been carried out in this area have numerous limitations, highlighting a need for more robust research.

With regards to the high degree of homogeneity in the samples used in the studies covered in this review, future research could include between-group designs, to compare the role of factors related to specific groups and services, such as presenting client difficulties, type of case management services, client-worker ratio, and specific interventions.

A further limitation that could be addressed pertains to the lack of alliance measures that have demonstrated sound psychometric properties outside the context of psychotherapy (Catty, Winfield, & Clement, 2007). The WAI (Horvath & Greenberg, 1989) has been identified as the most psychometrically sound measure in secondary mental health settings for those considered to have a SMI (Catty et al., 2007). However the measures that have been developed to capture the complexities present in the case management relationship appear promising – namely, the STAR (McGuire-Snieckus et al., 2007) used in Catty et al. (2012) and the WRS (Yamaguchi, 1999) used in Angell et al. (2007).

The former composes of three subscales - ‘positive collaboration’, ‘positive clinician input’, and ‘non-supportive clinician input’, whilst the later assesses both the ‘bond’ and ‘conflict’ elements of the alliance. Given the aforementioned tensions in the alliance centred on perceptions of limit setting and conflict in the worker’s role, such measures may further elucidate our understanding of relevant dimensions in the alliance in the case management context.

Whilst such improvements may contribute to more robust quantitative studies in this field, some would argue that the alliance does not lend itself well to being studied within a positivist framework because of the complex and dynamic processes involved and that in order to understand it in more depth, qualitative studies are required (Hewitt & Coffey, 2005). The need for such studies, particularly focused on client perspectives has indeed been highlighted as a priority (Harding et al., 2011; Nath et al., 2012).

Possible areas that could be the focus of future research include:

- How does the alliance change over time and what are the factors that may influence this change?
- Given the variability among the contexts of case management services covered and models used, what is the nature of the alliance in specific case management settings?
- What is the nature of the alliance in specific models or interventions within case management?

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MAJOR RESEARCH PROJECT

SECTION B

How do clients experience the alliance when working with the Mental Health Recovery Star in Rehabilitation Settings? A Grounded Theory

Word Count: 7,990 (243)

APRIL 2016

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Abstract

The Mental Health Recovery Star (MHRS) is a therapeutic tool and outcome measure, used widely in the UK and internationally for clients and keyworkers in mental health services to jointly assess and work towards client-centred recovery goals. As such it has been recognised as potentially offering a means of building a positive working alliance between clients and workers. The alliance is increasingly being highlighted as a key common factor across therapeutic models that may underpin positive clinical outcomes.

This study employed Grounded Theory Methods to explore the alliance within the context of using the MHRS in rehabilitation mental health services. Semi-structured interviews were carried out with ten clients and four workers across three services. The findings are presented in a theoretical model that explains the core category that emerged from this study – "being engaged in working together towards improved wellbeing". Working with the MHRS was seen to inform three particular alliance processes: collaborative working; negotiating new or shared perspectives; and motivation towards improved wellbeing. The findings also highlighted challenges that can hinder these processes when using the MHRS, calling for improvements in practices of negotiation and better support for workers. Further clinical implications alongside avenues for future research are discussed.

Keywords: Mental Health Recovery Star, alliance, working/helping alliance, therapeutic/helping relationship, rehabilitation mental health service

1. Introduction

1.1. The Mental Health Recovery Star

National policy stipulates a recovery-based approach to mental health services directed at providing person-centred care, characterised by collaborative working with professionals, service users and carers (eg: Department of Health [DoH], 2011).

The Mental health Recovery Star (MHRS) (Appendix 14) was developed as a keyworking tool, based on such recovery principles (Anderson, 2003) as well as anecdotal evidence and consultations with staff and clients, to be used both therapeutically and as an outcome measure (MacKeith & Burns, 2013). The theoretical underpinning of the MHRS reflects Prochaska and DiClemente's (1983) well-known transtheoretical model of change (Onifade, 2011), where clients are expected to progress through a series of stages directed towards making positive changes. There are five progressive stages outlined in the MHRS, namely 'stuck', 'accepting help', 'believing', 'learning', and 'self-reliance' (MacKeith & Burns, 2013). These represent the 'Ladder of Change' (Appendix 15), divided into ten descriptors which correspond with a rating scale from zero to ten across ten recovery-related outcome areas, such as 'relationships', 'work', 'trust and hope'.

The MHRS has grown in popularity internationally and in the UK, where the Department of Health endorsed its use across mental health services in England (HM Government, 2009). It was designed to facilitate collaborative engagement between clients and keyworkers in assessing and planning progress towards client-centred recovery goals (Onifade, 2011), and as such has been recognised as a potentially useful tool in aiding a positive working relationship between clients and workers (Tickle, Cheung, & Walker, 2013).

Whilst there have been studies that have looked at the MHRS's psychometric properties as an outcome measure, yielding some promising results (Dickens, Weleminsky,

Onifade, & Sugarman, 2012; Killaspy, White, Taylor, & King, 2012), no research has looked at how the MHRS might inform the alliance between a client and worker.

1.2. The Alliance

The evidence base for mental health treatment is increasingly pointing to common factors across therapeutic models rather than specific interventions, with a particular emphasis on the alliance between clients and providers (Anthony & Mizock, 2013; Thomas, Bracken, & Timmimi, 2011). There is a well-established evidence base associating the alliance with positive outcomes in psychotherapy, where the "therapeutic relationship" has its roots (Lambert & Barley, 2010; Martin, Garske, & Davis, 2000).

Over the years this relationship has been developed and researched across a range of clinical settings (Greenson, 1967; Rogers, 1961). A key milestone in this journey was Bordin's (1979) pantheoretical model of the "working alliance", which identified three key elements – shared goals, tasks, and bond. It is this conceptualisation of the alliance that has been widely researched in more recent times across a variety of mental health settings, including case management (Horvath & Greenberg, 1989; Kondrat, 2012; Stanhope & Solomon, 2008), where similarly a positive association between strength of alliance and clinical outcomes has been demonstrated (Chinman, Rosenbeck & Lam, 2000; Hicks, Deane & Crowe 2012; Priebe & Guyters, 1993; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Kondrat, 2012).

1.3. Case management

Case management, also referred to as 'key-working' and 'care coordination' (Ferrelley & Lester, 2014), is characterised by a mental health team or allocated staff member from diverse training backgrounds providing a full range of co-ordinated community-based social and health care services and interventions for clients with complex, severe, and persistent

difficulties (Angell & Mahoney, 2007). There are numerous case management models, which vary in terms of the types and level of direct input; however common features include a biopsychosocial approach in assessing, coordinating, and providing a full spectrum of health and social care services, including advocacy, housing, physical and mental health treatment, and emotional support (Angell & Mahoney, 2007; Mueser, Bond, Drake, & Resnick, 1998). The rehabilitation model is one such model, which is the setting focused on in this study, where an emphasis is placed on independent living or functioning skills, client-centred goals, and community integration (Mueser, et al., 1998).

1.4. The alliance in case management

Whilst there is a gathering evidence base associating the alliance with positive outcomes in case management services (Anthony & Mizock, 2013; Howgego et al., 2003), research in this field is relatively limited, particularly in terms of that focused on exploring the nature of the alliance between case managers and clients.

From the available evidence that has assessed the role of client sociodemographic factors in forming an alliance (commonly age, gender, ethnicity, and diagnoses), no consistent variables have emerged as predictors of strength of the alliance (Calsyn, Klinkenberg, Morse & Lemming, 2006; Draine & Solomon, 1996; Klinkenberg, Calsyn, & Morse, 1998; Klinkenberg, Calsyn, & Morse, 2002). However there is evidence that has shown the level of client difficulties, in terms of global functioning and perception of need for assistance, to be associated with strength of alliance as rated by clients and case managers (Catty et al., 2012; Klinkenberg et al., 1998; Klinkenberg et al., 2002). This echoes qualitative research of both parties' views of the alliance, which suggests that clients particularly value concrete assistance provided by case managers to meet their practical needs during the engagement phase of the alliance (Repper, Ford, & Cooke, 1994). However

the value clients place on such practical assistance may deteriorate over time (Klinkenberg et al., 1998).

Further studies in this field have focused on provider-related factors, where certain key components of a positive alliance have been identified – in particular building mutual trust, respect, and shared decision making (Farrelly & Lester 2013; Sullivan & Floyd, 2012; Yamashita, Forchuk, & Mound, 2005). The extent of service provision (such as number of services and contacts) has also been shown to positively influence the alliance (Hopkins & Ramsundar, 2006; Klinkenberg et al., 1998; Klinkenberg et al., 2002). However it has been argued that fundamental to the use of a wide range of interventions is a flexible and client-centred approach to meet clients' individual needs (Greene et al., 2006; Repper et al., 1994; Sullivan & Floyd, 2012).

Literature on this subject commonly highlights the varied demands of the role of the case manager (Farrelley & Lester, 2013). These include covering a broad range of often competing responsibilities, such as facilitating client empowerment alongside managing risk (Gaitskell, 1998; Thurston, 2003; Timms & Borrell, 2001). It is argued that in practice, the latter often takes precedence, which is disempowering for clients as well as workers in such services (Gaitskell, 1998; Lunt, 2004). Such conflicting demands in this role are a recognised precipitant to the high staff turnover rate in case management (Kondrat & Early 2010; Repper et al., 1994). This is seen to perpetuate difficulties clients may have with building positive alliances with workers because of past personal and professional relationships characterised by abuse, abandonment, trauma, and mistrust (Kondrat & Early 2010; Repper et al., 1994, Thurston, 2003; Watts & Priebe, 2002). Therefore power differentials in the alliance, where workers adopt a paternalistic approach over client autonomy, may be especially damaging to the alliance (Watts & Priebe, 2002). This may be a particular

dilemma among clients with complex and severe difficulties, such as those in rehabilitation settings, requiring high levels of input in relation to a wide range of needs and areas of functioning (Tobitt, Jenkins, & Kalidindi, 2015; Watts & Priebe, 2002).

2. Rationale and aims

As discussed, the MHRS has been identified as a tool that may help build a positive alliance because of its collaborative approach, rooted in recovery principles (Tickle et al., 2013). It has been employed in a variety of settings but was designed as a keyworking tool to help clients work towards a full range of recovery goals covering numerous life areas (Mackeith & Burns, 2013) and is popularly used in rehabilitation services (Meaden & Kalidindi, 2015).

Whilst the evidence base is increasingly highlighting the alliance as a fundamental element across therapeutic interventions in recovery (Anthony & Mizock, 2013), that which has explored the nature of the alliance in case management is relatively limited, particularly in terms of qualitative studies of client perspectives (Nath, Alexander, & Solomon 2012).

The MHRS is designed to implement recovery principles in joint working between workers and clients; however how clients describe their experiences of the interpersonal work with their keyworkers within the context of using the MHRS has not yet been explored. The aim of this study is to address this gap.

In order to address this aim, the specific research questions outlined were as follows:

1. What are the experiences of a sample of clients using the MHRS with a worker in rehabilitation mental health services?
2. How do these clients describe their relationship with a worker within the context of using the MHRS?

3. What specifically are the things about the alliance with a worker within the context of using the MHRS that clients perceive as more or less facilitative of their recovery?

3. Methods

3.1. Design

Evidence-Based Practice (EBP) tends to be rooted in epistemological frameworks that favour positivist approaches; however it has been argued that these do not lend themselves well to researching the alliance due to its abstract and subjective nature (Hewitt & Coffey, 2005; Stanhope & Solomon, 2008). Furthermore there is a call for more qualitative approaches to capture the unique interpersonal dynamics between workers and clients within case management (Nath et al., 2012).

The chosen method considered appropriate to investigate this subject in this study was Grounded Theory Methods (GTM) because it allows for an exploration of phenomena where there has been an absence of established theory (Strauss & Corbin, 1990) and also enables the development of a deeper understanding of psychological processes (Henwood & Pidgeon, 2003).

The epistemological framework of this approach reflects a critical realist position – that is a post-positivist perspective that maintains phenomena exist objectively and can be discovered through empirical methods of enquiry; however the full extent of their objective truth remains obscure as all phenomena are interpreted through subjective lenses of those observing the data (Gorski, 2013). Nevertheless possible bias arising from such subjectivity can be minimised through a reflexive approach of critical reflection of one's own perspective, the data, and comparisons with other's perspectives (Ahern, 1999; Mruck & Mey, 2007; Urquart, 2013).

3.2. Participants

The inclusion criteria for client participants were that they should be adults from rehabilitation mental health services who have used the MHRS with a worker, formally trained in using the MHRS, for at least 6 months. This was to allow for a reasonable timeframe for an alliance to have been formed. The rehabilitation setting was chosen to narrow the focus of the study and because of key distinct features, which may influence the alliance – namely the high level of contact workers have with clients directed towards assisting with a full range of functioning skills and community integration (Angell & Mahoney, 2007; Tobitt et al., 2015). However variation among such services was sought to enable the exploration of the emerging conceptual categories within different conditions (Wiener, 2007).

Participants were obtained using theoretical sampling, which is a fundamental strategy of GTM that involves an iterative process of using the developing data analysis to guide subsequent data collection and analysis to build the theory (Morse, 2007). To this end, five interviews with clients from a third sector rehabilitation service were initially carried out. The emerging data analysis steered the sampling towards obtaining perspectives of clients from a National Health Service (NHS) semi-supported living rehabilitation service and workers who were using the MHRS with clients in both rehabilitation settings. Perspectives were also sought from clients and a worker within an NHS inpatient rehabilitation unit. In total ten clients and four workers were interviewed (details provided below). Further explanation for inclusion of worker's perspectives is provided under data analysis below.

Table 1: Description of sample of clients
(names have been changed to protect confidentiality.*= client description of their diagnosis)

Participant - client	Diagnosis/ presenting difficulty	Gender	Ethnicity	Age	Setting/service	Time in services	Gender of worker	Age of worker	Ethnicity of worker	Length of relationship with worker	Length of time using MHRS	Frequency of use of MHRS
Simon	Psychosis (*Paranoid Schizophrenia)	Male	White British	46	Rehabilitation supported living (third sector)	20-30 years	Male	50-60	White Irish	8 years	3-4 years	6 months
Eileen	*Personality disorder & Mood Disorder	Female	White British	24	Rehabilitation supported living (third sector)	1-5 years	female	30-40	Albanian	8 months	4 years	3-6 months
Clive	Psychosis	Male	White British	58	Rehabilitation supported living (third sector)	30+ years	Male	50-61	White British	3 years	3 years	3-6 months
Peter	Mood Disorder	Male	White British	56	Rehabilitation supported living (third sector)	30+ years	Male	50-60	White British	6 months	2-3 years	2 months
Albert	Psychosis (*Paranoid Schizophrenia)	Male	White British	36	Rehabilitation supported living (third sector)	10-15 years	Female	40-50	African	3 years	3 years	6 months
Will	Psychosis (*Schizophrenia)	Male	White Irish	51	Rehabilitation semi-supported living (NHS)	30+ years	Female	30-40	White British	3 years	6-7 years	6 months
Keith	Psychosis (*Schizophrenia)	Male	White British	53	Rehabilitation semi-supported living (NHS)	30+ years	Female	30-41	White British	1.5 years	3 years	3 -6 months
Stuart	Mood disorder	Male	White British	54	Rehabilitation semi-supported living (NHS)	30+ years	Male	40-50	Black British	1 year	1 year	6 months
Jake	Psychosis (*Paranoid Schizophrenia)	Male	Black British	42	Inpatient rehabilitation setting (NHS)	15 years	Male	30-40	African	1 year	1 year	2 weeks (in the recovery group) & 3-6 months (as an outcome measure)
Rob	Psychosis (*Schizophrenia)	Male	White British	59	Inpatient rehabilitation setting (NHS)		Female	30-40	White British	1 year	1 year	2 weeks (in the recovery group) & 3-6 months (as an outcome measure)

Table 2: Description of sample of workers
(names have been changed to protect confidentiality)

Participant - worker	Gender	Ethnicity	Age	Setting /Service	Length of experience using MHRS	Years of experience	Profession	Education
Jennifer	female	White British	35	Inpatient rehabilitation setting (NHS)	4 years	8 years	Psychologist	Doctorate in Clinical Psychology
Sarah	female	White British	28	Supported living (third sector)	4 years	5 years	Key worker & Service Manager	Masters degree in Forensic Psychology
Miriam	female	Black African	62	Supported living (third sector)	3 years	18 years	Key worker	Secondary school
Olive	female	Black African	45	Supported living (third sector)	3 years	15 years	Key worker	Secondary school

3.3. Procedure

This research project was selected and developed from a range of projects presented to Canterbuy Christ Church University by numerous stakeholders, one of whom was one of the developers of the MHRS, Joy MacKeith from Triangle Consulting Social Enterprise, who fulfilled the role of external supervisor for this project. Ms MacKeith's vested interest in the MHRS was not seen to bias this study as she has had minimal input regarding the progression of the research, rather this was overseen by the internal supervisor, Dr Sue Holttum. Furthermore reflexive practice was used throughout with the use of a reflective journal and regular supervision with the internal supervisor (Ahern, 1999; Urquart, 2013).

The project was granted ethical approval through the NHS Integrated Research Application System (IRAS) (Appendices 5 & 7) as well as Local Research and Development (R&D) approval for three approved research sites in outer London regions (Appendices 6 & 8).

Staff teams were approached and asked to invite clients who met the inclusion criteria to participate in the study. Clients who expressed an interest were given an information sheet and consent form, explaining the research, process, and ethical considerations regarding the use of data gathered, confidentiality, and anonymity (Appendices 9, 10 & 11). Before any interviews were carried out, signed consent was obtained from each participant.

3.4. Data collection and analysis

The interview schedule developed for clients (Appendix 12) included semi-structured, open-ended questions to allow for in-depth, unanticipated insights (Willig, 2008).

The interview schedule for both client and worker participants consisted of open-ended questions and prompts covering the following areas: client experiences of using the MHRS; experiences of how MHRS scores are decided; experiences of the relationship between a worker and client when using the MHRS and how this differs when not using the MHRS; how the relationship is seen to affect working with the MHRS; perceptions of how this relationship affects the client's recovery, if at all; and any other key areas participants felt were important to highlight with regards to their experience of the alliance when working with the MHRS.

In order to ensure robustness of the data collection, the interview schedule was piloted (Barker, Pistrang, & Elliott, 2002), firstly with a colleague and then with the first client who was interviewed. No significant amendments were recommended; therefore the data obtained in this interview was included in the data analysis. Interviews were audio-recorded and transcribed verbatim. On average interviews lasted around 35 minutes (the shortest was 15 minutes and longest an hour and 20 minutes).

The first two interviews were analysed using line-by-line open coding (Strauss & Corbin, 1990) Further detailed coding was carried out for subsequent interviews, using axial coding

and focused coding (examples from four transcripts have been provided in Appendix 17).. The former is a theorising analytical process where codes are linked on a conceptual level and differentiated according to specific contextual conditions, which aids the development of subcategories and categories in the formation of the theoretical model (Kelle, 2007; Strauss & Corbin, 1990). The latter involves selecting codes that are seen to underpin the key emerging categories from the data (Charmaz, 2006). Constant comparison was used throughout in order to guard against missing any new emerging codes at a lower level of abstraction. This method was used to develop, distinguish, and refine emerging subcategories, categories and their theoretical links (Wiener, 2007).

Memos were used throughout to expand and clarify descriptors of codes, links between these, and the emerging theory (Strauss & Corbin, 1990) (examples provided in Appendix 18).

After the initial five interviews were completed with clients, it was decided that a sample of workers should be sought to obtain their perspectives of processes that clients had been describing, in particular investigating 'negative cases' - exceptions or contradictions to what the data had revealed thus far (Strauss & Corbin, 1990). Examples include a client reporting they could not remember using the MHRS or not understanding the rationale behind the use of the tool.

Further theoretical sampling was carried out in diverse settings (semi-supported living and inpatient units) to explore how such varied contexts and use of the MHRS might inform client experiences (Wiener, 2007).

With GTM, data collection continues until categories reach saturation, whereby no new properties or dimensions emerge (Strauss & Corbin, 1990). However it has been argued that complete saturation is unrealistic due to the possibility of infinite properties to a

particular construct (Dey, 2007). Therefore, categories were considered to have reached sufficient density to inform a coherent theory once no new conceptual codes emerged from the data (Dey, 2007).

3.5. Ethics and quality assurance

Prior to commencing the study, a consultation was held with members of two service user groups who reviewed the research proposal and raised no concerns regarding the aims and procedures outlined.

As mentioned, national and local ethical approval was obtained and best practice guidelines were followed throughout, including ensuring formal voluntary consent, anonymity and confidentiality, and safe record keeping (British Psychological Society [BPS], 2009).

Various quality assurance measures were implemented to build the rigour of the study. These included the following:

Reflexivity was used throughout this project (Ahern, 1999; Mays & Pope, 2000). This was evidenced by the use of regular supervision, which allowed for ongoing reflection throughout each stage of the research - study design, data collection, analysis and interpretation. Furthermore, a self-reflective journal was kept as a means of bracketing assumptions, thoughts and ideas in order to identify potential bias and assumptions that could interfere with the integrity of the data analysis (Ahern, 1999) (extracts provided in Appendix 18).

Numerous strategies were used to try to ensure the validation of the findings: As discussed the interview schedule was piloted before its continued use with other participants (Barker et al., 2002). The supervisor coded segments of the transcripts independently, which confirmed the credibility of emerging codes and categories (Urquart,

2013). Furthermore, respondent validation was obtained from two staff members and two clients, who reviewed a summary of the theoretical model developed and provided feedback that confirmed the analysis was consistent with their perspective and that no significant amendments were required. An audit trail of data analysis was also kept to ensure the integrity of the research (Mays & Pope, 2000).

4. Results

4.1. Overview of results

The final analysis identified 37 focused codes, nine sub-categories, four categories, and one core category (presented in Appendix 19 & 20, with examples of quotes from participants).

An overview of these is depicted in the model of the Grounded Theory below, along with a summary table of the key categories that emerged in this study.

Figure 1: Theoretical model conceptualising the Grounded Theory

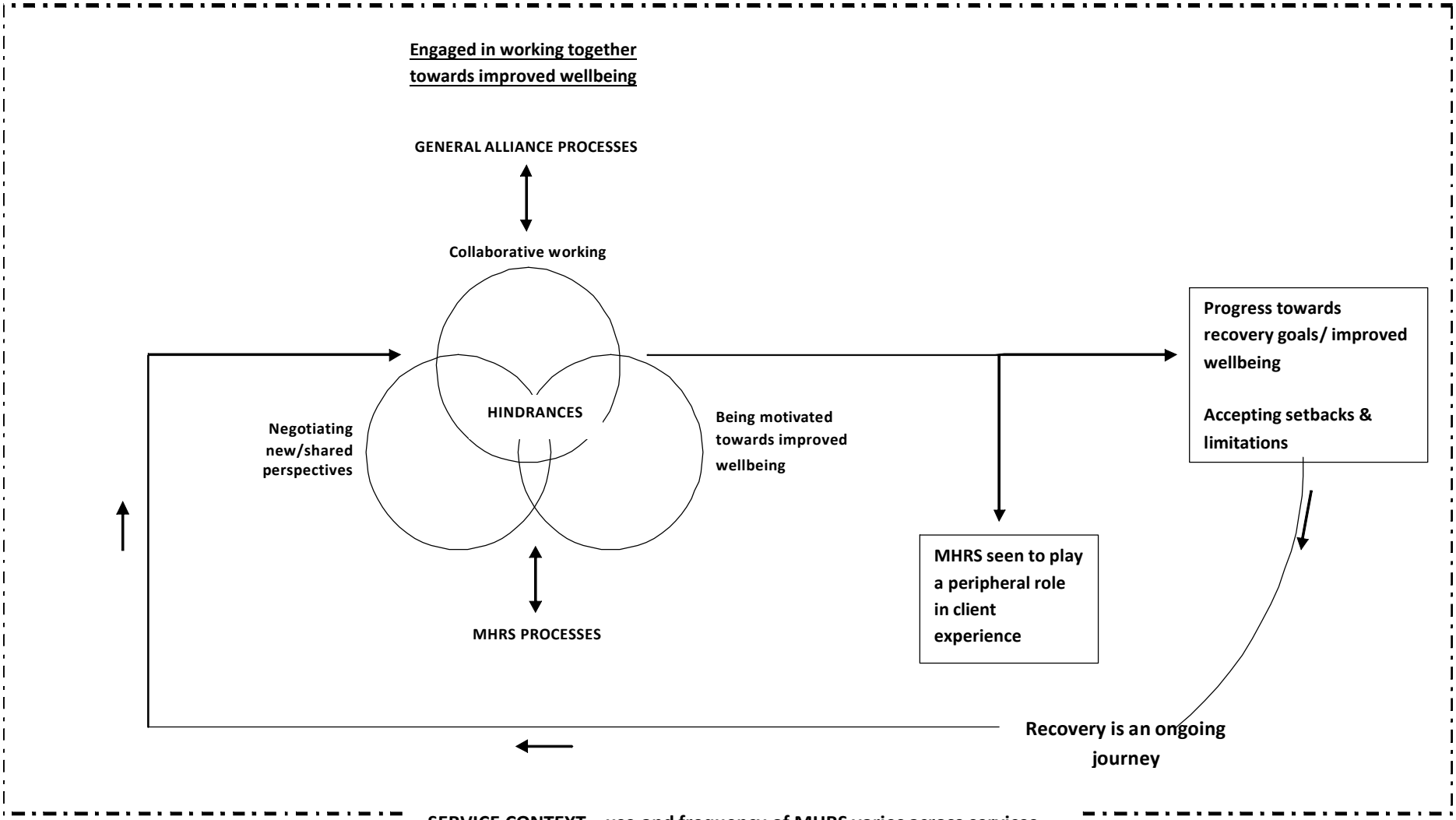

Table 3: Further detailed explanation of theoretical model with subcategories and codes

Engaged in working together towards improved wellbeing (seen in General Alliance Processes and MHRS Processes) <stands in contrast to>	
Collaborative working: Both client and worker participate in working towards agreed needs or goals; client demonstrates an active role (exercises agency, decision making)	**Hindrances to collaborative working** – Client has a 'passive compliant' role (lack of involvement or interest without worker's input); or 'oppositional' role (being opposed to/disengaged from worker; perceives unwanted pressure).
Negotiating new/shared perspectives: Having a holistic view of the client; facilitating change in client perspective of self	**Hindrances to negotiating new/shared perspectives** - Fixed conflicting perspectives between client and worker; Client's thought processes reflect mental health difficulties
Motivation towards improved wellbeing /recovery goals: acknowledging and identifying difficulties/needs and recovery goals to work towards; Accepting limitations and setbacks as part of the ongoing journey of recovery	**Hindrances to motivation**– Worker and client feeling discouraged/ frustrated with lack of progress

⇕ ⇕

Distinct features of General Alliance Processes or MHRS Processes that interconnect with being engaged in working together <distinct from>	
General Alliance Processes	**MHRS Processes**
• Worker providing wide range of practical, emotional and social support; • Perceived likeability of worker helps client connect; • Worker seen as trustworthy (non-judgmental, consistent, knowledgeable/experienced); • Knowing the worker as a person beyond their job role	• MHRS facilitates a helpful perspective, helps client to focus • MHRS helps client and worker negotiate scores and recovery goals • MHRS helps client notice progress, brings hope and motivation for client and worker • MHRS has a positive indirect influence on progress towards recovery goals/improved wellbeing • Working with MHRS is seen as positive (interesting, emotionally rewarding)

Distinct features of General Alliance Processes & MHRS Processes that that interconnect with hindrances <distinct from>	
General Alliance Processes	**MHRS Processes**
• Client has 'oppositional' position to worker if perceives unwanted pressure • Worker may feel discouraged or frustrated with client difficulties or setbacks	• MHRS can be seen as burdensome (difficult and taxing) • MHRS seen as restrictive (formal or inflexible) • MHRS seen to play a peripheral role in client experience • Lack of progress on MHRS may be discouraging / frustrating for client and worker

4.2. Explanation of the model

The core category seen in this model is "being engaged in working together towards improved wellbeing". This is made up of important processes pertaining to both the alliance in general (irrespective of the use of the MHRS) and the MHRS. These would be considered intervening conditions which informed the relevant interpersonal interactions and consequences thereof that emerged in this theory (Strauss & Corbin, 1990), as depicted in the model diagram. Here there were key areas of overlap, illustrated as interrelated processes in the model, which was the focus of this study. The ways in which key features that pertain distinctly to the MHRS or to the general alliance seemed to influence these processes will be discussed.

GTM situate the emerging theoretical concepts within the contexts in which they occur (Gibson, 2007). To this end, the service contexts in which these processes took place will first be addressed.

4.3. Service context

Whilst all services involved in this study routinely use the MHRS as a therapeutic tool and outcome measure, the frequency and way of using the MHRS varies. For all participants across services, their keyworker was involved in completing the MHRS. Those in the third sector supported living and NHS semi-supported living settings tended to complete the MHRS every three to six months, some over a few days, others in a single session. For the third sector service, two versions of the MHRS were commonly used - one completed with the client and worker together and another by the multidisciplinary staff team, which would take precedence in informing care plans and measuring service outcomes.

Similarly those in the in-patient unit had two versions – one used biweekly in a group therapy setting, covering one ladder of the MHRS per session, and another kept on file as an

outcome measure. The latter included input from the client, keyworker, and other members of the multidisciplinary team.

Distinctions in client experiences of using the MHRS with a worker were more apparent within service contexts than between contexts. These pertained to key interpersonal processes, which are discussed below.

4.4. Being engaged in working together towards improved wellbeing

The core theme of 'being engaged in working together towards improved wellbeing' is seen to be made up of the following three interrelated processes, identified as the main categories in this study: collaborative working; negotiating new or shared perspectives; and being motivated towards improved wellbeing. Each of these will be looked at below, alongside quotes from participants, demonstrating the properties and dimensions of the concepts that emerged in this study.

4.4.1. Collaborative working in the alliance in general and with the MHRS

The process of collaborative working involves both the client and worker participating in working towards agreed needs or goals. The clients interviewed and spoken about in this study were seen to rely on workers for a broad range of support (practical, emotional, and social), including assistance with the MHRS, because of the severity of their difficulties. This appears consistent with the high degree of input provided in rehabilitation settings (Tobitt et al., 2015).

Where clients appeared receptive of this support, this was seen to demonstrate collaborative working because there was evidence of input and participation from both parties towards an agreed goal or need.

> *She [worker] helps me with anything I need doing* (Eileen)

he [worker]'s there, you know, just to help me, to sort of coach me, but not coaching me in the sense of giving me answers to write down [on the MHRS] (Peter)

There are important factors present in the general alliance, apart from using the MHRS that seem to aid this process of collaborative working. From the client this includes demonstrating an active position in exercising agency or decision making.

They [workers] don't sort of direct me to go here or there… they allow me to just be myself and articulate what I want (Peter)

I am tackling my false beliefs and tackling my vulnerability….With the keywork sessions, I'm more consciously trying to change the way I live (Simon)

From the worker this includes their perceived likeability, trustworthiness, and provision of emotional and social support. Clients described particularly valuing the informal, social interactions with their worker that involve meeting in a range of social environments and knowing the worker as a person beyond their job role.

She's good company… I like being with her… I like to get out, I get to go out with her [worker], just go for a walk in the country… we go to the cinema on Tuesdays (Rob)

So you know rather than highlighting what we don't share, it's about what, well you know, we've got this in common, I like this, you like that, I know about this, you know about that (Sarah - worker)

These informal processes seem to help build a stronger alliance, which in turn was seen to help facilitate work with the MHRS.

> *If you have a bit more of a friendship with that person, it makes it [the MHRS] a sort of nicer thing to do, a bit more meaningful. … [without the worker there] maybe I wouldn't think about it [MHRS] so much...I'd probably rush it off or something like that* (Albert)

There were also processes that were seen to hinder collaborative working. This includes the worker appearing dominant with minimal involvement or participation of the client. Within the context of using the MHRS this was particularly evident when the tool was completed as an outcome measure by the multidisciplinary team at the exclusion of or minimisation of client involvement. Where clients did not oppose worker's input, this was seen to capture a 'passive compliant' position:

> *we did the questions (on MHRS), ticks them off and says well this is you, sort of thing. That's explained to me but the actual reason for it [MHRS], is not explained to me* (Clive)

One of the key factors that seemed to underpin the lack of client involvement in this position was the level of client difficulties, where those with greater difficulties were seen to require more staff involvement.

the clients that we're working with have quite a lot of cognitive difficulties for different reasons so some of the concepts I think are quite hard to grasp on the Star particularly with these clients so we had to really unpack them (Jennifer - worker)

Other clients expressed a more oppositional position in relation to workers' input in general and with the MHRS, particularly when they perceived unwanted pressure in relation to doing something.

if I felt there was like the pressure around, I wouldn't be so into it [MHRS] (Albert)

I don't decide on the [MHRS] scores..my care coordinator [does]… it's harder for you to input it than I thought it would be … (Jake)

some of our clients either don't want to do it [MHRS] or the way they've scored themselves is not perhaps realistic to where they are so what we do as a staff group is sit down and do one together (Sarah - worker)

The lack of client participation in this oppositional position appears largely underpinned by clients and workers holding fixed contrasting perspectives, discussed further below.

4.4.2. Negotiating new or shared perspectives

Clients and workers in this study demonstrated having contrasting perspectives, including views of reality as well as needs and goals. These included clients' thought processes seen to reflect mental health difficulties or lack of insight into their needs. This was presented as a challenge for both parties in their work with the MHRS.

I mean we have a lot of service users who are very unwell, there's not a huge amount of insight... I was watching someone here do one [MHRS] on Monday night and the client ranked himself 10 for everything. And actually they're probably not, they're probably three or four for everything. So I find it [MHRS] can make the relationship quite difficult actually (Sarah - worker)

some of our service users don't think they have mental health problems, they're not in any way interested in using a tool that's about mental health (Sarah - worker)

you have to take [worker's views] on board and even if they are not on the same page as you, you have to accommodate what their thoughts are … there's some issues that you don't want to discuss, or if you discuss it people think you're strange (Jake)

As can be seen in the examples above, where contrasting perspectives remain fixed, this is seen to hinder the process of openness and negotiating a shared perspective. In contrast, being able to negotiate new or shared perspectives appears to help the client and worker work together towards improved wellbeing. There were three key areas within the context of using the MHRS that seem helpful here. Firstly, the MHRS was seen to facilitate a holistic perspective of the client.

in using the Star it makes it easier for them to think more holistically about a client ...seeing the kind of varied ways that clients are thought about and the different needs they have (Jennifer - worker)

Secondly, the MHRS was shown to help clients focus their thoughts.

MHRS gives me focus (Simon)

[MHRS] took my mind off the illness (Stuart)

[MHRS] focuses your thoughts, you know, in certain areas of your life (Peter)

Thirdly, participants spoke of how working with the MHRS with their worker challenged their views of themselves and their recovery.

Sometimes you can be hard on yourself and a worker can say, "Oh, how would you explain that [rating on the MHRS] because you seem …like you're recovering well". Whereas you can't really do that yourself, you're overly critical and overly subjective, whereas somebody else with an objective view can just guide you, you know, just to another way of looking at things…"Have you considered this…or have you considered that?" And I think only somebody that knows you can really ask that (Peter)

4.4.3. Motivation towards improved wellbeing

Clients and workers spoke of their work together as being directed towards addressing clients' wellbeing and recovery goals. This reflects a process of acknowledging difficulties, a

need for change, and working towards this, which was captured by the category, 'being motivated towards improved wellbeing'.

The structure of the MHRS, with its ten 'Ladders of Change' and use as an outcome measure in assessing these areas on a regular basis, seems to help facilitate this process.

> *[MHRS] focuses on the issues that you face. … like a MOT done on your brain…Like now I don't have any responsibilities but yeah, there's still anxiety and stuff* (Jake)

> *well it's [MHRS] helped me to identify where I am and where I need to improve on in my life… helps me keep things on track* (Eileen)

> *we do three or four goals… I make them my recovery goals for the review in the next time*…(Simon)

Important sources of motivation identified were workers' encouragement and recording clients' progress, which brings hope and motivation. This was particularly aided by the MHRS's design of capturing improvements across a broad range of areas.

> *Because I've written it all down [on MHRS], you know, I was able to sort of see, "Well, I'm not so depressed now … when I come to review it with my keyworker I find that today I'm in a better place, a better mood*" (Peter)

> *it's helpful to see how you've improved over the months* (Albert)

> *It makes me feel happy, just to think I'm getting along a bit better in myself* (Keith)

Other clients spoke of the MHRS as having more of an indirect influence on their improved wellbeing without them necessarily explicitly working on goals. This includes finding the MHRS rewarding in itself.

> *I believe that's part of the empowerment of the Recovery Star that it is that heavy. Means it's doing something real to my subconscious. Somehow it's all going to happen… I really just let that, let the goals just settle into my subconscious and just hope that those goals integrate into my development. I don't feel the need to revise the goals every week or whatever* (Simon)

> *it just makes me sort of happy. I enjoy, you know, sitting down and reading it to each other* (Keith)

A significant part of maintaining motivation seen in the alliance in general and with the MHRS appears to be accepting recovery as an ongoing journey with setbacks and limitations, particularly important where a client's motivation and wellbeing seems to fluctuate.

> *Well one of the things I like about the Recovery Star, is it's about a journey, not a destination*… (Peter)

> *I just feel better some times. Other times I won't* (Keith)

> *…it was a continuing model of today's good, tomorrow's bad, today's good, tomorrow's bad* (Jake)

it is like a wave of up and down, up and down, up and down because with mental health you're with people who are not motivated. They feel very well, they are doing something today, tomorrow they don't want to face it (Olive - worker)

Facing such setbacks can be discouraging for clients and workers, which may be highlighted with the use of the MHRS if no progress is noted:

people might think, "Oh, I only got one star in all of these things" so it might not help to think that … if it's making you feel worried that you're not getting anywhere and there's all this pressure around then just leave it (Albert)

I think it's why it's so stressful trying to work with someone when we feel we can see something really positive that can change but they're perhaps not choosing to engage and I think that's where a lot of the kind of difficulties come in our work sometimes (Jennifer - worker)

Further limitations of the MHRS, identified by both clients and workers, that appear to hinder motivation, include it being perceived as restrictive, as well as burdensome, difficult or taxing.

I don't like the way it's written for each of the scores from one to ten because … I sometimes believe my response is in a different way to what the question is saying, to what the statement is saying about that score (Simon)

Some of the wording I would change, you know for, for some people who are less intelligent (Peter)

I have never known of anybody who has managed to do a whole Star in one session with clients because I think it's just too much. So then it can become a bit difficult because you can kind of end up taking 6 months to do it and by the time you're finished it you've got to start again (Sarah - worker)

In addition, for some clients, the MHRS appeared to play a peripheral or minimal role in their experience:

I don't mind doing it but I don't think it adds much (Albert)

This was particularly apparent with three clients from the semi-supported living service, who reported not being able to remember much about using the MHRS, despite their workers confirming they used it with their clients. Whilst hardcopy reminders and prompts during the interview elicited some recollection of their experiences, overall the personal significance of their work with the MHRS appeared minimal .

I can't remember using it.. we were ticking things up, average, poor, bad, alright. I was ticking them which ones. I remember that, yeah" (Will)

Clients' cognitive difficulties were seen to be a key influence here; however service factors were also identified as playing an important role – in particular restrictions with the use of the MHRS that fail to adapt to the needs of this client group.

I think for some clients it can be helpful to say, well let's break it [MHRS] down, …let's have pictures instead of the points on the Star. Let's change the name of

some of the areas on the Star to make them a bit more understandable…being able to use it flexibly would be helpful… We used to have free access to the LD Star [version of the Star designed for people with Learning Disabilities] and the other Stars and I know you can't do that now without training and I can understand that but I think actually it would be really helpful to use the Star that is most applicable to that client" (Jennifer – worker)

This worker points out the need for flexibility to address the difficulties presented by clients, whilst also highlighting broader service constraints related to the use of the MHRS that restrict this.

5. Discussion

5.1. Discussion of the theoretical model

This study has highlighted key processes involved in the alliance in general and also when working with the MHRS specifically. Three areas in which these overlap are working collaboratively; developing new and shared perspectives; and being motivated towards improved wellbeing in the ongoing journey of recovery, which overall are captured by 'being engaged in working together towards improved wellbeing'.

The results suggest there are pivotal ways in which the MHRS appears to facilitate or enhance these processes. This includes the tool's design and structure, which allows clients to focus their thoughts and for clients and workers to address a particular area of need as well as to consider new perspectives of a full range of areas pertaining to a client's life. This involves identifying and being motivated in making progress towards recovery goals.

In terms of validly assessing a client's needs, it has been noted that keyworkers are well-placed to do so because of the closeness and comprehensive nature of their alliance with clients (Macpherson, Varah, Summerfield, Foy, & Slade, 2003). Participants in this study

similarly reported that having a good relationship with their workers helped with completing the MHRS and made it more meaningful.

The importance of workers adopting a holistic perspective of clients, that goes beyond their diagnostic labels in acknowledging their 'personhood', is frequently highlighted across mental health settings (Borg & Kristiansen, 2004). This is seen to require workers to reflect on their own shared personhood, which similarly goes beyond their professional labels to acknowledging their own potential for vulnerability (Hamilton Wilson, 2009).

Kondrat and Teater (2012) similarly call for greater reflective practice for workers in mental health services. They argue that workers can help clients internalise alternative dimensions of their identity that align more with their recovery goals by reflecting such an identity back to the client in their interpersonal interactions. This requires workers to reflect and challenge their own perceptions of the client. The MHRS, with its broad range of recovery areas possibly offers a means for workers to do so, as was seen in the comments by Jennifer (worker):

> *in using the Star it makes it easier for them to think more holistically about a client ...seeing the kind of varied ways that clients are thought about and the different needs they have* (Jennifer - worker)

The MHRS's focus on measuring a clients' progress according to a goal they are working towards was seen to facilitate motivation and hope for both workers and clients. Setting goals has been recognised as a principle evidence-based process in promoting mental health outcomes in clinical research (Anthony & Mizock, 2013; Greene et al., 2006). The related concept of nurturing hope is not only a core principle within the recovery movement (Craig & Killaspy, 2015), but bringing hopefulness into the relationship has been

shown to possibly be more important in improving client wellbeing and the quality of the alliance than implementing specific strategies (Houghton, 2007).

Whilst there were examples of clients and workers feeling discouraged when there appeared to be a lack of progress on the MHRS, overall it appears that when working on the MHRS with a client, workers tend to highlight evidence that demonstrates a client's progress and achievements and this seems motivating for both parties.

Furthermore, accepting setbacks and limitations as part of the ongoing journey of recovery, as was highlighted by the participants in this study, is an important principle well recognised in the recovery literature (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

On the other hand, this study also highlighted ways in which working with the MHRS may hinder important alliance processes. This was particularly evident where clients perceived pressure in relation to working with the MHRS or held fixed conflicting views from their worker in terms of assessing their needs and goals on the MHRS.

Being able to describe and share a clear understanding of clients' mental health needs and goals is a vital precursor to change (Skantze & Malm, 1994; Wright, Callaghan, & Bartlett, 2011), including setting realistic goals (Sells, Davidson, Jewell, Falzer, & Rowe, 2006). However in case management in particular, conflict often arises from discord between clients' and workers' perspectives, including disagreements regarding care planning (Angell & Mahoney, 2007; Woltmann & Whitney, 2010).

This too was evident in the use of the MHRS, where contrasting views in relation to the MHRS were not only seen to potentially harm the alliance in creating opposition or disengagement, but also result in staff completing alternative versions of the MHRS, with little client involvement. Whilst the MHRS guidance allows for this in recognising that

reaching agreement may not be possible (Mackeith & Burns, 2013); it does not appear to address the impact that this might have on the working alliance.

Workers in this study attributed such conflicting perspectives to clients' cognitive and mental health difficulties, particularly having a lack of insight. This is a well-recognised challenge as empirical research has frequently shown poorer client insight into their difficulties and need for treatment to be associated with a weaker working alliance (Dunn, Morrison, & Bentall, 2006; Klinkenberg et al., 2002; Kvrgic, Cavelti, Beck, Rűsch, & Vauth, 2013).

A lack of insight may be seen to reflect the 'pre-contemplation' stage in the aforementioned transtheoretical model of change (Prochaska & DiClemente, 1983), which parallels the MHRS's 'Ladders of Change' (Onifade, 2011). With regards to the latter, clients lacking insight would be seen to be in the 'stuck' stage and challenged to consider progressing through the upper stages of 'accepting help', 'believing', 'learning' and 'self-reliance' (MacKeith & Burns, 2013). However, research that has looked at client perspectives of disengagement from services, has highlighted the responsibility services may play in clients appearing 'stuck' – in particular the use of coercive practices that have historically fostered client mistrust and disempowerment (Watts & Priebe, 2002).

Within case management services in particular, power imbalances are a particular dilemma because of clients' reliance on workers to meet a range of needs (such as housing, healthcare, and activities of daily living) (Watts & Priebe, 2002; Woltmann & Whitney 2010). The need to provide care and manage client risk has often lead to paternalism at the expense of client autonomy or self-determinism (Timms & Borrell, 2001). This has not only been criticised on ethical grounds but also clinically for potentially creating and reinforcing

client learned helplessness, a legacy of past mental health provision (Lunt, 2004; Skantze & Malm, 1994).

Within recovery services, it has been argued that collaborative working between professionals and clients should extend beyond therapy towards clients taking the lead in directing a truly person-centred approach in their recovery in every area of their lives (Perkins & Slade, 2012). However, how this might be put into practice in rehabilitation services, where clients require a high level of input to assist with a full range of everyday functioning , appears to be particularly challenging (Watts & Priebe, 2002) .

In contrast to positioning paternalism and client autonomy at extreme ends of a continuum, research within case management services has suggested that client views of decision making may not be so polarised (Woltmann & Whitney, 2010). Clients in this study described valuing a two stage process of prioritising autonomous decision-making in the first instance, followed by deferment to worker's views or decision-making. This was done either as a means of validating their own decision or trusting the worker's judgement above their own within a context of a trusting relationship. This perhaps serves as an example of how power can be better negotiated within services, which is what is called for among clients in case management services (Watts & Priebe, 2002).

The importance of establishing trust in the alliance was indeed highlighted by the participants in the current study and was seen to help with working with the MHRS, as one client said:

> *He [worker] tends to stop me from having 9 or 10, you know when really it's further down, which I think is part of his role in being my keyworker with the Recovery Star…. I'm seeing truly where I've gotten to in that recovery area" (Simon)*

Furthermore the use of the MHRS perhaps offers a similar model in seeking client input in the first instance, followed by challenging these views if differences are apparent, negotiating ratings and goals, or recording both perspectives where agreement is not reached (MacKeith & Burns, 2013). Nevertheless, given the focus on empowerment in the recovery movement, strongly advocated for across mental health services (Leamy et al., 2011; Craig & Killaspy, 2015), perhaps further considerations should be given to how to nurture this in the context of using the MHRS among clients with severe difficulties.

5.2. Limitations and research implications

There are numerous limitations to this study, which perhaps could be kept in mind for future research:

Firstly, the gender disproportion of participants in this study (mostly male clients and all female workers) is a key limitation, which may have restricted the views expressed. However it should be noted that in GTM, sampling is not based on demographic representativeness, rather the emerging data analysis (Hood, 2007).

Secondly, this present study was carried out within rehabilitation services only; therefore the findings would have limited transferable value to other mental health settings, where perhaps the MHRS is used differently among clients who present with different types and level of needs. Future research might benefit from considering alternative population groups.

Thirdly, access to participants was obtained through staff; therefore there may have been selection bias in terms of their choice of clients they referred to this study. Furthermore, ideally it would have been preferable for the participants of this study to consist of dyads of workers and clients in order to better gain an understanding of their shared alliance.

Fourthly, this study did not follow the participants specifically through the process of completing and using the MHRS (such as providing initial scores, setting goals and reviewing these accordingly). Given the ongoing process of recovery and evolving nature of the alliance, perhaps it would have been preferable to use a longitudinal design to better capture such processes. This could be an area for future research.

Finally, as is common with qualitative studies of the alliance, data collection used in this study relied on interviews that arguably replicates some elements of the subject matter of this study – that is interpersonal processes between clients and professionals. Complexities recognised in this dynamic among this client group, such as suspicion or mistrust towards professionals (Thurston, 2003; Watts & Priebe, 2002), might have interfered with what clients felt comfortable disclosing at interviews. An alternative approach that has been used in other studies that may be helpful here is action research, which focuses on participant involvement and elucidating a shared understanding of phenomena, whereby participants become co-researchers in the planning, data gathering, analysis and evaluation (McAllister et al., 2001). This would also be consistent with the call for greater service user involvement in research that informs mental health services (Harding, Pettinari, Brown, Hayward, & Taylor, 2011).

5.3. Clinical implications

The findings in this study suggest the MHRS potentially offers a means of implementing principles of recovery in practice and yielding clinical benefits for clients. In particular it was seen to possibly aid the following evidence-based processes: positive alliance-building, goal setting, and facilitating hope (Anthony & Mizock, 2013; Greene et al., 2006; Martin et al., 2000).

In terms of the MHRS's focus on recovery goals, it has been argued that professionals need to have a greater appreciation of the relative value clients place on different recovery goals, rather than assuming they hold an equal weighting (Skantze & Malm, 1994). This has been highlighted as a concern in relation to traditional outcome measures in mental health, which have often been service-led, neglecting the prioritisation of outcomes that are personally meaningful to clients (Harding et al., 2011).

Whilst clients and workers in this study spoke of the MHRS helping them to progress towards person-centred goals, this was not the case for all clients. Elsewhere, facebook-based service user group, "*Recovery In The Bin*" has indeed criticised the MHRS for focusing on goals related to client functioning rather than the fulfilment of client values, without considering socio-political inequalities underpinning mental ill-health (Gadsby, 2015). It is argued that staff who use the MHRS tend not to be trained in a holistic approach of formulating client difficulties within the broader context of socio-political influences (Gadsby, 2015).

This criticism is somewhat reflected by the negatives highlighted by participants in this study, who found the MHRS too restrictive or peripheral to their experiences. Perhaps the relevant stakeholders should consider not only the use of alternative versions, as was suggested by one of the worker participants, but how their use of the MHRS could be more flexible.

Overall, services should consider how best to build on the promising elements of the MHRS whilst guarding against the potentially damaging effects it may have to the alliance if not used sensitively. This may require an improved means of negotiating shared decision-making between clients and workers discussed earlier (Woltmann & Whitney 2010). In addition workers might need specialist training and support, such as training in developing

holistic formulations of client difficulties (Gadsby, 2015), or skilled supervision to better understand and respond to problematic interpersonal dynamics, such as power imbalances (Thurston, 2003).

To this end, Clinical Psychologists arguably are well-placed to help address this need due to their training in biopsychosocial models of formulating client difficulties, informed by critical approaches that consider socio-political factors (BPS, 2011); as well as the growing expectation for them to take on leadership responsibilities in providing systemic input in improving service development (Kat, 2015).

6. Conclusions

This study aimed to describe and explain clients' experiences of their alliance with workers in rehabilitation settings within the context of using the MHRS and how this related to their recovery.

Fundamental processes seen to help build a positive alliance were also evident in the use of the MHRS, overall reflecting enablers and hindrances to working together towards improved wellbeing. A key challenge is upholding recovery-based, person-centred principles that prioritise client decision-making and personally meaningful recovery goals.

Services using the MRHS also need to consider how best to negotiate such challenges to safeguard a positive working alliance with this client group, which may require a more flexible approach. Keyworkers may be best placed to work with the MHRS, given their in-depth knowledge of the client and relatively close relationship based on the full range of their responsibilities; however further support in terms of specialist clinical training and supervision may be beneficial.

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Section C: Appendices

Appendix 1: Summary table of empirical studies

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Angell, Martinez, Mahoney & Corrigan (2007)	Examined effects of payeeship and perceived financial leverage on the alliance.	205 adults with Severe Mental Illness (SMI) from an urban community mental health clinic in the US, complete data for 201 participants used in this study.	Interviews with measures, including Brief Psychiatric Rating Scale (BPRS), Global Assessment of Functioning Scale, Insight and Treatment Attitudes Questionnaire, Working Relationship Scales (WRS).	Bivariate statistics, logistic regression, multivariate logistic regression, and hierarchical multiple linear regression.	Clients with a comorbid substance misuse disorder, lower functioning, and lower insight were more likely to have a "clinician payee", 40% of whom perceived financial leverage in the relationship. Those with a clinician payee reported a higher degree of conflict in the relationship; however there was no significant difference on the 'bond' component in comparison to those with no payee or a non-clinician payee.
Calsyn, Klinkenberg, Morse & Lemming (2006)	Data obtained from a Randomised Control Trial (RCT) comparing three types of case management treatment. This analysis sought to identify predictors of the alliance using case manager and client ratings of alliance.	115 clients in two types of US Assertive Community Treatment (ACT) services in the US, who presented with a Severe Mental Illness (SMI), substance use disorder and homeless at baseline.	Interviews with measures, including an adapted Working Alliance Inventory (WAI) with demonstrated reliability to obtain case manager and client ratings of alliance measured at baseline, 3 months and 15 months. Structured interviews covered questions pertaining to: willingness to seek help; Treatment variables (including services received and program contacts); outcome variables (number of days in stable housing, symptomology using Brief Psychiatric Rating Scale (BPRS), Readiness to Change (RTC) substance use and number of conflictual relationships).	Hierarchical logistic regression.	Overall ratings of the alliance were not highly correlated between time intervals and between clients and case managers. Variance in alliance accounted for by dependent variables assessed only to a moderate degree - client age, race and diagnosis not shown to predict alliance but RTC was a strong predictor. Male clients rated alliance slightly higher than women but gender did not predict alliance for case managers. Treatment variables predicted alliance ratings for case managers more so than for clients. Correlation with outcome variables was modest (accounting for *10% of variance).

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Catty, Cowan, Poole, Ellis, Geyer, Lissouba, White & Burns (2012)	Cross-sectional survey that sought to determine inter-relationships between: clients' social network quality and size and ratings of the alliance; and attachment style (team attachment, alliance, social networks, clinical and social functioning).	93 adults from four UK community mental health team operating a case management service	Data obtained from a parent study (5 year longitudinal study of continuity of care) as well as additional data collected from subsample of participants. Data from parent study included sociodemographic details of participants obtained at baseline interview with clients and professionals' ratings of the alliance obtained during face-to-face and telephone interviews. Clinical and social functioning measured using range of measures. Each participant's keyworker completed measure of the alliance using the professional version of the Scale to Assess the Therapeutic Relationship (STAR). Additional interview with clients included range of measures: social networks (The Social Network Schedule (SNS), attachment in current relationships (Relationship Scales Questionnaire (RSQ), therapeutic relationship with the CMHT keyworker (Scale to Assess the Therapeutic Relationship (STAR), and attachment to the clinical team (Team Attachment Questionnaire (TAQ).	Pearson's correlations; independent t-tests; one-way Analysis of Variance (ANOVA); regression analysis	Ratings of the alliance were not shown to be associated with the size of a client's social network or number of confidants. Similarly, social network variables were not associated with a client's attachment to the community team. Attachment style was not associated with a client's rating of their alliance with their keyworker and only one attachment style (preoccupied) was shown to be associated with attachment to the team. Team attachment was associated with having poorer global functioning.

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Dixon, Turner, Krauss, Scott & McNary (1999)	Compared workers' and clients' view of representative payee relationship, looking at associations between sociodemographic factors, experience of payee relationship, and views of how this impacts on the alliance.	54 case manager-client pairs (11 case managers, 54 clients) from a US Assertive Community Treatment (ACT) service for those experiencing mental health difficulties and homelessness.	Structured questionnaires completed during interviews with clients and workers - covering questions pertaining to client satisfaction with payee experience, impact of representative payee program on the alliance, perceived benefits of the program, incidents of verbal abuse, and reasons for establishing the payee relationship. Questionnaires were developed by the authors with no psychometric properties reported.	Chi square analysis for categorical data, nonparametric between-group tests for ordinal data.	Both parties viewed payeeship arrangements to be positive and beneficial in terms of improved housing, budgeting and substance misuse and for this not to interfere with a positive alliance. However workers reported verbal abuse from 44% of clients in relation to their payeeship responsibilities. Greater satisfactionwith the payeeship was associated with longer duration of the current arrangement as well as previous experience of payeeships.
Draine & Solomon (1996)	Cross-sectional study using data from a parent Randomised Control Trial (RCT) study comparing different case management services in Assertive Community Treatment (ACT) services in the US. This analysis assessed whether age predicted strength of alliance whilst controlling for sociodemographic and clinical factors.	Data was obtained from 86 of 96 clients from Assertive Community Treatment (ACT) services in the US who participated in the parent study.	Structured interviews with clients completed at 1 month, 1 year and 2 years. Questions pertained to services, hospitalisations, amount and source of income, sociodemographic details, Brief Psychiatric Rating Scale (BPRS). At baseline history of hospitalisation, homelessness, and arrest was noted. Working Alliance Inventory (WAI) administered at 2 years to measure alliance.	One-way Analysis of Variance (ANOVA)	Older clients (45 years of age or older) was shown to be a significant predictor of a stronger alliance. Client hospitalisation and homelessness were not shown as predictors of alliance. History of criminal arrest was significantly associated with a higher score for subscales 'bond' and 'task' on the Working Alliance Inventory (WAI).

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Hopkins & Ramsundar (2006)	Sought to identify predictors of case management services over 12 months.	30 case manager client dyads (30 clients, 5 case managers) with a Severe Mental Illness (SMI) in a case management program in Canada.	Case managers completed the Working Alliance Inventory (WAI) – short form version (12 items); Multnomah Community Ability Scale (MCAS) at 1 month and 12 months later; daily contact logs (detailing time spent with the client, phone calls to other stakeholders concerning the client's needs, frequency of community visits and type of support, covering housing, vocation, Activities of Daily Living (ADL), social, medication and other).	Multiple regression analysis.	The working alliance as rated by the case manager was shown to be a stronger predictor than a client's community functioning profile on the extent and type of intervention implemented. A stronger working alliance predicted more case manager support, community visits, meetings to discuss Activities of Daily Living (ADL's) and meetings to facilitate social skills.

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Klinkenberg, Calsyn, & Morse (1998)	Data obtained from a parent study (randomised experiment) comparing three case management services. This analysis assessed client variables and service variables as predictors of strength of the alliance as rated by the client.	Participants obtained from a parent study (randomised experiment) that involved 135 clients (homeless with Severe Mental Illness (SMI), comparing different case management services in the US. For this study, sample was taken from 105 who were in Assertive Community Treatment (ACT) programs. Sample size varied from 74-93 clients because of missing data.	Measure of the alliance: 15 item self-report measure of the alliance developed by the authors completed by the client at 2 and 14 months. Other self-report measures to assess: psychiatric symptoms amended Brief Psychiatric Rating Scale (BPRS), Alienation, conflictual relationships (Arizona Social Support Interview Schedule), recognition of need for treatment (two item denial of illness scale), perceived needs (seven item scale covering housing, financial assistance, job training, medical care, and mental health treatment). Service variables measured included number of services and service contacts, days in stable housing, and income.	Multiple regression analysis.	At month two: 4 out of 22 client variables were significant predictors of the alliance - low hostility/suspicion, multiple perceived needs, multiple service contacts, and ethnicity (Caucasian associated with lower alliance). Month fourteen: only significant predictor of alliance was strength of alliance at month two.

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Klinkenberg, Calsyn & Morse (2002)	Data obtained from a parent study (randomised experiment) comparing three case management services. This analysis assessed client variables and service variables as predictors of strength of the alliance as rated by the case manager as well as how stable the alliance rating was over a period of 18 months.	Parent study involved 135 clients, comparing different case management services in the US. For this study sample taken from those in Assertive Community Treatment (ACT) programs only. Sample size varied from 84-93 because of missing data.	Measure of the alliance: 3 item self-report measure of the alliance developed by the authors completed by the case managers at 6 and 18 months (psychometric properties reported). Also measured: number of client conflictual relationships (Arizona Social Support Interview Schedule), Denial of illness (two item scale asking if the client acknowledged their condition). Service variables: Days of contact (averaged monthly); Number of specific services (assistance with housing, Activities of Daily Living (ADL), mental health treatment).	Multiple regression analysis.	Case manager ratings of the alliance remained moderately stable. Most client variables did not predict alliance (including gender, conflictual relationships, and diagnoses). Stronger alliance was associated with less denial from the client about their need for treatment. Alliance was stronger at 18 months for clients who were African American (in comparison to clients who were Caucasian) and without a substance misuse disorder. In terms of case management variables, number of contacts did not predict alliance and a wider range of services predicted a stronger alliance at 6 months but not 18 months. A stronger alliance at 18 months was associated with a stronger alliance at 6 months.

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Kondrat & Early (2010)	Cross-sectional study, looking at associations between: (1) client ratings of the alliance and case manager to whom they were assigned; (2) client ratings of the alliance and client's level of self-stigma; (3) and to what degree is the association between self-stigma and client ratings of alliance different for different case managers.	160 clients from a case management service in the US (receiving treatment from 47 case managers).	Control variables obtained from service records. Individual interviews completed with clients to identify case manager, measure the alliance using the Working Alliance Inventory (WAI), and measure self-stigma using the Devaluation and Discrimination Scale.	Hierarchical linear modelling.	Some case managers were associated with stronger working alliances as rated by clients (case manager accounted for 11% of variance in the alliance rating). Client perceptions of stigma did not predict working alliance; however when combined with the case manager this relationship was significant. Of the variables controlled for, a significant inverse association was found between length of treatment and alliance ratings.
Neale & Rosenheck (2000)	Sought to assess the association between a range of limit setting behaviours and client and case manager's perceptions of the alliance over a period of 6 months.	1564 veterans with a SMI across 40 US Assertive Community Treatment (ACT) teams.	Semi-structured interviews completed at baseline and 6 months. Alliance was measured using authors' adaptation of the Working Alliance Inventory (WAI). Range of additional measures were used to assess: relationships with family, substance use, arrests, violent behaviour, and quality of life (some items developed by the authors with no demonstrated psychometric properties. Some standard measures are referred to in the reference list but it is not clear what exactly was used). Workers completed semi-annual structured reviews of clients' progress and service delivery, which included frequency of contact with client, client's family, nonfamily members, and other staff. Therapeutic Limit Setting Questionnaire developed by the authors was also used.	Factor analysis and multiple regression.	The main limit setting behaviours employed by case managers were verbal confrontations. The other main forms of limit setting in descending order of frequency were: money management, contingent withholding, enforced hospitalisation and invoking external authorities. Workers were more likely to use limit setting with clients with greater difficulties. Overall Therapeutic Limit Setting (TLS) was negatively associated with perception of the alliance, especially for case managers' ratings. For clients, a negative association was found between money management and the alliance whereas for case managers there was a negative association with all TLS except for money management. The variable most negatively associated with the alliance for case managers was contingency withdrawal.

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Priebe & Guyters (1993)	Assessed quality of the alliance as rated by clients in terms of their perceptions of their case manager's understanding, involvement, criticism, adequacy of treatment, and whether or not clients felt better after their sessions.	72 clients in a case management service in Germany.	Alliance measured using five item questionnaire of closed questions developed by the authors: workers' understanding, involvement, criticism, adequacy of treatment, and whether or not clients felt better after their sessions.	Pearson's correlation.	Clients tend to rate their alliance with their workers as relatively positive in terms of workers' understanding, involvement, criticism, adequacy of treatment, and whether or not they felt better after their sessions. Most of these items were significantly positively correlated except for client perception of criticism which was negatively correlated with the other items.
Repper, Ford & Cooke (1994)	Qualitative study - Sought to identify, describe, and understand case managers' relationships and interventions with clients using qualitative interviews.	All participants recruited from four case management services in the UK - 17 case managers discussing 33 of their clients (16 workers discussed 2 clients each and one worker discussed 1 client). Participants also included 13 of these 33 clients and 3 other clients recommended by workers.	Structured interviews with clients and case managers separately, regarding activities over the last 6 months with a focus on describing their relationship and feelings.	Thematic analysis of transcribed interviews, validated by second researcher.	The initial thematic analysis yielded a coding framework of key interrelated themes, centred around problems and strategies in the case manager-client alliance. Further analysis identified the following principles: Realism; Long-term perspective; Positive, empathic understanding of the client; and Client-centred flexibility. Key processes identified included: A trusting relationship; Engagement; Assessment; Communicating with clients; Variety of therapeutic and educational interventions and Monitoring.

Study	Aims and Design	Participants	Data collection methods	Analysis	Findings
Sullivan & Floyd (2012)	Qualitative study - Exploratory study of case managers' attitudes about clients focused on the helping process within the alliance.	40 case managers from two case management services in the US.	Semi-structured interviews that involved ethnographic interviewing.	Thematic analysis.	Themes: Engagement; Goal planning; Pushing, Pulling and Letting Go; Moving Forward; and Building on the relationship.
Yamashita (2005)	Qualitative study - Grounded theory of nurse case managers' views of processes of care.	16 nurse case managers from Inpatient; Transition (between inpatient and community settings); and Community Services in Canada.	In-depth interviews.	Grounded theory analysis of transcribed interviews.	The core category identified across these settings was negotiating care together in a developing trusting relationship, characterised by forming an on-going holistic understanding of the client in order to elicit the support required to meet the client's needs and goals. This involves workers directly providing support themselves as well as liaising with staff, community providers, and family in the community. The focus of such negotiations varies across settings.

Appendix 2: Quality review of quantitative studies

STROBE checklist		Angell, Martinez, Mahoney & Corrigan (2007)	Calsyn, Klinkenberg, Morse & Lemming (2006)	Catty, Cowan, Poole, Ellis, Geyer, Lissouba, White & Burns (2012)	Dixon, Turner, Krauss, Scott & McNary (1999)	Draine & Solomon (1996)	Hopkins & Ramsundar (2006)	Klinkenberg, Calsyn, & Morse (1998)	Klinkenberg, Calsyn & Morse (2002)	Kondrat & Early (2010)	Neale & Rosenheck (2000)	Priebe & Guyters (1993)
		1	2	3	4	5	6	7	8	9	10	11
Title and abstract	1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Introduction [Background/rationale]	2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Objectives	3	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Methods												
Study design	4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Setting	5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Participants	6	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	CT
Results												
Variables	7	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Data sources/ measurement	8	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bias	9	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Study size	10	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Quantitative variables	11	Y	Y	Y	Y	Y	N	Y	Y	Y	y	Y
Statistical methods	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Participants	13	Y	Y	Y	Y	Y	N	N	Y	Y	y	Y
Descriptive data	14	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outcome data	15	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Main results	16	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Other analyses	17	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Discussion												
Key results	18	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Limitations	19	Y	Y	Y	Y	Y	N	Y	Y	Y	y	Y
Interpretation	20	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Generalisability	21	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N
Other information												
Funding	22	N	Y	N	N	N	N	Y	N	N	N	N

Key: Y=YES, CT=Can't Tell, N=No

STROBE quality checklist for quantitative studies (Vandenbroucke, et al., 2007)

	Item No	Recommendation
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
Methods		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(*a*) *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants
		(*b*) *Cohort study*—For matched studies, give matching criteria and number of exposed and unexposed *Case-control study*—For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding
		(*b*) Describe any methods used to examine subgroups and interactions
		(*c*) Explain how missing data were addressed
		(*d*) *Cohort study*—If applicable, explain how loss to follow-up was addressed *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of sampling strategy
		(*e*) Describe any sensitivity analyses

Continued on next page

Results		
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
		(b) Give reasons for non-participation at each stage
		(c) Consider use of a flow diagram
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders
		(b) Indicate number of participants with missing data for each variable of interest
		(c) *Cohort study*—Summarise follow-up time (eg, average and total amount)
Outcome data	15*	*Cohort study*—Report numbers of outcome events or summary measures over time
		Case-control study—Report numbers in each exposure category, or summary measures of exposure
		Cross-sectional study—Report numbers of outcome events or summary measures
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included
		(*b*) Report category boundaries when continuous variables were categorized
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based

Appendix 3: Quality review of qualitative studies

(using Critical Appraisal Skills Programme, available at http://www.casp-uk.net)

CASP checklist		Repper, Ford & Cooke (1994)	Sullivan & Floyd (2012)	Yamashita (2005)
		1	2	3
Was there a clear statement of the aims of the research?	1	Y	Y	Y
Is a qualitative methodology appropriate?	2	Y	Y	Y
Was the research design appropriate to address the aims of the research?	3	Y	Y	Y
Was the recruitment strategy appropriate to the aims of the research?	4	Y	Y	CT
Was the data collected in a way that addressed the research issue?	5	Y	Y	Y
Has the relationship between researcher and participants been adequately considered?	6	N	N	N
Have ethical issues been taken into consideration?	7	N	Y	N
Was the data analysis sufficiently rigorous?	8	CT	Y	CT
Is there a clear statement of findings?	9	Y	Y	Y
How valuable is the research?	10	Y	Y	Y

Key: Y=Yes, CT=Can't Tell, N=No

Appendix 4: Approval letter from Independent Research Review Panel
This has been removed from the electronic copy

Appendix 5: Ethics approval letters from NHS ethics
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Appendix 6: Ethics approval letters from Research and Development
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Appendix 7: Ethics approval letters from NHS ethics confirming amendments approved
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Appendix 9: Participant Information Sheet – client version
(confidential information has been omitted)

Information about the research

Version 6
15/07/2015

A grounded theory examining the nature of the therapeutic alliance within the context of using the Mental Health Recovery Star

Hello. My name is Louise Joy-Johnson and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
The purpose of this study is to explore the possible role of the therapeutic alliance between service user and mental health professional within the context of using the Mental Health Recovery Star (MHRS) as an intervention for recovery from mental ill health. In particular the aim will be to form a theory that explains:

1. What are the experiences of service users using the MHRS with a staff member (worker)?
2. How do service users describe their relationship with a worker within the context of using the MHRS?
3. What is the role of this relationship in a service user's recovery?

Why have I been invited?
You have been asked to participate in the study as you have used the MHRS regularly with a worker who has been trained in using this tool for at least 6 months and your perspective regarding the use of this tool would be highly valued for the purpose of this study.
You will be invited to a one to one interview with myself. There will probably be a total of around 10-14 service users who will be interviewed for this study.
In addition, the mental health worker with whom you do the Mental Health Recovery Star may also be interviewed to ask about their views of the use of the Recovery Star and their therapeutic alliance with you in this context. In total there will be 3-4 staff members interviewed.

Do I have to take part?
Your participation in the research is entirely voluntary. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?
You will be asked to attend a one to one interview with myself that will probably last about 60 minutes. This will take place in a private room at the service you attend.

The interview will be audio-recorded and transcribed and anonymous quotes may be used in published reports of the study findings. This will only take place if you provide written consent. All information will be kept confidential and anonymous. Audio recordings will be kept secure and all transcriptions will be saved on an encrypted memory stick.

The audio recording of your interview may be passed to a professional transcriber external to the service. No personal details will be passed to the transcriber who will be required to sign a confidentiality agreement that involves anonymising all data and maintaining its privacy and security. You will be given a copy of the transcript of your interview for you to review and to make any changes or comments to ensure its accuracy. All the data gathered will be analysed using a grounded theory approach. This means that what is said will be looked at in great detail and common themes will be drawn from all the interviews to form a coherent explanation regarding experiences of using the Mental Health Recovery Star.

The research will be ongoing for the next 2 years after which a report will be produced. The final report will be made available and you will be provided with a summary report of the findings.

What will I have to do?
You will be invited to attend a face to face interview with myself that is expected to last between 60-90 minutes. You will also be invited to provide feedback on the analysis as it is carried out as a means of validating the findings.

What are the possible disadvantages and risks of taking part?
There are no identifiable risks or disadvantages for participating in this study.

What are the possible benefits of taking part?
It is not the intention of this study to result in clinical benefits for participants but the information that we get from this study will help with our understanding of the therapeutic alliance within the context of using the MHRS.

What if there is a problem?
If you have any complaint about the way you have been dealt with during the study or any possible harm you might suffer, this will be addressed in accordance with standard procedures that are in place. Should you feel you require support, you will be referred to the appropriate services. The details are included in Part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

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

You may withdraw from the study at any time. If you withdraw from the study, we would like to use the data collected up to your withdrawal but would request your consent for us to do so.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions [details provided below]. If you remain unhappy and wish to complain formally, you can do this via the xxxTrust NHS Complaints Procedure or contacting xxx.

Will my taking part in this study be kept confidential?

The interviews will be carried out in a private room in a clinical setting and will be audio recorded. All information which is collected about you during the course of the research will be kept strictly confidential within certain ethical limitations – that is if it is disclosed that there is a risk of harm to yourself or others this will be escalated to relevant professionals in the service and this will be discussed with you. All data and any identifying information will be anonymised.

Audio recordings will be kept secure and all transcriptions will be saved on an encrypted memory stick.

Data will be coded and kept on a password protected CD in the Doctorate in Clinical Psychology programme office in a locked cabinet for 10 years after the study is completed.

You have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

The results of the study will be submitted to Canterbury Christ Church University as a Major Research Project that forms part of the assessment process for the Doctorate in Clinical Psychology programme.

It is also intended that a report will be produced and published in a relevant journal (eg: Journal of Mental Health).

A version of the report in lay terms will also be produced and you will receive a copy.

You will not be identified in any report/publication; however, with your consent, anonymised quotes from interviews may be used in the reports.

Who is organising and funding the research?

Canterbury Christ Church University.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by [*name of Research Ethics Committee*].

Date: 4th February 2014

A copy of the information sheet and signed consent form will be provided for you to keep.

Further information and contact details

1. Specific information about this research project.
If you would like to find out more about the study or have questions about it answered, you can contact me on:

xxx

2. General information about research / Advice as to whether they should participate.
If you have any general queries about research or would like advice as to whether you should participate it may be helpful to talk xxx

3. Who you should approach if unhappy with the study:
If you are unhappy with this study or have concerns you wish to raise please feel free to contact me on xxx.

Appendix 10: Participant Information Sheet – staff version
(confidential information has been omitted)

Information about the research

Version 5
15/07/2015

A grounded theory examining the nature of the therapeutic alliance within the context of using the Mental Health Recovery Star

Hello. My name is Louise Joy-Johnson and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
The purpose of this study is to explore service user experiences of the therapeutic alliance with a mental health professional within the context of using the Mental Health Recovery Star (MHRS) as an intervention for recovery from mental ill health. In particular the aim will be to form a theory that explains:

1. What are the experiences of service users using the MHRS with a staff member (worker)?
2. How do service users describe their relationship with a worker within the context of using the MHRS?
3. What is the role of this relationship in a service user's recovery?

Why have I been invited?
You have been asked to participate in the study as you have used the MHRS regularly with a service user for at least 6 months and your perspective regarding the use of this tool would be highly valued for the purpose of this study.
You will be invited to a one to one interview with myself. There will probably be a total of around 10-14-service users who will be interviewed for this study, and 3-4 staff members who have worked with yourself or them.

Do I have to take part?
Your participation in the research is entirely voluntary. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
You will be asked to attend a one to one interview with myself that will probably last about 60 minutes. This will take place in a private room at the service where you work.

The interview will be audio-recorded and transcribed and anonymous quotes may be used in published reports of the study findings. This will only take place if you provide written consent. All information will be kept confidential and anonymous. Audio recordings will be kept secure and all transcriptions will be saved on an encrypted memory stick.

The audio recording of your interview may be passed to a professional transcriber external to the service. No personal details will be passed to the transcriber who will be required to sign a confidentiality agreement that involves anonymising all data and maintaining its privacy and security. You will be given a copy of the transcript of your interview for you to review and to make any changes or comments to ensure its accuracy. All the data gathered will be analysed using a grounded theory approach. This means that what is said will be looked at in great detail and common themes will be drawn from all the interviews to form a coherent explanation regarding experiences of using the Mental Health Recovery Star.

The research will be ongoing for the next 2 years after which a report will be produced. The final report will be made available and you will be provided with a summary report of the findings.

What will I have to do?
You will be invited to attend a face to face interview with myself that is expected to last between 60-90 minutes. You will also be invited to provide feedback on the analysis as it is carried out as a means of validating the findings.

What are the possible disadvantages and risks of taking part?
There are no identifiable risks or disadvantages for participating in this study.

What are the possible benefits of taking part?
It is not the intention of this study to result in clinical benefits for participants but the information that we get from this study will help with our understanding of the therapeutic alliance within the context of using the MHRS.

What if there is a problem?
If you have any complaint about the way you have been dealt with during the study or any possible harm you might suffer, this will be addressed in accordance with standard procedures that are in place. Should you feel you require support, you will be referred to the appropriate services. The details are included in Part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?
You may withdraw from the study at any time. If you withdraw from the study, we would like to use the data collected up to your withdrawal but would request your consent for us to do so.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (please see contact details below). If you remain unhappy and wish to complain formally, you can do this via the xxx Trust NHS Complaints Procedure (please see contact details below) or contacting xxxx.

Will my taking part in this study be kept confidential?
The interviews will be carried out in a private room in a clinical setting and will be audio recorded. All information which is collected about you during the course of the research will be kept strictly confidential within certain ethical limitations – that is if it is disclosed that there is a risk of harm to yourself or others this will be escalated to relevant professionals in the service and this will be discussed with you. All data and any identifying information will be anonymised.
Audio recordings will be kept secure and all transcriptions will be saved on an encrypted memory stick.
Data will be coded and kept on a password protected CD in the Doctorate in Clinical Psychology programme office in a locked cabinet for 10 years after the study is completed.
You have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?
The results of the study will be submitted to Canterbury Christ Church University as a Major Research Project that forms part of the assessment process for the Doctorate in Clinical Psychology programme.

It is also intended that a report will be produced and published in a relevant journal (eg: Journal of Mental Health).

A version of the report in lay terms will also be produced and you will receive a copy.

You will not be identified in any report/publication; however, with your consent, anonymised quotes from interviews may be used in the reports.

Who is organising and funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NHS xxx Ethics Committee.

Date: 4th February 2014

A copy of the information sheet and signed consent form will be provided for you to keep.

Further information and contact details

1. Specific information about this research project.
If you would like to find out more about the study or have questions about it answered, you can contact me on:

xxxx

2. General information about research / Advice as to whether they should participate.
If you have any general queries about research or would like advice as to whether you should participate it may be helpful to talk to xxxx.

3. Who you should approach if unhappy with the study:
If you are unhappy with this study or have concerns you wish to raise please feel free to contact me on xxxx. Alternatively you can do so following the xxxTrust NHS Complaints Procedure through the following contact details:
xxxx

Appendix 11: Participant consent form

Version 3
Centre Number:
Study Number:
Participant Identification Number for this study:

Title of Project: A grounded theory examining the nature of the therapeutic alliance within the context of using the Mental Health Recovery Star

Name of Researcher: Louise Joy-Johnson

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that any data gathered from my interview will be audio recorded, transcribed, made entirely anonymous and deleted after the final analysis. ☐

4. I understand that any data gathered from my interview will be kept confidential within certain limits – that is if there is a concern for my own safety and/or those of others. ☐

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings ☐

6. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix 12: Interview schedule – client version

Version: 2
15/07/2015

1. How long have you been using the Recovery Star with your worker? (A rough idea will do if you don't remember exactly when you started).
2. Could you tell me about some of your experiences of staff using the Recovery Star with you?

   Prompts: What is it like to have it as the basis of your work with the staff member?

   Is there anything you particularly like about working with the Recovery Star?

   Anything you are not so keen on about it?

   Anything else you would like to say about your experience of the Recovery Star?
3. How would you describe your relationship with your worker who has used the MHRS with you?
4. How did you use the Recovery Star? – Could you tell me about a recent meeting with a worker when you used the Recovery Star together?
5. How did you decide on the scores?
6. How did your relationship affect this process?
7. How did your relationship with your worker impact on your work towards recovery?

   Prompts: What did they do that was helpful?

   Why was this helpful?

   What did they do that was not helpful?

   Why was this not helpful?
8. Would you say that you work differently with your mental health worker – or they work differently with you - when it involves the Recovery Star, compared to when it doesn't? Or does it make no difference?
9. Is there anything else that you would like to say about your experience of working with mental health staff when the MHRS is involved?

   Prompts: Why do you think that is?

   Do you have some thoughts about that?
10. Do you have any other thoughts or anything you think would be helpful for workers or other service users to know about working with the MHRS?

Appendix 13: Interview schedule – staff version

Version: 3
15/07/2015

1. How long have you been using the Recovery Star with your client? (A rough idea will do if you don't remember exactly when you started).
2. Could you tell me about some of your experiences of using the Recovery Star with your client?

   Prompts: What is it like to have it as the basis of your work?

   Is there anything you particularly like about working with the Recovery Star?

   Anything you are not so keen on about it?

   Anything else you would like to say about your experience of the Recovery Star?
3. How would you describe your relationship with your client with whom you have used the MHRS?
4. How did you use the Recovery Star? – Could you tell me about a recent meeting with your client when you used the Recovery Star together?
5. How did you decide on the scores?
6. How did your relationship affect this process?
7. How do you think your relationship with your client impacted on their work towards recovery?

   Prompts: What do you think they found helpful?

   Why do you think this helpful?

   What do you think they did not find helpful?

   Why do you think this not helpful?
8. Would you say that you work differently with your client – or they work differently with you - when it involves the Recovery Star, compared to when it doesn't? Or does it make no difference?
9. Is there anything else that you would like to say about your experience of working with your client when the MHRS is involved?

   Prompts: Why do you think that is?

   Do you have some thoughts about that?
10. Do you have any other thoughts or anything you think would be helpful for workers or other service users to know about working with the MHRS?

Appendix 14: Mental Health Recovery Star
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Appendix 15: Mental Health Recovery Star - Ladders of Change
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Appendix 16: Extracts of interview with line-by-line coding
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Appendix 17: Extracts of interview with examples of focused coding
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Appendix 18: Extracts from Reflective Journal including memos

2014.10.12 – 2015.01.08: In accordance with Ahern's (1999) guidance on Reflexive Bracketing, I have started a reflexive journal to further develop my awareness of my assumptions, thoughts, and feelings about my research topic and to reflect on these as I gather and engage with the data. Ahern has helpfully provided key questions to consider at the early stages to help explore these:

Why did I choose this project?
I selected one of the research projects presented at the research fair at university. My initial research proposal, which had adhered to the specification presented at the research fair, had to be amended following the University's panel review. This was because the initial proposed research question had been to explore service user's experience of using the Star. However feedback from the panel was that this constituted a service evaluation not a major research project and the suggestion was put forward that I explore something more theoretical. Hence my chosen topic of the "alliance" within the context of using the Star.

Why did I gravitate towards the Star in the first instance?
I am familiar with the Star in previous AP roles. I have not used the Star with service users but I have used another version of the Outcomes Star, namely the Life Star, that adapted to those with a Learning Disability. As a clinician I find the Star very appealing – very fitting with my preference for a "recovery" orientation in adopting a holistic approach, considering all aspects of an individual's life instead of being "problem/symptom-focused". It intrigues me that the Star is so popular, used internationally and yet does not have an established evidence base. It's attractiveness therefore appears universal in a way and it is indeed attractive to me. I like its visual presentation - colour and structure and have found working with it with LD service users enjoyable. I am curious how service users find it.

Why did I want to focus on the therapeutic relationship?
My background in counselling and what led me to that in the first place clearly shows my interest in one-to-one work with individuals. My assumptions are that the "helping relationship" is indeed "helping". But I am curious to hear from service users for them to dissect elements therein. I have been in both chairs in the therapy room. How did I find the therapeutic relationship when I was in therapy? Was it just the relationship as a "common factor" that I found helpful or specific tools or skills employed by the therapist? Would I have wanted some structure – the Recovery Star for instance? I don't think so. My immediate feeling about being put in that place is anxiety, bringing me back to a classroom setting – will the teacher mark me well? Of course the Star is not intended to be used in this way but my immediate connotations and projections were that of my relationship with my teachers and wanting to be a "super star". Will the participants have similar feelings? Will they want to please their keyworker? Would I have wanted my therapist to directly ask about the various ladders on the Star - my "identity and self-esteem"; "physical health and self-care" . Probably not. I'd want to talk about what I want to talk about.
What about setting goals with me to try to make progress in these areas? My immediate reaction is "back off", fearing I might fail and disappoint him/her as well as myself.
My own reaction to these thoughts has surprised me because they differ starkly to my initial impressions as a clinician. From personal experience, I have enjoyed working with the Life

Star. The structured approach and goal-setting seems very helpful and if I'm honest, also removes some anxiety associated with unstructured therapy in a way. But is this for me only as a clinician or for service users as well?

Perhaps for some service users the structure of the Star similarly removes such anxieties but for others this may be frustrating/ intrusive. Would this help or hinder an alliance? Would a clinician think this helps an alliance – having clear goals and ratings, where progress can be "tracked"? As a clinician this also appeals to me, it offers a means of direct feedback perhaps as to how effective or not my work with an individual may be and enable me to perhaps adjust the intervention, consider other possibilities, whereas with other forms of therapy the outcome measures may be more vague and it is difficult to identify in what particular areas one is or isn't making progress.

My experience of working with the LD Star as a clinician was mostly positive and my impression was that the service users that I used this with mostly liked it – the pictures and colours facilitated discussions that I don't think we would have had otherwise. It opened conversations into areas that did concern them but perhaps they would not feel comfortable raising themselves (such as money and living skills).
However as an Assistant Psychologist at the time it did raise issues of role confusion for me as it touched on social and health needs as well, concerns beyond my remit. I was more comfortable discussing the mental and emotional wellbeing elements but this was sometimes not the service users' priority.

Ahern suggests reflecting on power imbalances. Here I see a difference between my own experience of therapy and experience as a clinician. The "type" of therapy I had I imagine to be different – because it was private, I felt very much in control, I initiated contact, I paid for the service so to speak, I was conscious and aware that my time in therapy was **for** me and **about** me. In some ways I felt I directed a lot of the sessions, in terms of being committed in a way and very consciously wanting to go down certain avenues. This led to some "surprises", talking about things that I did not necessarily plan for (eg: YY) and in some way made me feel like I wasn't in control, not in a disempowering way, just in the sense that there was something greater that happened despite of my efforts or intentions and part of my learning was to surrender to those experiences that couldn't necessarily translate verbally. However my experience of working in the NHS is quite different. My experience is that service users are referred to our service, put on a waiting list, often unsure about what they need to "do" in psychological treatment. And then are recipients of whatever might be offered. And this might, most likely, involve having to fill out outcome measures, forms etc. Conform to the system. A system that probably feels alot more powerful than them. They have to comply or they won't be seen. And their allocated clinician is an extension of this system. Surely the use of the Star may fall into this as well – particularly if it's used as an outcome measure, will it be seen as beaurocratic paperwork? My own experience of using it was as a therapeutic tool, not an outcome measure, so it didn't feel this way. The service users tended to enjoy colouring the Star in etc and it felt creative and fun. But in other contexts, such as those in supported living settings, how will they find it? They have complex needs and difficulties. My initial assumption is that they would like the Star because it considers a full range of life areas. I am assuming that discussing these with a keyworker will be helpful and will lead to actions that will help these areas. But what if this is not the case?

What if service users find that they can highlight lots of needs but the keyworker (or others) can't help them in these areas? Will they wonder if such an exercise is just tokenistic? Will it bring shame into their relationship with their keyworker? Frustration? Resentment?
These issues touch on my thoughts about the ***content*** of what might come out in the interviews but what about the ***process*** of the interviews themselves?
How can I try provide a safe, non-judgemental context to facilitate openness? I'll obviously employ basic therapeutic skills (Rogerian) to create as much warmth as possible but the time is so limited. I will definitely need to try establish a rapport at the start. The "do-er" in me will want to "crack on" and get in there with the interview but pacing is key. Step back, make the participant feel comfortable and relaxed and go where they lead and also gently bring them back to the questions in order to explore the aims of this research. Gentle.
I'm particularly conscious that the set up of the interview will reflect in some way the subject matter to be explored – that is a "one-to-one relationship with a professional". I'm wondering how much parallel there will be between the participants' experience of their therapeutic relationship and how they might engage with me during the interview.
Will my ethnicity/ non-British background impact on this? For example if a participant has had a bad experience with a keyworker of a different ethnicity will they feel comfortable sharing this with me? My "theoretical sensitivity" on this subject stems from literature, which has looked at the role of "ethnic matching" in the alliance, with mixed results. What seems to really matter is the competence of the worker. However, without the time to establish trust in me as person or my competence as a professional (as a researcher in this instance), will my ethnicity be a barrier to engaging the participants? Will the lack of time itself be a barrier regardless of my ethnicity?

How accurate an account will I be able to capture with limited time to build rapport with my participants – how open will they be? Perhaps my own worries or anxieties about this will interfere with me creating a relaxed atmosphere that might elicit more open and honest responses. This must be a common concern or limitation.

I wonder whether participants will feel compelled to give positive reports regarding the use of the Star or their relationship with their keyworkers in case they feel this would be fed directly back to them? I hope they feel safe enough to offer a critical perspective. Given the power imbalances between providers and users this may not be the case. I may have to listen out for more subtle expressions that indicate a reluctance to talk about something and then to gently probe further. (ref Strauss & Corbin, 1990 "deviant/ negative" cases).

Clarify your personal value systems and acknowledge areas you know you are subjective, identify role conflicts
I am hoping that service users' experiences of using the Star and their alliance with the keyworker are positive. This reflects my valuing therapeutic work in general and how I have used the Star in the past and would like to think that this was a positive experience for users. Furthermore my external supervisor developed the Star and I would be conscious of her preference for more positive feedback in relation to users' experience of the helping relationship within the context of this tool. Of course, my aim is to be as objective as possible, capturing people's real experiences and valuing negative feedback just as much as the positive. In the long run this may be helpful for both the developers of the tool and users thereof. This was raised at the panel and it was agreed that there would be no conflict

of interest in me carrying out the research but this requires transparency and a declaration of her vested interest.

2015.02.01 The ethics application process has been so much more difficult than I thought it would be. Not because there are any major red flags or worries about ensuring ethical guidelines are followed but because the IRAS form is so long, almost a hundred pages and it took a long time trying to familiarise myself with the online system. I feel far behind my colleagues and just wish I could start the research. It did make me wonder if others felt this process was a box ticking exercise. It is frustrating but at the same time it has affirmed my appreciation of working in an established body like the NHS that keeps people accountable. Perhaps people in the system take this for granted. My memory of university ethics in South Africa was that it is far less stringent. Not a place with a great history of ensuring human rights. Of course politically, an extreme example of the abuse of power, which is a global problem in all spheres of life. Power imbalances are prolific and always have been - extending from the natural world through to human societies, across different races, genders, ages, classes, abilities etc etc etc. How important then is it for us to take nothing for granted. And how important is it then for authorities such as the NHS to have stringent monitoring processes in place to keep those with 'power' (researchers in this case) accountable – having to show *how* you have considered ethical practice, to operationalise good intentions in a measurable way.

And this requires a thorough application form - having to think about every little detail of the process - exactly who is going to be contacted and who is not going to be contacted? how much time will you be asking participants to give up? What is the worse case scenario in terms of harm that they could face and how are you safeguarding against this? Is it fair to ask for their involvement without them benefitting directly from this? How might all parties, including the service be affected? Who are your contacts in the local services and are they going to take responsibility for granting you access to participants? How am I going to ensure they won't be biased. Some of these questions seem like standard protocol in terms of adhering to official guidelines and I have discussed the form with my supervisor to ensure I am adhering to sound ethical practice but others have raised bigger questions for me.

I think the gatekeepers of the services are problematic in the sense that I have to approach staff in the first instance and ask if they can identify any service users who they are working with who would be suitable to participate in the study. A key limitation here is the possibility of selection bias [*refer to for "*Limitations*"]. I will need to communicate to staff that they need to be objective, asking as many service users as possible who meet the inclusion criteria if they would be interested in participating unless there are any reasons for concern (eg: applying the exclusion criteria of being vulnerable etc). However staff may select service users with whom they have had a more positive experience. Similarly, users who are more likely to express a willingness to participate may be those who have also had more positive experience but perhaps not. Perhaps some who have not liked working with the Star or with their keyworker may welcome the opportunity of expressing their dissatisfaction. I am expecting more positive experiences, perhaps because of this potential selection bias or due to the experiences I have had in the past which have been positive. If

this is the case, I will need to identify negative cases or through theoretical sampling explore negative experiences (or indeed visa versa if this is not the case).

I guess what the ethics process has also done is heightened my sensitivity towards always keeping in mind the wellbeing of the participants – talking to me about their experiences of using the Star with their keyworker does not present as an obvious high risk but it is important to always keep in mind the potential sensitivities of any type of querying into another's experiences. What would be triggers of distress? Having a history of mental health difficulties may present as a risk for experiencing distress. This may be unrelated to our interview (unspecified biopsychosocial factors etc) but what about the interview may trigger distress? The aforementioned power imbalances? Will I be trusted? Why should I be trusted? I will not have the time to establish a trusting relationship as one would do in a therapeutic alliance. How much trust is enough for participants to feel comfortable to disclose their thoughts and feelings? I imagine they might 'side' me with the professionals with whom they have worked in the past, including their current Keyworker, which will be the subject of inquiry. How honest might they then be? How valid will the data then be? The information sheet is directed at explaining this objectivity and if one anticipates discomfort I would presume that they would simply decline to participate. I will of course try to reiterate my "objective" position (as in not siding with one's keyworker) when I meet with them face to face but even if there is a conscious understanding of this, the unconcious processes (transference) may present something different –eg: might I be admired? Seen as a teacher? Resented (eg seen as a competitor)? Protected in some way (eg seen as a daughter or younger sister?), the list could go on and on and on...

What if they have had negative experiences? What if they have felt judged, misunderstood? And me asking questions reminds them of this? Or are experiencing distress for a range of reasons. Of course I have considered safeguards (eg how to provide support and to ensure clinicians on hand in the services) but it is important that the interview is carried out in as comfortable a way as possible – that the service user feels respected, in control in deciding to continue or discontinue as he or she thinks is best. Ultimately as they have given their consent, I would hope and expect that participating in this interview interests them and they anticipate finding it rewarding. I do hope that they do indeed find it rewarding and I will try to build a good rapport with each participant and ensure that their experience is a positive one. However this will not prevent me from asking potentially uncomfortable questions because one might not initially be forthcoming with information about their experiences and it may be necessary to probe further to obtain a more in-depth understanding. Of course this will be done appropriately, gently, using sound clinical judgment – eg: tentative language whilst giving the participant the option of not disclosing further (that seemed like it meant something important to you.. I wonder if you wanted to say anything more about that...?).

2015.06.23 Reflections following the first interview

Interview with P1 "Simon": As advised by my supervisor, I asked whether we could use the interview as a pilot interview– he said all questions were straight forward and would not suggest any changes, which is great. I was a bit nervous, not too sure what to expect as this was the first time meeting this participant.
I have yet to transcribe this interview but what stood out for me was how he spoke about his keyworker in quite an idealised way and this relationship seemed largely built by his relationship outside of formal "keywork sessions", such as working on the Star. His relationship with his worker was described as "intimate". What seemed to create this was worker's self-disclosures about himself and informal, friendly, social conversations in different contexts, such as the living room whilst he is watching TV and making silly jokes (participant lives in supported living accommodation).

The participant seemed to especially value characteristics of the keyworker - particularly ways in which the two of them were alike (eg we both like the weather etc). He did mention appreciating his expertise, described him as "experienced" "[he] knows his stuff", although he could not really provide concrete examples, just a sense that he was knowledgeable and helpful.

He described his keyworker more like his friend beyond his professional role and that is what has helped him. Although when asked about the Star he said he also found this helpful – in particular in that it helps him to focus on recovery goals and likes to see himself progress although tends to get lower scores. He also described working with the Star as "heavy" in a mental not emotional sense and "challenging". Somehow the process of going through the Star with a worker allowed for more accurate reflections, enabled him to not only to act on things consciously but more so change his subconscious. I did try ask him to explain this further but perhaps should have tried more to see if he could specifically provide some concrete examples. I did try probe but at times it was difficult to follow his thought processes (eg he spoke of the Star having an "environment" that changed him on a subconscious level in ways he could not describe). I felt a bit uncomfortable and confused about some of these descriptions and didn't want to challenge his views but perhaps should have explored these better.

He spoke paradoxically about the Star facilitating self-judgment but in a positive way and working this through with his keyworker to be transformative in a way.
The whole interview seemed very positive – he could not say anything he did not like about the Star or about his keyworker. Maybe his experiences have just been positive but this seems extreme.
I wonder whether he felt I was hoping to hear this? Or did not want to criticise any element?

2015.06.23 Reflections following interviews 2&3 ("Eileen" & "Clive")Interview with P3 "Eileen": I found this interview a bit difficult. The participant was not very forthcoming, seemed a bit wary of me (understandably, I am an "outsider" who does not know her). I tried to build a rapport but time was limited and it felt like a struggle.

Nevertheless once the interview got going, what seemed to matter most to Eileen was not what her keyworker **does** but rather who she **is** – that is a "nice person". The things that she does which makes her "nice" are mostly the social activities out in the community. Also knowing the worker as a person – this knowing helps them to connect in the alliance. Perhaps Eileen not knowing me, kept her withdrawn a bit in the interview.

Eileen said she found the Star, helpful – particularly in that it helped her to "keep things on track", again this idea of "**focus**" and "**progressing**" towards something desirable (away from ill health towards improved wellbeing). But importantly what Eileen stressed was that her worker does the Star in a way where there is **no pressure** – she reiterated how she is **adverse to pressure** being put on her with regards to any type of activity her worker might bring up.

"Clive" also highlighted the personality of his keyworker over their professional skills. As a professional I feel a bit despondent / unappreciated in a way – "expertise" or "clinical" work does not seem to be as appreciated as other factors, what matters are "friend-like" qualities. Is this what matters? I think both have come out as important – the "helping" side that goes beyond friendship. But as a Clinical Psychologist my role would be more boundaried than what these service users would perhaps like and what they say matters to their recovery. Can I still be "friendly" "nice" " helpful"? There are constraints on this depending on which psychological model I would be using. I feel annoyed and frustrated. This probably has to do with my own needs for recognition and also to feel like what I do matters, **IS** helpful and valued (especially when so much investment is going into the training etc).

Clive did seem to struggle to concentrate a bit during the interview, and also expressed some descriptions that might be considered "psychotic thoughts" (eg in the relationship with his worker he feels he can "take over his personality").
I wonder how such thought processes/ perspectives/ difficulties are experienced in the alliance with the worker and the use of the Star?

Further subsequent reflections:
This came up in the interview with "Peter", who in contrast was very articulate and detailed in his descriptions of his alliance and work with the Star. Peter describes himself as a big fan of the Star – it similarly helps him to **progress** in his Recovery – by assessing / "**seeing**" where he is at and where he needs to get to in relation to recovery goals. It made me think of Eileen's description of keeping things on track – this idea of steering a course in the right direction. However Peter normalised this experience – saying the Star wasn't just for service users/ clients but for anybody – it helps with one's "Life Journey" not just "Recovery Journey". So for him it's not just about helping one to progress away from ill-health but towards a desired improvement/ wellness. Whilst Peter described the tool as "excellent" and could not fault it in anyway, he did say the Star might not be work for someone who's "less intelligent or less able to formulate or articulate their thoughts", implying it requires a certain level of cognitive ability/ aptitude. Both Clive and Simon expressed some difficulty with understanding the Star, needing a lot of worker support in completing it. However Clive spoke of how the worker tends to lead with the Star without really explaining it to him, so

the worker clearly also has a role in how the Star is understood. It was clear that in Peter's experience of using the Star he directed much of the action/input, took the lead in completing it, was highly engaged, which stood in contrast to Clive who described his worker taking the lead, with apparent minimal involvement from himself. Whilst Peter found that the tool could be done without the worker, he also said having the worker there, who is "empathic", understanding, made it more meaningful. Like Simon, there is this idea that feeling known helps with the Star and possibly highlights the importance of a trusting alliance outside of the Star.

2015.07.05 – initial coding

[following first 5 interviews and open coding of first 2 interviews]:

I think my initial open coding is too descriptive (a reported common mistake for those new to grounded theory according to Kelle, 2007) . I need to start coding transcripts on a more conceptual level (refer to Urquart as well as S&C for axial coding). Need to distinguish "conditions" under which the described interactions are evident – the most apparent here are the interpersonal processes evident outside of the Star compared to when using the Star.

Going through the initial open codes, have relabelled some of these linking them to "the Star-specific" versus "general alliance processes". Also developing focused codes at a higher level of abstraction:

"General Alliance Processes":

- Worker actions - provides high level of practical support (apparent high level of dependency on worker?)
- Worker actions – providing a social connection between client and worker (client receiving informal, "friendship-like" support, social activities in the community)
- Worker actions – providing emotional support (understanding, a listening ear for the client, as well as encouragement for the client to make behavioural changes)
- Worker "likeable" characteristics (nice personality, can "get on with", seeing the worker as a person not just a worker)
- Worker "highly esteemed" characteristics (described as professional, skilled, experienced, knowledgeable)

Applicable to both "general alliance processes" and "the Star processes"

- Client actions – client actively engaged in working on recovery goals
- Client characteristics - "difficulties" – (mental processes seen to underpin distress - "false beliefs/ vulnerability"; evidence of psychosis; seen to impede joint-working)
- Client characteristics – passivity? (allows worker to lead with the Star scores/ other work)
- Client experience of recovery – ongoing cycle of making progress and experiencing setbacks

Processes specific to using the Star:

- Variable ways and frequency of completing the Star (eg: every 6 months versus 2/3 months)
- Likes & Dislikes re the Star
    - Likes: sense of achievement from improved scores
    - Likes: the Star helps client to "**see**" to focus, to assess self and review progress
    - Likes: the Star is a challenge that can bring about positive change
    - Likes: Client describes the Star as enjoyable /interesting
    - Dislikes: the Star can be seen as difficult, hard work (language used in the Star is too complex?)
    - Dislikes: the Star is imposed – client opposed if pressurised into doing the Star, seen as a "have to", client prefers the "fun", social interactions with worker

Emerging hypotheses:

- **Ref: Worker "likeable" characteristics:**
    - The worker's perceived personal qualities matters most to clients (more so than what they **do**)?
        - What are these "personal qualities" in more concrete terms? (how might workers describe their experience of being liked – what helps this? Is this a conscious effort of actions or just "personality" that connects with a client?)
        - Does using the Star make the worker more or less likable in any way?

- **Ref: Client apparent difficulties (cognitive/mental health/other):**
    - The Star requires the client to have certain cognitive abilities or aptitudes, for it to have value for the client/alliance?
        - How do workers find such apparent difficulties when working on the Star/ how do they respond to this? [ie do such difficulties impact the alliance, particularly when working with the Star? If so, how?
        - Is this evident in other rehabilitation services (semi-supported as opposed to supported living, where clients would be considered to be higher functioning)?
- **Ref: the Star can be seen as difficult, hard work:**
    - Working on the Star impedes the alliance because it is seen as too difficult or hard work?
        - Is this evident in other rehabilitation services (semi-supported as opposed to supported living, where clients would be considered to be higher functioning)?

...

2015.07. 08: Revisiting SU's descriptions of their relationships with keyworkers & hypothesis above, I need to hear how keyworkers describe their relationship. When I first submitted the proposal for this project I had spoken with my supervisor about interviewing both clients and staff but after numerous discussions it was agreed that I should focus on client's views because trying to do both would likely be spreading it thin and the aims of my research really are to capture in-depth service user views. However now that I have interviewed clients, I think staff views would be very valuable.

GT methods require a range of perspectives from different angles (part of theoretical sampling). I would like to interview some workers to hear their views on working with the Star and how this informs their relationship with clients. Interviewing staff would help explore the emerging hypothesis, develop the properties of the emerging codes/categories, whether they experience something similar/different in their work with clients. How might this impact on their alliance? Work with the Star?

2015.07. 09: Discussed the above with my supervisor. This was really helpful. At first I had been feeling despondent about some of the interviews – ie where there was difficulty of client expression of their experiences and how to elicit this but she affirmed this was valuable information in and of itself, possibly reflecting elements of the interpersonal dynamic evident in their working alliances.

I will need to go back to the ethics committee to obtain approval for asking staff to participate in this study. Also clarified that I need to ensure the aims of the study remain focused – that is how client's experience work with the Star and their alliance. Therefore the interview schedule has been minimally amended –focus remains on their views regarding clients' experiences of the alliance when using the Star.

...

[2015.08.03]

I have coded 3 further transcripts now and reviewed some of my initial "focused codes". Further hypotheses:

- **Ref: MHRS provides a helpful perspective, focus:**
    - Working with worker on the Star helps client to channel thoughts that otherwise run awry?
        - One client spoke of the Star making him feel safe, others speak of 'focusing'. Is there something here about the Star being able to provide a frame? Is it the content of the Star or the worker that facilitates this focus?

- **Ref: MHRS seen as limited/restrictive**
    - Clients may feel restricted by the MHRS, their experiences may not fit with what the tool is asking of them.

- **Ref: Social connection between client and worker (client receiving informal, social support)**
    - Work with the MHRS creates formality in the alliance that works against the more informal/ social type interactions that clients seem to value?
        - Clients consistently highlight the social/informal type of interactions with their worker as highly important (going for coffee/ outings / just having chats etc). This also extends to workers being seen beyond their professional role, the client knowing about their personal life/ feeling like they're connecting to the person not "work persona" as one client put it.
        - What is the worker's view of this? This seems to stand in contrast to the formality of the Star - How does this relate (if at all to using MHRS)?

...

Ideally would have interviewed staff before interviewing more clients but did not know how long it would take before ethics approved staff so interviewed more clients in the meantime – that is from a different service though, ie NHS semi-supported living.

2015.08.16: *Reflections following interviews with "Will" & "Keith":*

I was disappointed with these two interviews. These two clients not recall much about their use of the MHRS. Listening again to the interviews, they do appear to have cognitive difficulties ("Will" in particular really struggled to understand my questions), even though neither of the participants officially have a diagnosis of a learning disability. Anecdotal discussion with their keyworker suggests they do have a level of cognitive impairment related to mental health difficulties, including use of anti-psychotic medication. "Will" struggled not to be distracted, expressed psychotic beliefs and anxieties, seeking reassurance from me. I found it difficult not to switch into therapy mode, but also not to dismiss his feelings whilst staying on the subject. Made me think that trying to steer a balance between being directive (sticking to the interview schedule) but not too directive (dismissing his thoughts and feelings that seem unrelated) is probably a difficult balance for workers when doing the MHRS with workers.

...

Feedback from supervisor following her independent coding of transcript 1 and review of extracts from first five interviews: I feel very reassured that my supervisor's "conceptualising" of the data is very much in line with mine. We discussed further hypothesis that appears to be emerging from the data thus far:

- the MHRS helps client move towards valued goals (in the everyday interactions they have with the keyworker).
- Keyworkers keep goals in mind, even when clients might not remember or actively work on goals in between sessions
- A positive experience of using the MHRS requires trust in the alliance – client seems to trust worker's perspectives of themselves and are encouraged by their input.

- Building a close alliance outside of the alliance, the client feeling "known", by the worker largely depends on the informal/social type interactions, which seems to overlap with the emotional support that the worker gives the client.

2015.09.15

I have completed my first interview with staff ("Jennifer") - a psychologist from the NHS inpatient rehab service [I had wanted to first interview staff from the supported living rehab service but they are still getting back to me..]
I found this really helpful and insightful as she drew from experience across two different settings (compared her experience in this service with that in a secondary care CMHT where clients presented with far fewer functioning difficulties).

She was really able to help validate some of the hypothesis that I had formed following the initial coding of the interviews with clients – in particular that client cognitive difficulties might negatively impact on developing a shared understanding in the alliance when working on the MHRS in particular. She did indeed confirm that clients in such rehab settings often present with cognitive difficulties, not too dissimilar to those with a learning disability. This might be related to something organic that was never diagnosed, mental health, or linked to medication. However she also raised a vital issue here – that is that staff should be able to be more flexible, to adjust the MHRS to compensate for client difficulties. Interestingly, she referred to the LD Star, like me she has worked with this in past roles and feels this would be a more suitable version for clients in this setting. However she pointed out that there are restrictions now in terms of licensing, and the Trust won't pay for use of different versions of the Star so she can't use this Star with these clients. Nevertheless one way in which staff in this service (inpatient unit) have tried to use the MHRS in a more flexible way with clients is to do a group every 2 weeks where they look at just one ladder of the Star at a time and have group discussions about it. They still use the MHRS in the more standard way – that is each client's keyworker, as well as the rest of the MDT, completes the Star with the client in a one-to-one session outside of the group. However during the group they (she and a co-facilitator) also work individually with clients and help them to rate themselves on that particular ladder and consider possible goals to work on.

Hypothesis that have emerged from this interview that I would like to follow up with from clients in this inpatient unit are:

- The flexible use of the MHRS in the group might help the client's experience of engaging with the MHRS and/ or their worker.
    - Is the group work with the MHRS more or less helpful in building the alliance in anyway?

As part of the theoretical sampling, I have asked this worker to refer me to potential participants who partake in the group who might be willing and able to discuss their experiences with me.

....

2015.09.24

I have completed 3 more interviews with one service manager "Sarah" from the supported living rehab service, who had also been a keyworker in semi-supported and supported living services and two female workers from the supported living service. These were selected because of their diverse ages, races, professional backgrounds and experiences in using the Star – "Miriam" really liked using the MHRS and found it very helpful with clients, "Sarah" and "Olive" were more mixed in their views – "Sarah" in particular, whilst acknowledging some benefits to using the Star, overall did not like using the MHRS. (There was one male but he had declined participation).

Despite the diversity in demographics of this sample, characteristics pertaining to age, gender and race have not emerged as a relevant variables in the alliance & work with the Star (although "Sarah" did say that at first some clients, when hearing her young age, had questioned her credibility in being able to manage the service but when they got to know her this quickly did not become an issue and if anything, what seemed to matter more to clients was the fact that she had a masters degree (rather than her age), which links in with this idea of worker's being seen as "**knowledgeable/ skilled / experienced**" and this helping the alliance. Other studies have explored whether certain sociodemographic variables are relevant in the alliance (more so with race than other factors), but this hasn't emerged as relevant code/category in my study. I think it is because it has not been the focus of my study (I have not explicitly focused on exploring the impact of this for clients), rather the focus is on the alliance within the use of the MHRS. Furthermore it is difficult to see how such sociodemographic variables would specifically relate to work using the MHRS.

... *[in the meantime working on Part A]*

2015.10-11: Theoretical sensitivity – working on Part A: Background reading on the alliance has increased my sensitivity towards both common and contrasting elements concerning the alliance across contexts. Now that my focus is on case management, I am coming across papers which resonate with the data collection I have done myself, which is reassuring - for example the uniqueness of the alliance in this context, very much unlike other contexts (psychotherapy or generic mental health services). My experience of my interviews with clients is making more sense to me – in particular how at the start I was not finding what other papers had reported on the alliance – for example articulated views of the empathy of a mental health practitioner and how one felt understood or had their personhood acknowledged and respected. Some of my participants seemed more difficult to engage, less forthcoming with descriptions, seemed to have difficulty expressing themselves and described their experiences in ways that were at times difficult to understand (for example the 'environment' of the MHRS and how this undercurrent influences other areas like 'smoking') as well as reflection of psychosis (such as beliefs about one being rich and famous). Now that I am coming across research that has been carried out particularly within case management, I am appreciating the role of the CM in meeting those with more severe difficulties and how this informs the uniqueness of the CM relationship.

Within this context there are more examples in the literature of using more controlling or even coercive measures (eg payeeship arrangements), perhaps due to the greater severity

of difficulty among those in CM treatment – their needs may be greater (including the need for others to manage their risks) so the input and support from the worker may be greater; however how does this sit with the recovery literature on the importance of "empowerment"?

2015.12.04: Ref collaborative working/ social connection in the alliance

In class today we looked at the quote from Philosopher and journalist, Albert Camus: " Don't walk behind me; I may not lead. Don't walk in front of me; I may not follow. Just walk beside me and be my friend." Initially I liked this quote and thought how apt it perhaps was for what has emerged from my data analysis, especially in relation to the construct of the "social connection" in the alliance – connecting on a social level, having informal, friendship-like interactions, going out in the community in informal/social settings(coffee shops, walks etc) and how meaningful this is for clients. Is this 'collaboration'? Walking beside the client? The more I reflected on this quote the more critical I became of it. What about professional boundaries that guard against "friendship-like" dynamics?

A friendship-like dynamic seems like a humble position and I like that - power equality, care-focused approach that considers an equal personhood of both parties beyond the titles of "worker" and "client", the "well" and the "not well" . Rather a client being seen for the full person that they are [**a holistic perspective of client beyond their diagnosis**]. But what of the mutuality of this? What of the worker's personhood? Should this be exposed? Clients in my study have spoken about how they like workers who do not present with a "work persona" who they get to know – knowing about their personal life, families, mutual interests etc, this helps them to connect to the worker. I like the idea of a more balance of power but what of professional boundaries? A worker cannot be a client's friend because that is not honest/sustainable and will lead to disappointment/possible damage (ref Klockmo paper).

Just because the relationship is more one-way (focused on the client's needs and getting to know them in a more holistic sense without reciprocating this process) does not mean that there is an exploitation of power. Going back to the quote, I think workers do need to lead in a way. When workers use the MHRS they are leading, being directive. Clients have expressed how helpful this is – it helps them to 'focus' to 'progress' in ways that they wouldn't do otherwise. Perhaps such leadership is a good thing. It does not have to mean dominance or dependence or sabotaging a client's autonomy?

2015.12.11: Further coding of interviews with staff etc: I am continuously reorganising and redefining my codes (collapsing certain codes by condensing these and converting previous codes into "properties" of higher order codes (refer to table summary of focused codes & categories etc.). This reorganising of my codes etc has helped in revisiting some of the earlier hypothesis and discarding or clarifying these:

- Going back to some of my earlier hypothesis: *Ref: Worker "likeable" characteristics:*
    - *The worker's perceived personal qualities matters most to clients (more so than what they **do**)?*

  Service manager and keyworker "Sarah" spoke of how clients in her service were given the opportunity of choosing their keyworker - clients had known these workers as generic support workers in the supported living rehab service already

and when they introduced a keyworking system (including an assigned keyworker to work on the MHRS with the client as well as all other responsibilities), clients were asked to select their preferred worker. Sarah said that different clients mostly chose different keyworkers – just people "they get on with" which again emphasises the importance of this "social connection" and perhaps individually perceived likeability of the worker. Having said that she did acknowledge that the fundamentals were important – being trustworthy, non-judgmental and empathic (links to providing "**worker providing emotional support**"). Furthermore with regards to her personal experience, being young at first had raised some preconceived ideas about her competence but she said that when clients knew she had a Masters degree this seemed to dispel such preconceived ideas (links to "**being perceived as knowledgeable/ experienced/ skilled**). On the other hand the other two keyworkers interviewed did not have such qualifications but similarly pointed out the importance of being good at their job, where there was a focus on **motivating clients and being patient** with their setbacks. Both "Miriam" and "Olive" saw this as the crux of their role – helping clients with the practicalities of everyday functioning skills (personal care, shopping, cooking, laundry etc), which they said required a lot of encouragement from them. "Miriam" also said she asks clients to tell her if she is not doing a good job, again stressing the importance of being seen as **competent/skilled**. Both Miriam and Olive spoke of how they very much kept the MHRS in mind in between "formal sessions" even when they did not communicate this to the client so as not to put them under pressure. Miriam gave examples of goals she had set and then worked on with clients – it was clear that she herself felt very motivated when she was able to notice and record client progress in a goal (eg: client getting on a train by himself to town and back and how she broke this down into little steps) [**motivation towards improved wellbeing**]. Olive in particular, spoke of trying to make the MHRS as informal as possible, and doing it in stages – key strategies to help motivate clients to do it. Olive also highlighted processes that might **hinder** such motivation – in particular client's frequent setbacks and limitations.

Sarah also noted this, highlighting how staff feel under pressure to see progress on the MHRS and when clients don't show such progress it can be discouraging for both workers and clients. She also pointed out further **hindrances to the alliance** – in particular frequent disagreements [**/conflicting perspectives**] between workers and staff about their MHRS scores (clients tending to score themselves at either extremes) and how having to disagree about these could damage the alliance. The interviews with clients thus far have mostly suggested the MHRS facilitates a process of negotiating new or shared perspectives (common example is workers pointing out to clients areas in which they have made progress or examples reminding clients of the positives in their life that suggest their MHRS scores should be higher. Another example, also commonly seen is workers offering a more "accurate" perspective where a client might overrate themselves identifying areas to work on, and clients appreciating this assistance).

Sarah pointed out how client "lack of insight" [**cognitive/other difficulties**], is a major hindrance, resulting in the staff team completing alternative "accurate"

versions of the MHRS on their behalf. I felt a bit uncomfortable about this, especially given some of my participants' descriptions about their experience (eg Peter reiterating that staff should not and do not lead with the MHRS, it is the client's tool). It felt as though the client's voice was being silenced. But the examples Sarah provided evidently presented ethical dilemmas –eg a client with "grandiose psychotic beliefs" about herself and not accepting she has a mental health problem so refusing to engage with a tool like the MHRS [reflecting this idea of "**conflicting perspective**" regardless of the reason behind this]. Workers need to provide a care plan and care for this client (MHRS is the means by which they do this in this service) but when a client does not "have insight" into their need for care this is difficult.

Further reflections on earlier hypothesis:

- With regards to the idea of *The worker's perceived personal qualities matters most to clients (more so than what they **do**).* Even though the "likeability" aspect is important, the role of the worker is very much "hands on" and being good at being able to provide a full range of support (social as well as practical) is very important. Indeed, this **does** also resonate with what clients have described – "getting on" with the worker involves liking and connecting socially, but this also seems to involve getting "on with....." helping in practical matters and being seen as experienced/ knowledgeable and trustworthy.
- With regards to the hypothesis of the **MHRS being perceived as difficult and burdensome**, this does appear to be the case, requiring motivation and encouragement from the workers. To this end "Sarah" (who does not particularly like the MHRS, even though she acknowledged numerous benefits) also pointed out how staff (not just clients) can find the MHRS difficult, taxing, burdensome, which also resonates with what "Jennifer" from the in-patient unit said – that staff in the service were very stretched and the MHRS takes significant time to complete which puts staff under pressure. Overall though Jennifer strongly supports the use of the MHRS, in particular in that it **allows a more holistic view of the client** and enables workers to see the client from fresh perspectives.
- Both Jennifer and Miriam (as well as Olive but to a lesser degree) spoke of how the MHRS helped the client to identify and progress towards a desired recovery goal [also reiterates how the **MHRS helps facilitate a helpful perspective, focus**]. This idea of MHRS helping clients to **focus** goes beyond clients liking structure, it highlights the importance of "taming thinking", having distractions filtered out. I have a greater appreciation for this after revisiting transcript with "Will" for example which I had found quite difficult – it seemed difficult for him to focus during the interview, easily distracted and seemed to struggle staying with a single line of thought. Key properties of "MHRS helping client to focus" includes not just the *content* of what the client and worker can focus on (although focusing on recovery goal is helpful here) but also the *process* of focusing – filtering out distractions, offers a helpful perspective, seems to help improved wellbeing.

...

2015.12.18-29: Reflections & coding of interviews with "Jake" and "Rob" from the inpatient rehab unit:
Interestingly for both of these clients the "group format" seemed to make little difference to their experience of their alliance with a worker when using the tool. Perhaps because the tool is used as an outcome measure, completed outside of the group every 3-6 months anyway, to inform their care plans and feed into CPA meetings. So as is the case in [*3rd sector supported living rehab service*] two versions are kept - the one completed during the group is used to help complete the "official" one used as the outcome measure but the latter is completed mostly by the MDT, including the keyworker, where client involvement or participation appears not to be prioritised (reflecting this idea of a "**lack of client voice/participation/involvement**"). Also during the biweekly group, the facilitators (one of whom was "Rob's" keyworker), also work individually with each client in a one-to-one setting to help them complete one ladder of the Star and to think about goals to work on with their keyworker. Instead of the group format having an impact on their experience of the alliance when using the MHRS, what seemed to be relevant factors for these clients are what previous clients have already highlighted. No new concepts seemed to arise.
For "Jake" who was favourable towards the MHRS, elements which he found particularly helpful were it helping him to "**focus**", "**assess his progress towards desired goals**" - he described it as an "MOT on his brain". This resonates with what Eileen had said earlier about keeping things on track (interestingly another type of "travel metaphor", this idea of **recovery being a journey**).

In contrast "Rob" did not like the MHRS, he clearly **felt a lot of pressure** associated with it – saying what he did not like was being told where to go and when (for the group) and then being "marked", even though he had a very good working alliance with his keyworker. He spoke of her like a younger sister and contrasted his experience of being in the group (where he felt restricted) with the more social elements of the relationship – in particular the social outings to the cinema and going for coffee just for a chat etc. The **formality of the MHRS** was a clear hindrance for him in his experience of the alliance.

Ref "fixed conflicting perspectives": Like staff and some of the other client participants, Jake too spoke of having views /opinions/ perspectives about himself and reality that conflicted with staff's views. Previous clients have spoken about this in the context of the MHRS and how they trust the worker's view of themselves, seeing their ratings as more "accurate" and taking their views on board (eg "Simon") (hence "**negotiating new perspectives**"). Having a worker "**offer new perspectives**" seems to include "**challenging thoughts**" (as one might do in CBT) for instance in offering evidence of a client's functioning to justify ratings on the MHRS – eg: progress in certain areas to identify strengths etc or difficulties that the client might not want to acknowledge. However it also seems to go beyond this - worker seems to **offer a reflection of "reality", that is trusted** and valued by the client, especially by those who acknowledge (have insight into) their cognitive difficulties, not necessarily trusting their own perspectives/judgments.
However where staff spoke of clients not having insight into their difficulties there was more of a position of "**fixed conflicting perspectives**" eg disagreements about the MHRS which could hinder alliance-building processes. Jake spoke of having conflicting perspectives with staff resulting in a stuck "**oppositional**" position.

Possible distinction between:

- 1) a client and/ worker acknowledging that they and their worker hold different views about where they are at in terms of their recovery as reflected in the ratings on the MHRS, and agreeing to negotiate a new perspective (linked to "**worker seen as trustworthy**" , "**negotiating scores**", and "**worker and MHRS offer client a different perspective of self**")

AND

- 2) Clients and workers holding **fixed conflicting perspectives** that prevent a sense of shared working - 2 "stuck" positions where negotiating does not seem possible. Examples include a client's psychotic beliefs / workers describing clients as being in denial because they rate themselves at the extreme ends on the MHRS, refusing to acknowledge difficulties they might have. This seems to linked to "oppositional position/ disengaged from working together).

2016.01.04: Reviewing emerging categories - **Where to draw the line within and between categories?**

I am reviewing my table of list of codes, trying to distinguish between some of their properties (where these overlap, condensing these into single codes), reworking the table of emerging subcategories & categories.

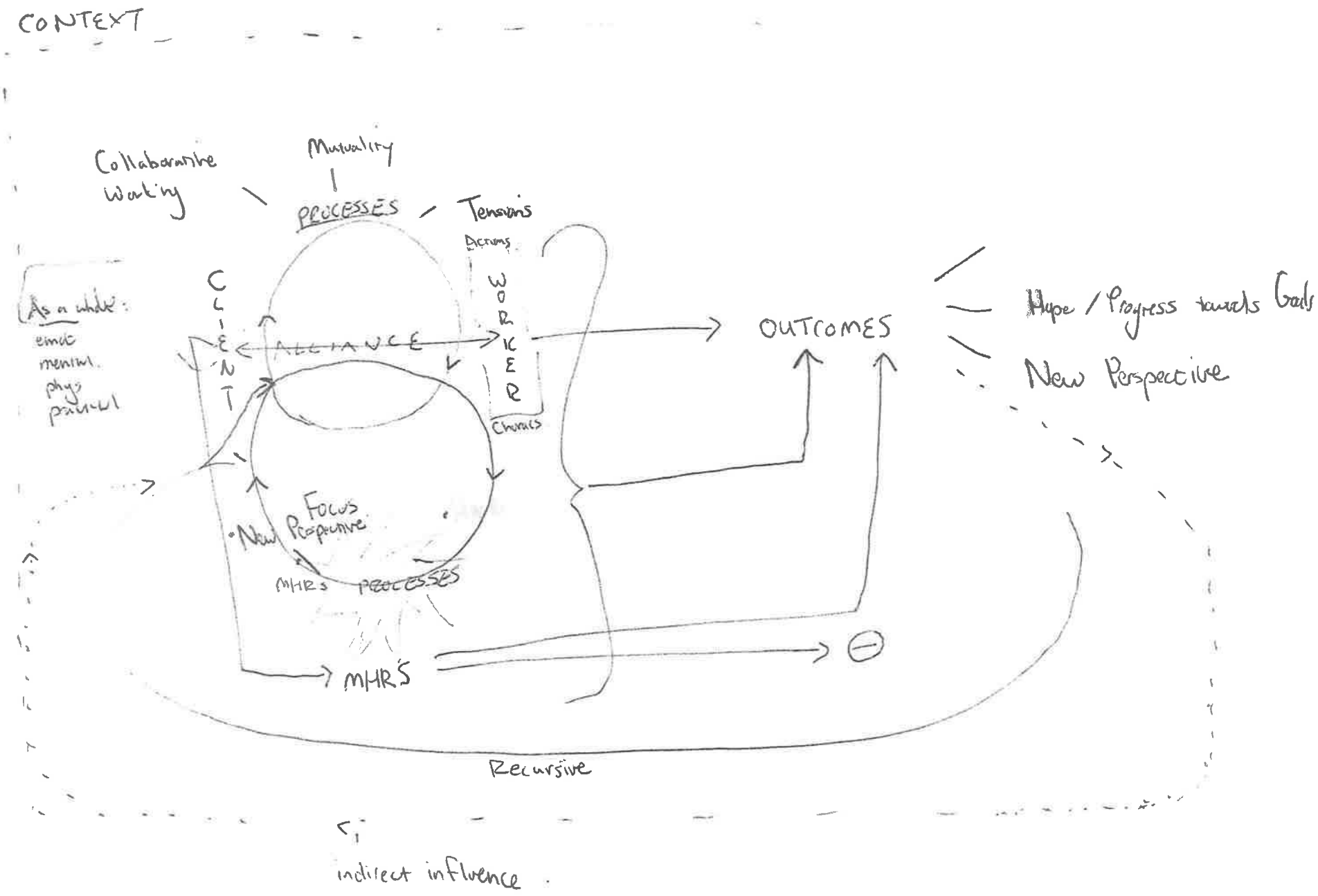
A difficulty I am having with the 'constant comparison' method is trying to compare the properties and dimensions of codes related to "MHRS processes" distinct from "General Alliance Processes" that are involved in the alliance and in recovery. Initially I had separated them but they really do overlap which is no surprise given that the MHRS is in fact designed to be a collaborative recovery tool used between a keyworker and client.

I have identified dominant processes that pertain to both (eg: Client demonstrating an active position in engaging in collaborative working with worker; Client and worker accepting setbacks in the ongoing work of recovery) versus processes that are more distinct/exclusive to either "MHRS" or "General Alliance Processes".

With regards to "**MHRS-specific processes**", key examples include: MHRS facilitating a helpful perspective, helping client to focus; client being motivated in being able to see progress they have made towards recovery goals on MHRS.

With regards to "**General Alliance Processes**", key examples include: Client receiving a range of practical support from the worker; building a social connection with the worker- a key example is how "**MHRS formal structure / MHRS being perceived as hardwork/ burdensome**" seems at odds with the "**friendship-like**" dynamic; also the MHRS is all about the client, in contrast to the more "**shared interests**"/ "**mutuality with the worker**" reflected in the "**social connection**" that seems prevalent outside of this dynamic. (refer to sketches distinguishing some of these processes and areas of overlap to inform the model that will be produced..)

CONTEXT
- practicalities of completing the (H)MIL
- How it is used in the setting - different professionals use it differently


CONTEXT
Collaborative Working
Mutuality
PROCESSES
Tensions
Across
As a whole:
emot
mental
phys
psych
CLIENT
ALLIANCE
WORKER
Chorals
OUTCOMES
Hope / Progress towards Goals
New Perspective
New Focus Perspective
MHRS
processes
MHRS
Recursive
indirect influence

2016.01.08 **Reflections on "Motivation and hope towards improved wellbeing" & "Recovery as an ongoing journey"**

On placement at the moment I have a client I saw this week – presents with suicidal ideation with a history of numerous overdoses before being admitted onto to the neurorehab ward (after injury has left her in a wheelchair) - she is understandably really struggling at the moment and having difficulty engaging with other therapies, not motivated at all - history of hopelessness (numerous suicide attempts) and now presents with even greater hopelessness.... With regards to the MRP, I thought about the importance of client experience of motivation & hope in relation to the potential to progress towards a recovery goal that has come up in the interviews – particularly evidenced when using the MHRS. No clients spoke of having achieved the ultimate positive outcome: "10 out of 10" on their MHRS rather they were working towards some incremental improvement on these scales and could "see" their progress and this gave them hope and motivation. Just having something to aim towards on the MHRS, promise – perhaps hope is an outcome in and of itself.

2016.01.15-24.Ref: collaborative working - what about client factors?

Further comparing table of codes, subcategories, etc.., why had I hoped/expected to see more "client factors" emerge from my data? Focus is on worker, their helpful characteristics – providing practical, emotional and social support in helping the client with a full range of activities; providing encouragement and motivation despite setbacks [under "**motivation towards improved wellbeing**"], offering **new**, helpful **perspectives** particularly with the use of the MHRS .

But what of the client's actions/ characteristics? As I am doing my part A, I am noticing numerous studies that have sought to identify client factors that have been associated with a positive alliance – they tend to be focused on sociodemographic factors. These mostly suggest there are no clear consistent indicators (bar one study, Draine & Solomon, which suggests older age may help a stronger alliance). Such studies were completed within positivist epistemological (quantitative frameworks). Mine is qualitative and other qualitative studies similarly have not identified clear client factors that may underpin the alliance. I had been hoping some would emerge from my study – possibly because the results may then seem more balanced and reflect "recovery – based principles" (clients taking responsibility for their recovery, exercising agency etc.) I have gone back to the data and found incidents of this, which is important as it is a key component of "collaborative working" (**client participation / client exercising agency/ taking an active role**) .

Nevertheless client's description of the alliance and experience of working with the MHRS with their worker suggests the worker directs or leads much of the work – is this really "collaborative working"? Where is the distinction between collaborative working and compliance/ co-operation?

Not sure where the following codes/properties fit: "depending on the worker"; "worker taking the leading", "away from power-sharing", "worker completing MHRS with little client involvement" etc. On the one hand I want to put these down as the **opposite** of collaborative working, "**hindrances to collaborative working**".

In my work on Part A a similar (perhaps) concept that comes close is "paternalism" and a related concept "beneficial coercion" (ie workers saying to clients "this may seem controlling but it's for your own good", which ties into the literature on "therapeutic limit setting" and how clients seem somewhat ambivalent–finding some of it helpful (especially

money management) but it also creating conflict in the alliance (cf Angell et al., 2007 & Dixon et al., 1999 & Neilee & Rosenkeck, 2000).
How are these different to what the participants in my study are describing? They are all in some level of supported living accommodation, which by its very nature involves a level of "dependence" on the worker and clients value this, in particular assistance with ADL's. This too then extends to the work with the MHRS, clients have reported liking the support that workers provide, including the worker's perspective on the 'rating'/ score and what goals they should work on etc. This is expressed in phrases such as "they tell me where I'm at" (score on the MHRS).
But there are also examples of workers completing the MHRS as an outcome measure apart from the client or with minimal client involvement. Both the inpatient unit and supported living third sector rehab service included 2 versions – ie one MHRS completed by both the client and worker where the worker "lets" the client put down scores etc whilst disagreeing with it (eg client gives high ratings for everything). The worker may try to challenge this but if a client maintains that that is how they want to fill the MHRS in then they are "allowed" to do it; however staff then will meet, in some cases without the client, and complete a separate one with what they see as more "realistic" and keep both records on file. This is captured under the category of "**fixed conflicting perspectives**" but what I am still struggling with is how this fits with "collaborative working"?

What seems to be coming to the fore is this idea of a degree of "dependence " (seen in worker providing full range of support – especially practical but also emotion and social) that does indeed reflect a power imbalance or "paternalism". However clients want/need this. Where they are open to and participate in such processes, perhaps reflects a different type of "collaborative working" because it's not being done "to" them as such, they are wanting/ requesting this type of assistance, even though the worker's role still seems quite dominant. However when this crosses over into something being done "to" them (such as feeling pressured into doing the MHRS), there is a lack of ownership/agency/ client decision making. The latter has not necessarily been described as something negative, (unless clients have explicitly said they feel pressured into doing it); however, being conscious of recovery literature etc, I do notice that this seems to stand in contrast with the idea of "empowerment/ power-sharing etc". It would be "neater" to say that this "paternalistic" dynamic disrupts the alliance (the literature puts this as the polar opposite of "client autonomy"). However this does not seem to be the case. Perhaps client autonomy exists as a separate dimension to "paternalism/ dependence" (which does not seem to fit the idea of a single continuum of independence/autonomy at the one end and dependence/ paternalism on the other). These clients are simultaneously/ paradoxically working towards "independence" whilst having to depend on their workers. And we see this in their every day activities (supporter/ semi-supported living) as well as work with the MHRS. Both need to coexist. And perhaps this coexisting of autonomy and dependence is indeed "collaborative". Just because clients may depend on workers in certain ways does not mean that they are not "working together".
To this end the following distinctions seem more fitting with the data:

Client demonstrating an active role in the alliance (exercises agency, decision-making, including work on the MHRS) – forms part of "collaborative working" with worker.

Client being open to and receptive of worker's input/support (involves clients agreeing to, valuing, or requesting worker input /decision making, including valuing worker perspective and help with MHRS) – forms part of "collaborative working" with worker

Client passive compliance (client may not request or seek out help but is cooperative to work that is directed by the worker/service. Client is seen to have a lack of participation / initiating involvement but also lack of resistance. Work here is seen to be done "to" the client but in an agreeable way, includes MHRS used as an outcome measure competed by MDT only) – seen to hinder "collaborative working"

Client adopts an "oppositional" position to worker (worker seen to dominate in a way where client appears disengaged from the process, work here is seen to be done "to" the client but in a more disagreeable way, particularly seen where client feels pressurised into doing something, including the MHRS) – seen to hinder "collaborative working"

2016.01.29: Ref: theoretical model of grounded theory

I have drawn numerous (messy) sketches of "links between" the main codes, subcategories etc.. What is my core category? Starting to think about how my theory is going to come together. Referring back to Strauss & Corbin, 1990 – when refining the theory:

- Drop bits that don't fit/aren't well developed
- Go back and compare model with raw data –does it explain most cases?
- Present it to participants and ask for their feedback

*Going back to the raw date...***Ref: Links between "collaborative working", "negotiation new/shared perspectives", "motivation towards recovery":**
Reviewed the codes, particularly those relating to 'negotiating new/shared perspectives' whilst comparing data from interview with "Sarah" (worker) and "Jake"(client in inpatient unit). I can see why 'fixed conflicting perspectives' can cause frustration for worker and client – for worker, not just hoping client has insight, acknowledges need for change and is motivated to make efforts towards recovery goals (which clearly has come out in the interview) but having a different worldview altogether –eg are workers' trained/experienced in how to respond to clients' apparent psychotic beliefs? I can see why a client might adopt an "oppositional" position where a worker disagrees with them and tries to lead where the client does not want to follow. "Collaborative working" is clearly fed by being able to negotiate new/shared perspectives.
Similarly, developing "new/shared perspectives", particularly aided by the MHRS seems to feed into the process of "being motivated towards improved wellbeing", particularly in terms of workers challenging negative views of themselves, pointing out progress they have made and them recording this on the MHRS helps them to feel encouraged/ hopeful/ towards improved wellbeing.

Ref: "**Hindrances to motivation - MHRS seen as limited/restrictive/peripheral**".
Going back to the transcripts more detail was required regarding what staff and clients dislike about the MHRS. Is "**difficult**" the same as "**burdensome**"? The MHRS brings in a formality that is felt to be burdensome ("it's a lot", resulting in often just one or two

sections being covered in a session) or it is seen as "**difficult**" (descriptors are difficult to understand/ difficult to apply). But might this also relate to the client's cognitive difficulties? I went back to the transcripts, highlighting where staff themselves report seeing the MHRS as difficult. This is linked with the idea of clients acknowledging their need for and appreciation of help with the MHRS from the worker. How is this then related to the code "**client does not remember much about using the MHRS**"? I have put this under "MHRS **seems to play a peripheral role in the client's alliance or experience**". But then think this also captures the idea that "**MHRS is seen as limited/ restrictive**" – that is where a client's experience seems not to "fit" with the MHRS – this was said in relation to the ladders (eg "Jake's" "spiritual" view of the world that also seemed to reflect psychotic beliefs that he said could not be captured by the MHRS). This is linked to the code of "**conflicting perspectives**". So again there are these overlaps. Going back to the transcripts, these need to be separated out:

MHRS being seen as "**peripheral**" (properties: MHRS does not play a big role in the alliance; client does not engage much with it; client seems disinterested in it; client does not remember much using it; staff don't have the time or interest in using it or see it as a box ticking exercise)

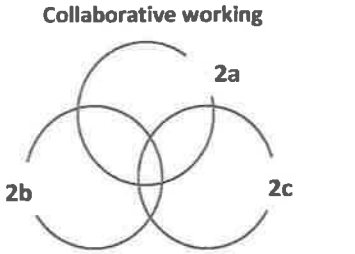
MHRS being seen as "**burdensome**" (properties: descriptions of staff and workers finding it difficult to understand and **difficult** to apply; completing the MHRS being described as **taxing** – ie time-consuming/ too much hard work; a formality that clients do not like). Although one participant ("Simon") in particular described the "heaviness" of the MHRS as being a positive – that is challenging, and because of it being challenging it is seen as having a positive influence. This has been captured under the "**MHRS has a positive indirect influence on progress toward recovery goals/improved wellbeing**".

Both of these (MHRS being seen as limited/ restrictive and MHRS being seen as peripheral) are seen to stand in contrast to / hinder the process of "**motivation in working on the MHRS**".

...

Theoretical model conceptualising the Grounded Theory

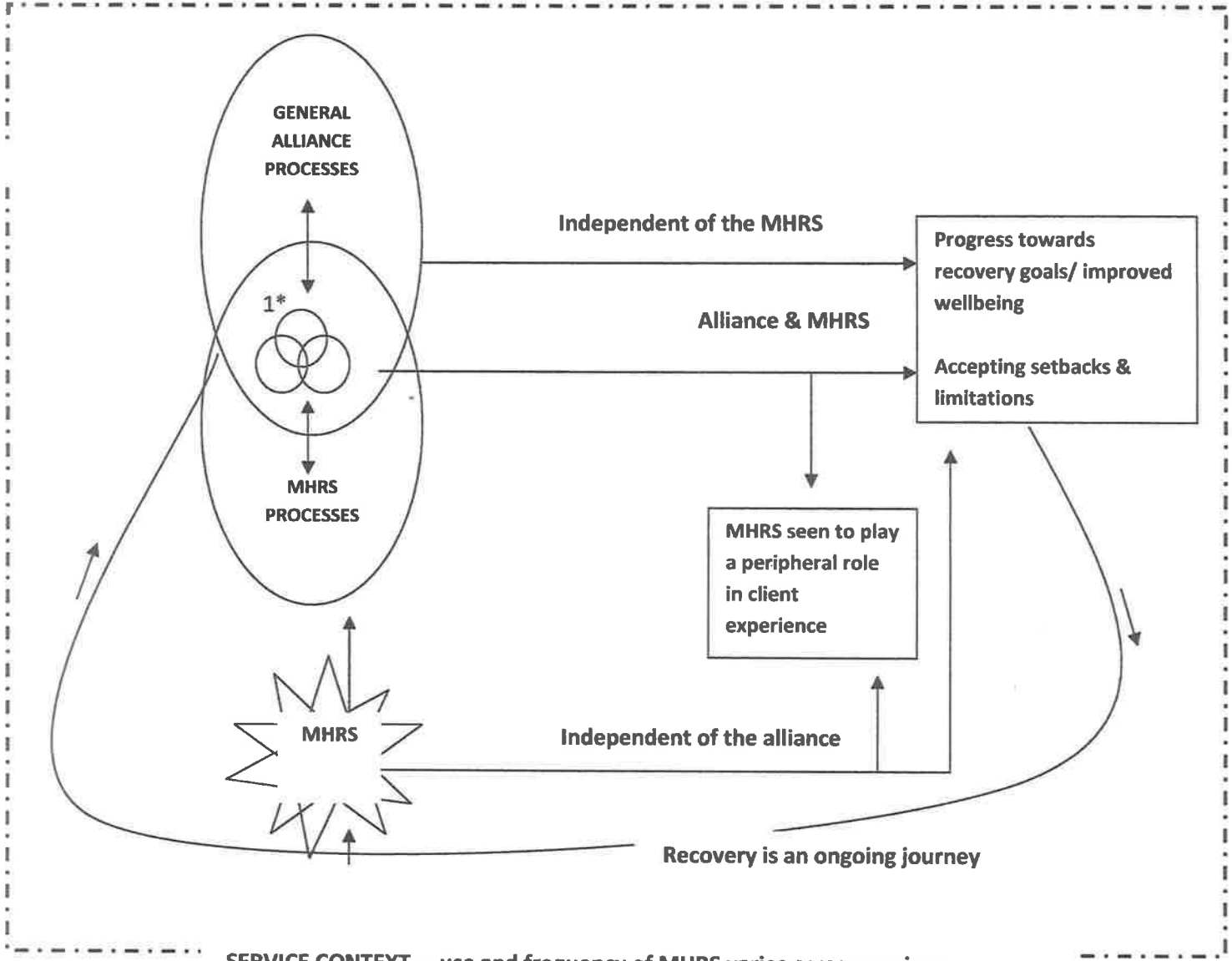
1*Engaged in working together towards improved wellbeing



2a) Hindrances to collaborative working

2b) Hindrances to negotiating new /shared perspectives

2c) Hindrances to being motivated



2016.03.03: Ref Validation from participants

I have received feedback from 2 staff and 2 participants regarding the grounded theory model – they have all been really positive, saying that the diagram and table captures their experiences well. Client ("Peter") reviewed the summary report himself whilst "Simon" did so with the assistance of his keyworker.

Examples of some of the feedback:

> *"this looks like an interesting analysis highlighting a lot of themes" ("Jennifer", worker)*
>
> *"It makes sense. Recovery is a journey rather than a destination. In my experience staff do not lead in the process. There is that understanding between staff and client. I like the Recovery Star because it begins where one is at not where one would be...I have found it very helpful in my journey towards wellbeing" ("Peter", client)*
>
> *"I think the summary fits very well with my own experience, and also that of my staff. It is clearly explained. I don't have much to add really because the summary really resonated with my views!*
> *... I think there is a lot we could take away from it so I would really like to share it with both of my teams." ("Sarah", worker)*

It feels very reassuring and encouraging to have the views of participants reflected back to me. It has highlighted to me again the importance of "interpersonal processes" and "conversation" in what we understand to be the "meaning" of something, which seems to apply regardless of what journey we might be on (eg: recovery towards improved health/ completing a research project). I have sought to capture, describe, and explain such interpersonal processes through interpersonal processes (not without its limitations!) and appreciate that the conversation continues ...

Appendix 19: Table of categories and codes with quotation examples

Core category	Categories	Subcategories	Focused codes
Engaged in working together towards improved wellbeing	Collaborative working - in the alliance in general and with the MHRS (input from both client and worker in connecting and working towards agreed needs or goals)	Collaborative working in the alliance in general (not specifically within in the context of using the MHRS)	Client open to receiving a wide range of practical support from the worker
			Client receiving emotional support from the worker
			Social connection between client and worker (client receiving informal, social support)
			Perceived likeability of the worker helps client to connect in the alliance
			Worker seen as trustworthy (includes non-judgmental, consistent, knowledgeable/ experienced)
			Knowing the worker as a person beyond their job role (includes worker self-disclosure)
			Client demonstrating an active role (exercises agency, decision-making)
		Collaborative working with the MHRS	Client demonstrating an active role with MHRS (exercises agency, decision-making)
			Client receiving support with completing the MHRS from the worker (helps explain the MHRS)
			A good alliance (outside of working with the MHRS) helps with work with the MHRS
		Hindrances to collaborative working - in the alliance in general and in working with the MHRS	Client has a 'oppositional' position (being opposed to or disengaged from worker input, including perceiving unwanted pressure)
			Client has a 'passive compliant' role with MHRS (client lack of involvement or interest without opposing worker's input)

			Client 'oppositional' position in relation to working with MHRS (if perceived unwanted pressure)
	Negotiating new or shared perspectives in the alliance in general and in using the MHRS	Negotiating new or shared perspectives in the alliance in general (not specifically within in the context of using the MHRS)	Knowing the client from a holistic perspective, beyond diagnosis
			Worker helps client change perspectives (about self and reality)
		Negotiating new or shared perspectives with the MHRS	MHRS considers holistic perspective of client (covers a broad range of areas)
			MHRS facilitates a helpful perspective, helps client to focus
			Agreeing or negotiating MHRS scores and goals with client
		Hindrances to negotiating new or shared perspectives –fixed conflicting perspectives in the alliance in general and in working with the MHRS	Client's thought processes seen to reflect mental health difficulties that hinder a shared perspective in general and in working with the MHRS
			Fixed conflicting perspectives between worker and client regarding completing MHRS scores and goals
	Being motivated towards recovery goals or improved wellbeing - in the alliance in general and with the MHRS	Being motivated (not specifically within the context of using the MHRS)	Acknowledging difficulties and need to progress towards desired goals
			Worker provides encouragement and motivation for client to make changes
			Accepting limitations and setbacks as part of the ongoing journey of recovery
		Motivation in using the MHRS	MHRS helps client and worker assess needs and identify recovery goals
			MHRS helps client notice progress, brings hope and motivation for client and

			worker
			MHRS has a positive indirect influence on progress toward recovery goals/improved wellbeing
			Working with MHRS is seen as a positive experience (interesting, emotionally rewarding)
			Accepting limitations and setbacks as part of the ongoing journey of recovery with the MHRS
		Hindrances to motivation - in the alliance in general and in working with the MHRS	Worker feeling discouraged or frustrated with client difficulties or setbacks
			Lack of progress on MHRS may be discouraging and/ or frustrating for client and worker
			MHRS can be seen as burdensome (difficult and taxing)
			MHRS seen as restrictive (formal or inflexible)
			MHRS seen to play a peripheral role in client experience
	Service Context in which working with the MHRS takes place - frequency and way of using MHRS varies across services and workers		Variable frequency of using MHRS
			Variable ways of completing the MHRS in a session
			Variable ways of using the MHRS in the service – as a therapeutic tool and outcome measure completed by numerous professionals in the multidisciplinary team
			MHRS used as therapeutic tool in a biweekly group setting

Appendix 20: Table of categories and codes with quotation examples

Core category	Categories	Subcategories	Open codes	Examples of quotations
Engaged in working together towards improved wellbeing	Collaborative working - in the alliance in general and with the MHRS (input from both client and worker in connecting and working towards agreed needs or goals)	Collaborative working in the alliance in general (not specifically within in the context of using the MHRS)	Client open to receiving a wide range of practical support from the worker	"She [worker] helps me with anything I need doing" (Eileen) "it [worker's support] would lead to me, to my independence, where hopefully I'm self-motivated whereas I need the support at the moment" (Simon) "She would give me some money to go shopping with and buy some cigarettes and other belongings, furniture... she would come and take me shopping, come and check my medication" (Keith) "It's just the everyday, so it's helping with their laundry going out to community, going to appointments, doing cooking classes with people" (Sarah - worker)
			Client receiving emotional support from the worker	"she [worker] cheered me up" (Keith) "It's all like, he picks on your emotions and just gives you, gives you what's what I suppose" (Clive) [reasons for clients choosing to work with specific workers:] "they say "they're kind, they listen to me", those kind of things seemed to be important when people were picking keyworkers, so nothing too sort of high brow" (Sarah - worker)
			Social connection between client and worker (client receiving informal, social support)	"She's [worker's] good company ...I like being with her... I like to get out, I get to go out with [her], just go for a walk in the country. We set out to go to [Town] and we ended up in [different Town], had a cup of coffee.... we go to the cinema on Tuesdays" (Rob) "I might be watching TV with the lads and he [worker] will come into the lounge and he'll crack his crap jokes and, just chat about things" (Simon) "[worker] comes to meet us in the project. [He] comes in the evening and

				he generally spends about an hour with us. You know, chatting, watching the telly with us, talking, you know, all of that" (Peter) "We're able to chat outside of the building... go to a lovely Italian café. [Another time] we went to the pub, it put me at my ease... you're nice and relaxed, you have a drink and it was a good setting, an easy setting" (Peter) [in relation to workers with whom the client did not like working] "People [workers] have got their work persona on and you can't really talk to them...they're not really understanding you" (Clive) "I thought what was nice the other day, we [client and worker] were sitting by the river having these conversations, we sat outside on a bench by the river" (Stuart)
			Perceived likeability of the worker helps client to connect in the alliance	"there's something about her [worker] anyway, she's a special person... she had that soft spirit" (Peter) "she's a nice person" (Keith) "I liked her, you know" (Stuart) "She's a nice person and she's down to earth and I mean I find my relationship with all the staff to be quite wonderful" "she's nice, down to earth" (Rob) "all of them [workers] are non-judgmental...empathic... They're all easy to talk to" (Peter) "She [worker] always gives me time to talk. She helps me with anything I need doing" "I think the clients are much more tolerant of suggestions if they know you and they like you and they have a good relationship with you" (Sarah-

				worker)
			Worker seen as trustworthy (includes non-judgmental, consistent, knowledgeable/ experienced)	"he [worker is] someone who you trust" (Peter) "he makes me feel comfortable because I've known him for three years, I think he's stuck" (Clive) "They have, present with the same persona whether they're doing the Star [MHRS] with me, whether they're doing something else with me" (Peter) "She was the best because of her struggles and she was able to understand where I was... she rolemodeled recovery" (Peter) "He's got a wealth of experience from being there so long, over 20 years. That really shows sometimes... he knows his stuff... you know we feel like I'm being supported by someone that I can trust... he's excellent at both the keywork sessions and the Recovery Star sessions" (Simon) "I think if someone trusts you they're more willing to take the risks that they might need to take towards their recovery. So someone like the guy I worked with...it wasn't until he trusted me and we had a good relationship that he was willing to try not sitting down on the way [being out in the community]" (Sarah - worker) "I'm always very honest with my clients and try and make sure that I am very reliable, you know, if I tell them I am going to do something I try and make sure I do it" (Sarah - worker)
			Knowing the worker as a person beyond their job role (includes worker self-disclosure)	"She [worker] tells me how her son's getting on, [Name] he's three now" (Rob) "he [worker] is a songwriter and he's written albums ... I think he feels good showing off to me" (Simon) "she's fighting battles in her own life, you know. Doesn't offload them

				onto me, but I mean that's a big thing for women being, you know, so heavy and then suddenly she can get into skirts and all that, you know, which is quite an achievement" (Peter) "we've got similar interest... his jokes are terrible" (Simon) "So you know rather than highlighting what we don't share, it's about what, well you know, we've got this in common, I like this, you like that, I know about this, you know about that" (Sarah - worker)
			Client demonstrating an active role (exercises agency, decision-making)	"They [workers] don't sort of direct me to go here or there... they allow me to just be myself and articulate what I want" (Peter) "I can control my emotions a lot" (Clive) "I haven't touched drugs for years... I won't do that no more... Now the only thing I have to worry about is the other facts, you know, where is the money, how can I get access to the money, how am I going to spend my money" (Jake) "You can go along and sit and give people all kinds of information or try and support them in something we feel they need support in but it might not be what's going on for them at that time" (Jennifer - worker)
		Collaborative working with the MHRS	Client demonstrating an active role with MHRS (exercises agency, decision-making)	"I am tackling my false beliefs and tackling my vulnerability... with the keywork sessions, I'm more consciously trying to change the way I live" (Simon) "Well using the descriptions for each scores, I just put my thinking cap on a bit and just, it's like deduction really, just deduce which score is more likely to be me; is more which score is more me " (Simon) "I decide [on the MHRS scores] I do that myself" (Eileen) "It [working with the MHRS with the worker] is a bit more serious. I suppose it's just more relaxed when we [client and worker]are just doing

				activities...It's not it's not relaxing it's just because I have to put effort into it " (Eileen) "The Recovery Star is about the client, staff need to remember that... not sort of guide them through, asking them questions. Just to let it sit with the client...let the client decide" (Peter) "I am doing it [MHRS] for me but, the staff are there, not to guide but just, to reinforce how good I'm feeling" (Peter) "I think if the client feels that your role is to talk to them about one specific thing and they might not necessarily want to talk about that then they, again, are going to struggle to kind of engage with it [MHRS]. But I think if they feel they can come and kind of lead a conversation and talk about what's important to them at that time then that can really build up a relationship because they're seen as more involved in it" (Jennifer - worker)
			Client receiving support with completing the MHRS from the worker (helps explain the MHRS)	"it [MHRS] can be difficult. I think, I think because he's [worker's] got the experience it's easier for him to understand the descriptions of each score. So when we discuss it and then he explains it and I say oh yeah I realise that is that score not that one" (Simon) "he worker's there, you know, just to help me, to sort of coach me, but not coaching me in the sense of giving me answers to write down" (Peter) "You can't give it to a client to complete themselves necessarily I think most of them around here wouldn't be able to do that themselves. They need support with it, and have a discussion around it so it's just a different level of need really, a different type of client group... the clients that we're working with have quite a lot of cognitive difficulties for different reasons so some of the concepts I think are quite hard to grasp on the star particularly with these clients so we had to really unpack them" (Jennifer - worker)
			A good alliance (outside of working with the MHRS) helps with work	"I might not do it [the MHRS] as well as I would if I had a staff member doing it with me ...having a helpful, empathetic staff member gives it

			with the MHRS	more meaning" (Peter) "If you have a bit more of a friendship with that person [worker], it makes it [the MHRS] a sort of nicer thing to do, a bit more meaningful. ... [without the worker there] maybe I wouldn't think about it so much, so deep and so I'd probably rush it off or something like that rather than spending time, a few minutes over each one" (Albert) "it [having a good relationship with worker] is easier sitting down going through the things [on the MHRS], you know. It helped" (Keith) " If you have a bit more of a friendship with that person, it makes it a, sort of, a nicer thing to do, a bit more meaningful" (Albert) " [Doing the MHRS with keyworker] helped with my confidence yeah. She knows the story with me...life story, you know, what I'm doing, yeah" (Stuart) "I think the relationship is really important. I think you need to be able to have quite a good rapport with a client before they are going to be able to sit and talk to you about really difficult things...it's going to work the best if they've built up a positive relationship with their keyworker before trying to engage with it or else they're either not going to be honest about it or they're just not going to want to engage with the process. ... I co-facilitated the group [with the MHRS] with the OT who had been on the ward for several years and she had a good relationship with them. And I think that really helped because they didn't know me very well but they knew her incredibly well so that was kind of a useful co-facilitator to have" (Jennifer - worker) "I think having a good relationship helps, I think the clients are much more tolerant of suggestions if they know you and they like you and they have a good relationship with you. I think it's very hard to persuade people who don't want to do something if they don't know who you are or if you haven't put the time in to get to know them and that kind of thing. So I think having a good relationship with them is essential in getting them to

				sit down and do it [MHRS]" (Sarah - worker)
		Hindrances to collaborative working - in the alliance in general and in working with the MHRS	Client "oppositional" position (being opposed to or disengaged from worker input, including perceiving unwanted pressure)	"I think they're trying to make me stop smoking. They're trying to sort of stop me" (Will) [in relation to comparing two different workers] "With [worker 1] we can talk more, about this or that. [Worker 2] is more office work things, "you've got to do this, you've got to do that" and [Worker 1] is "can we do this"" (Rob) "She [current worker] just doesn't, some of the other workers I've had have tried, they've put pressure on me to do things but [current worker] doesn't, she's very relaxed and takes, she takes things at my pace" (Eileen) "you work with him [client] on the ideas he has because you are not planting ideas on him because if you plant ideas on him, he will challenge you and tell you, "I didn't want to do this and do this" but if you challenge him and work on what he has said it becomes easier" (Olive - worker) "she [client] probably doesn't like me that much because I am the person that is putting boundaries in place. So, although I think it's been good for her and actually what we've seen is an improvement in her, sort of, mental health since I've been there, she probably doesn't think I'm great because of it, because it's changed things and it's sort of put kind of limits on some of the things that she was doing...she particularly didn't like if she felt I was telling her what to do or even advising her so that's why I had to go for very much of a, you know, "take me with you, let me keep you company" because any other sort of aspect she would get sort of, you know, "I'm a mother, don't tell me what to do" (Sarah - worker) "You have to tell them [clients] why they need to do it, you know, and why you are saying what you are saying. It's within their interest. Probably, they may not feel, they might not think it's in their interest because they spent their money to buy their food, they don't want to throw it away but you need to tell them why, you know. You need to

				explain to them why" (Miriam - worker) "If you have a client who doesn't do, like do cleaning, and you are asking them to clean their room or wash their clothes, or a simple thing like shaving, they feel like when they see you they start telling you like, "Oh our shift mother""(Olive - worker)
			Client has a passive compliant role with MHRS (client lack of involvement or interest without opposing worker's input)	"I can't remember using it.. we were ticking things up, average, poor, bad, alright. I was ticking them which ones. I remember that, yeah...They [workers] ask a question [related to MHRS] and they say, do I agree with this, 6 out of 10, 4 out of 10, 8 out of 10 and I tick the one" (Will) "Nothing much. He [worker] just asks me questions and then goes away again when he comes back he says, well that's your point [score on MHRS] and that's it...the actual content is not explained to me but the actual answer at the end he explains to me, but not the content so... we did the questions, ticks them off and says well this is you, sort of thing. That's explained to me but the actual reason for it is not explained to me... I'm puzzled because he doesn't give me the reason he does it in the first place" (Clive) "I don't decide on the scores.. my care coordinator [does]... Well, the doctor will tell you the things he thinks you're doing good on and the things he thinks you're not so good on. With me he hasn't seen any of my family so he's quite concerned about it. So he will say something like, "Yeah, we're happy with everything else but we need to be able to get in touch with your family and notes on [the MHRS] your family" And he'd ask you to help out if you can... it's harder for you to input it [MHRS] than I thought it would be because even with [worker] if I start talking about that I feel like he's like, "Nah, let's talk about things that work, making sure that your days are organized well and you don't do drugs and you're cooking for yourself" you know, "that you get back into the habit of going to the dentist"... once [worker] identified the scores and how well you're doing on each one of them and it's been discussed with the OTs and psychiatrist then the psychiatrist is going to ask you because he'd say,

				"we'd like you to do more about your relationships with your family, can I do anything about your family, we'd like to know more about your family"" (Jake) "it's a real mix. We have a few service users who don't want to be involved but are happy for staff to do it so they're clients we would say, "we sat down here..." and sometimes you'll find the client will then get involved because we'll say, "Look here's what we thought. Do you agree with this, do you disagree?" so there you can be a bit more kind if open and clear, "we talked about you, we talked about these areas, what do you think?" Some of them you would just with a more subtle approach. So it's a real mix, it's a real mix" (Sarah - worker) "when we're drinking a cup of tea and laughing, he'll do it [MHRS] and finish it without knowing what he is doing" (Olive - worker)
			Client oppositional position in relation to working with MHRS (if perceived unwanted pressure)	"if I felt there was like the pressure around, I wouldn't be so into it [MHRS]" (Albert) "you get told what time to go [to the MHRS group], what time it happens. It's just like class in school, doing history or something... It's like you're being marked" (Rob) "you can have a fight about it [disagreeing with worker about MHRS scores] but it's not going to do any good...he will explain why he's giving a score and well I don't know, he, I perceived he had a lot of power over me when I came here, you know I was still in section and the doctors word was like God's word so when you are in those circumstances you can feel persecuted and stuff but when you're not on section or have not been on section there's less pressure. You can disagree with the doctor, you can walk out of the meeting and nothing is going to happen" (Jake) "I think it's why it's so stressful trying to work with someone when we feel we can see something really positive that can change but they're perhaps not choosing to engage and I think that's where a lot of the kind of difficulties come in our work sometimes" (Jennifer - worker)

				"don't make it [MHRS] so official like they have to do it. Show them they have freedom to do it or not to do it ..[saying] "you are doing it for yourself and this is what you want to achieve so don't think you are doing it for the office to see, you are doing it for yourself" (Olive - worker) "some of our clients either don't want to do it [MHRS] or the way they've scored themselves is not perhaps realistic to where they are so what we do as a staff group is sit down and do one together" (Sarah - worker) " I think it's important that it [MHRS] is seen as something useful for the client. I can imagine that in some cases clients don't particularly want to engage with it and it feels like it's forced upon them so I find it quite helpful. However, when it's been used at ward rounds when someone's talked about where they are in the recovery star, it's often discussed and then some of the clients are just not engaged with it and I think the staff have felt that they've had to do it and I think that can be probably detrimental to a relationship in the end. If a client's not really engaged in the process and the staff are saying, well we rated it as this but it feels like it's totally disconnected from the client's world really" (Jennifer-worker)
	Negotiating new or shared perspectives in the alliance in general and in using the MHRS	Negotiating new or shared perspectives in the alliance in general (not specifically within in the context of using the MHRS)	Knowing the client from a holistic perspective, beyond diagnosis	" [staff] were honest and open because we're all human beings...you know, because you have your mental illness, sometimes people can think down on you or just expect a certain kind of behavior. Whereas they were completely open.. [worker] knows the client, the client group and doesn't slot you into a box... treats us like normal people" (Peter) "I think it's about being, it's about being, or offering kind of individualised care so you know it's going back to what I said so, you know, they're all people so just cause, you know, those two have got the same diagnosis and they're the same age, it's irrelevant. It's about finding what works for that person" (Sarah - worker) "No two persons are the same and you've got to recognize that and as well capabilities might be slightly different in some ways. So you have to make yourself, you have to tailor yourself to meet their needs... I don't look at them [clients] as, in a strange way I don't look at them as somebody who is unwell that I'm talking to. For me, it's not them and us,

				it's just me and me. Do you know what I mean? I don't look at them as though they are ill that you can't say certain things to them. I like to know that I am honest with them and I can talk to them about what they need to talk about... not as a sick person or a label, someone with mental issues, I don't see them as that" (Miriam - worker)
			Worker helps client change perspectives (about self and reality)	" [worker helps with] tackling my false beliefs" (Simon) "none of us [worker and client] knows each other completely, we're all sort of finding things out and finding out moods and things" (Peter) "Sometimes they [clients] do change because you know you talk to them and they say, "I don't want to end up back in hospital". Probably they don't have such a nice experience there and they don't want to go back, so you say "this is part of what you need to do to stay away from it"" (Miriam - worker) "Sometimes when they talk of very high jobs I tell them, "Jobs is not only being employed, there are jobs you can do. You can train to do something for yourself"" (Olive - worker)
		Negotiating new or shared perspectives with the MHRS	MHRS considers holistic perspective of client (covers a broad range of areas)	"He [worker] knows me basically, without him it [MHRS] would just be like doing the Recovery Star with a complete stranger..." (Peter) "...although I could just do the Recovery Star on my own, I might not do it as well as I would if I had a staff member doing it with me. So I think having a good empathetic staff member who knows the client, the client group, and doesn't slot you into a box. You know, [client]'s got schizophrenia therefore he's going to think this, this, this and this. He'll let the Recovery Star speak for itself" (Peter) [in relation to comparing different workers] "I think [worker 1] knows me more, basically. They could both have it written down [on the MHRS] - not married, three children, divorced. [worker 1] has asked me about it...asked me why" (Rob) " probably in using the star it makes it easier for them [workers] to think

				more holistically about a client and that is something I've been quite impressed with coming onto the ward, is seeing the kind of varied ways that clients are thought about and the different needs they have...I think it really does helps with staff kind of understanding and formulating clients as well because it gives them a lot more information...when people come into services we become quite blinkered and we see the thing that we're meant to be working with though the staff on the ward are probably very focused on their psychotic symptoms and the rehab work, trying to support someone to become more independent in their living skills, which is great but then you kind of forget some of the other areas and I think this [MHRS]kind of helps staff to bare in mind that there are all these other areas in someone's life...it can open up conversations about interests that people have that just might not come out otherwise..." (Jennifer-worker)
			MHRS facilitates a helpful perspective, helps client to focus	"MHRS gives me focus" (Simon) "it [MHRS] took my mind off the illness" (Stuart) " [MHRS] focuses your thoughts, you know, in certain areas of your life" (Peter) "you can channel your thoughts in that area when you're talking about that particular Star" (Albert) "it [MHRS] focuses on the issues that you face. You might or might not face" (Jake) "it [MHRS] can also be a helpful structure if someone is finding it hard to focus. I think if it feels like the therapy gets a bit unfocussed, I think it can helpful to tool to think with someone about what areas they want to work on" (Jennifer - worker)
			Agreeing or negotiating MHRS scores and goals with client	"he gave me the forms, he let me fill it all in by myself first and then we met up and did it to see whether it's accurate or not ...He [worker] tends to stop me from having 9 or 10, you know when really

				it's further down, which I think is part of his role in being my keyworker with the Recovery Star.... I'm seeing truly where I've gotten to in that recovery area" (Simon) "She [worker] can sometimes get it right, so... like of, yeah Social Networks maybe in the past was maybe a 4, and I still think it's a 4 and she'll say, "No but you've been doing this, you've been going to your volunteering, you been doing this, maybe it's increased now" (Simon) "Sometimes you can be hard on yourself and a worker can say, "Oh, how would you explain that [rating on the MHRS] because you seem blah blah blah. You seem like you're recovering well". Whereas you can't really do that yourself, you're overly critical and overly subjective, whereas somebody else with an objective view can just guide you, you know, just to another way of looking at things. Not driving you off but, you know, "Have you considered this [Participant Name] or have you considered that?" And I think only somebody that knows you can really ask that" (Peter) "For example, we had addictive behavior, his assessments and the notes that they'd taken, we came across it and I, say for example I smoke a lot, or drink, or smoke ganga, and we work out on a 1 to 10, you know, when I'm taking it too much or less" (Jake) "So when you do it with a client, it's led by them. So if they say they're a 10 and I think they're a 2 we'll try and have a conversation about why but if they want to put themselves as 10 then I will. But what I will tend to do is put down that it was just done by the service user. So if there is no shifting at all, they're not willing to have any discussion, I'll put it down as service user. If there's a bit of a shift and we're able to sort of come to a number between the two of us then I'll write worker and service user and if it's just the team then I put worker. That's how I've always done it" (Sarah - worker) [regarding disagreements over MHRS ratings] "We'll talk about it. Because, you know, again, if that person's thinking that they're that low down, they will need to talk about it. "So why do you think, why do you

				feel you are, you know, number 3". And if they explain to me then I'll say, "you know probably you should think again because maybe, what you are saying to me, you know, you're probably a little bit higher than that". You know and it's, it's confidence building as well. If they say a number 3 and I'm thinking, probably a number 4 or 5, you know, maybe they're bringing themselves down. So you talk about it and find out why they think they're so low and then you come to conclusion" (Miriam - worker)
		Hindrances to negotiating new or shared perspectives –fixed conflicting perspectives in the alliance in general and in working with the MHRS	Client's thought processes seen to reflect mental health difficulties that hinder a shared perspective in general and in working with the MHRS	"But the funny thing is when you're talking to somebody you take over their personality without even realising it" (Clive) "when you're coming here and you're under section and you know your life is in danger or you feel persecuted that your life is in danger" (Jake) [client who hears voices:] "She [worker] tries to say, it's not really there but I know he is there. I can't think. He made his way into my memory for 6, 7 years ...It's in your mind all the time ... I think they [workers] try to tell me I haven't got cancer" (Will) "I can't really express it in terms of mathematics but he [worker] will be doing me a favour by bringing my money from the underworld or the spirit world into this world by me cashing it in and making a sale but I'll be losing some of my saving which belong to me in the spirit world or the underworld" (Rob) "What I can say about the star is atoms, atoms, is what the star is. I don't know what the star is" (Clive) "I don't remember [the MHRS] to tell you the truth" (Will) (Sarah - worker) some of our service users don't think they have mental health problems, they're not in any way interested in using a tool that's about mental health "she didn't acknowledge me as her keyworker. If I said I was her

				keyworker, she wouldn't like that so I would more just, I would offer to keep her company. To go and do things rather than say, "we're going to keywork" " (Sarah - worker)
			Fixed conflicting perspectives between worker and client regarding completing MHRS scores and goals	"There could be all sorts of reasons [for client giving self high MHRS scores], maybe that I want the doctor to think that I'm well or maybe I don't want to think about myself that way" (Albert) "you have to keep, you have to take them [workers] on board and even if they are not on the same page as you, you have to accommodate what their thoughts are ... there's some issues that you don't want to discuss, or if you discuss it people think you're strange" (Jake) "the fact is, if we think responsibilities is a problem but the client does not see it as an issue then it's about how you try and manage that, which is a bit more complicated" (Sarah - worker) "I think often I was always fascinated in the conflict where the staff feel someone has rated themselves in a different way, it came a little bit in the group. And I think in some places the staff would put their rating down, and see that as the right one. Some would put the client rating down. Some places would try and work out a compromise. I think that's kind of been how we've seen it, is if someone is seeing themselves as very low on an area and you think actually they've got examples where they've done a bit better on it, to try and encourage them to think about those examples and think about if that shifts at all. If it doesn't shift then it's meant to be a tool for them so they can rate it where they want to really. But it might also be helpful to have a note to say, well they put this but the staff feel this because of x, y, and z, and then that's also a helpful tracker I think to keep over time" (Jennifer - worker) "my experience of using the Star has often been that actually it puts strain on the relationship because it can bring all sorts of conflict because if I am working with a client and they rate themselves as 10 and actually I think they're a 2, you then have to have a fairly, yeah, I like to be honest with

				people I work with, I like to sort of say, you know, "I'm not sure about that, I'm thinking you're a 3 or 4". It can be quite difficult, particularly, I mean we have a lot of users who are very unwell, there's not a huge amount of insight so, yeah. I was watching someone here do one on Monday night and the client ranked himself 10 for everything. And actually they're probably not, they're probably 3 or 4 for everything. So I find it can make the relationship quite difficult actually" (Sarah - worker)
	Being motivated towards recovery goals or improved wellbeing - in the alliance in general and with the MHRS	Being motivated (not specifically within the context of using the MHRS)	Acknowledging difficulties and need to progress towards desired goals	"I've got my three dreams, I've got my chess, got my computer programming and I want to be a psychiatric nurse and I believe that as time passes I am getting closer to making all three dreams true" (Simon) "I'd like to get this burden off, this burden like all the time. I have these burdens on me. Sort of pain it does. It stops you from doing what you want to do. Burdens do" (Will) "Once you're healthy, you have respect for professionals because they're doing their job and they're trying to make you well. .. you don't do foolish things, like they say, "Don't smoke that on the ward" so you don't smoke that on the ward ... you've got to do your best" (Jake)
			Worker provides encouragement and motivation for client to make changes	"he [worker] just encourages me to do these things like saying just try if you can you know but it doesn't matter if it doesn't happen" (Simon) "it [worker's support] would lead to me, to my independence, where hopefully I'm self-motivated whereas I need the support at the moment. I think that's [the service], or any hostels, rehabilitation hospital's main vision is to empower their service users so they can become independent, self-motivated" (Simon) "I do enjoy going out with the staff members. 'cause travelling up to [Town] on my own, I wouldn't fancy it at all" (Peter) "He would feel very discouraged that he [client] has done that [wet himself] and I told him, "you know what, we can sort out this" and he was

				asking me, "How? How?".....I told him, "You know what you are going to do? You are going to buy [an incontinence pad]...I did not force him, telling him, "You've got to do it because you are wet" I told him, "don't worry, even if it is here for two years, let it be near you" but now he use it every day." (Olive - worker) "When you talk about their [client's] appearance it's like they have given up on appearance... So you have to really motivate them so hard to think that appearance comes in many forms, not only the way you dress yourself, the way you talk, the way you appear in the park that is what I'm looking for... [in response to client saying] "Ah, it's not important, I'm ugly" I said, "No, nobody is ugly. We are all beautifully made. We are all wonderfully made. And then like you, when you smile, I was telling you, when you smile, I can't explain how you look, you glitter because of the smile" "I am giving them education ...so when they see me in the afternoon they even tell me, "I had a shower this morning". I'm not even thinking about the shower but they are reminding me they had shower" (Olive - worker) "So it was me saying to him [client], "it is safe for us to do this, you know, now what's the worst thing that's going to happen if we don't sit down"' and him believing that I probably was telling him something that he could trust I think meant that he could take other risks. Whereas if they don't trust you, they're not willing to try things they're not sure about so" (Sarah - worker)
			Accepting limitations and setbacks as part of the ongoing journey of recovery	"I believe one day I'll come off the meds, but it's not that I'll never take them again, it's just that I won't take them regularly anymore. I'll just take them when I feel I need them. Whereas at the moment I feel like I don't need them all the time but I'm at a stage in my life where I have to take them all the time so they're already in me when I need them to work" (Simon) "I just feel better some times. Other times I won't" (Keith)

				"I just have to be patient [with]both my recovery journey and my general journey in life" (Simon) "it didn't happen in like one stage, it was continuing module of today's good, tomorrow's bad, today's good, tomorrow's bad" (Jake) "it is like a wave of up and down, up and down, up and down because with mental health you're with people who are not motivated. They feel very well, they are doing something today, tomorrow they don't want to face it" (Olive - worker)
		Motivation in using the MHRS	MHRS helps client and worker assess needs and identify recovery goals	"we [client and worker] do three or four goals... I make them my recovery goals for the review in the next time..."(Simon) "Now the only thing I have to worry about is the other facts, you know, where is the money, how can I get access to the money, how am I going to spend my money" (Jake) "well it's [MHRS's] helped me to identify where I am and where I need to improve on in my life... helps me keep things on track" (Eileen) "it's [MHRS's] a good tool, not only for people with mental illness but the Recovery Star is good for anybody because it can give you some measurement of where certain areas of your life are and, I, I just think, I'm a big fan of it. I just think it's a tremendous piece of work. And as I say a tool for guiding you through life and anybody can use it, you know" (Peter) "It focuses on the issues that you face. You might or might not face. And going through all these issues is like a MOT done on your brain, so you realise your breaks might need changing next month or your responsibilities for example might increase. Like now I don't have any responsibilities but yeah, there's still anxiety and stuff" (Jake) "for example one of the Stars is Social Networks and I'm always thinking about how to try make friends, or trying to meet new people, things like

				that. So in that sense, you can channel your thoughts in that area when you're talking about that particular Star. And you can think, "Well maybe I can try and build on this and make it better, a better area of my life" (Albert) "I set an objective with him to be able to get him back to be able to travel on the train on his own... and that took me, I would say, the best part of 6 months and yeah we achieved that goal about a month ago. He was able to travel to [Station] on his own on the train and back...and now he's travelling all over the place" (Miriam - worker) "the aim was to get keyworkers to use it with their clients to structure conversations. It kind of structures some of the ward rounds input and the CPA input in theory it should bleed into those" (Jennifer - worker)
			MHRS helps client notice progress, brings hope and motivation for client and worker	"I like it when my score is 10... I am going to get closer and closer to 10... [MHRS] gets easier...it does move on and you increase incrementally your understanding of the Recovery Star" (Simon) "we do three or four goals... I make them my recovery goals for the review in the next time... I think the actual recovery environment is involved a lot in accomplishing recovery goals" (Simon) "Well one of the things I like about the Recovery Star, is it's about a journey, not a destination... to know how you're doing mentally and as I say how your recovery is going...like a map... measures your progress ... because I've written it all down [on MHRS], you know, I was able to sort of see, "Well, I'm not so depressed now," you know 'cause, you know, to see it was a low score, you know, meaning I was very depressed and then the next Star would be a lot brighter because I've come out of that depression or something...the Star helps me to understand, you know, that at this point, you know, maybe I wasn't so good and then when I come to review it with my keyworker I find that today I'm in a better place, a better mood" (Peter) "it helpful to see how you've improved over the months" (Albert)

				"It makes me feel happy, just to think I'm getting along a bit better in myself" (Keith) "He [client] is happy, now he's actually happy. You know he can take the train whenever he wants now or he can go wherever he wants.... He's able to take the train now and I feel good about that" (Miriam - worker) "I think it can be difficult if someone feels very hopeless and sees themselves very negatively in all of the areas [on the MHRS] but there's normally at least one area where you can pick something positive for them, so I think this helps build the relationship" (Jennifer - worker) "The idea is that you should see some progress... actually what you tend to see is the ones [MHRSs] that are done with the staff or by staff as a group, you do see progress, you'll see the people's score increase" (Sarah - worker)
			MHRS has a positive indirect influence on progress toward recovery goals/improved wellbeing	"I believe that's part of empowerment of the Recovery Star that it is that heavy. Means it's doing something real to my subconscious. Somehow it's all going to happen... I really just let that, let the goals just settle into my subconscious and just hope that those goals integrate into my development. I don't feel the need to revise the goals every week or whatever" (Simon) "it [MHRS] sort of feels helpful but not too sure how" (Eileen) "It's [MHRS's] not something I think about in my mind, like when I'm thinking about, when I'm not doing it, I'm out doing my life or doing whatever it is, volunteering or groups, or whatever. I'm not thinking, "well is this going to increase my Recovery Star?" But when I come to do the Recovery Star, I can bring that experience to the table and it's kind of, in those moments, it's quite helpful to see how you've improved. It's not something I think about too much after I've done it" (Albert)
			Working with MHRS is seen as a positive experience (interesting,	"[doing the MHRS with the keyworker], it just makes me sort of happy. I enjoy, you know, sitting down and reading it to each other sitting down

			emotionally rewarding)	talking to someone can help you, help you feel better" (Keith) " [MHRS] took my mind off the illness" (Stuart) "I enjoy working with the Star because it makes you think as well. You don't just, you know, you take up a heading and you think about what you need to say, you sit down, you discuss it, you find out where you are with it and you know, it helps, it is a helpful tool" (Clive) "for some staff this will really fit with them and they will really enjoy using it and it will be really helpful. But not all staff (Jennifer - worker) "I enjoy working with the star because it makes you think as well. You don't just, you know, you take up a heading and you think about what you need to say, you sit down, you discuss it, you find out where you are with it and you know, it helps, it is a helpful tool" (Miriam - worker)
			Accepting limitations and setbacks as part of the ongoing journey of recovery with the MHRS	" So what I do take on from the keywork sessions isn't necessarily doable but is, I am able to try with the things that we discuss in keywork session...so last time we met I said to him [worker], "Look I tried [a diet that was a recovery goal] for a month, I can't do it. I'm just going to put a lid on the diet for the minute." And I think he accepted that. And say the showering in the morning, I don't manage to have a shower every morning and that's a goal to have a shower every morning. I don't do badly I have three or four showers every week but still I wish, the dream is, or the recovery goal is to be able to have a shower every morning and brush my teeth every morning and night" (Simon) "so what I do take on from the keywork sessions isn't necessarily doable but... I just have to be patient [with] both my recovery journey and my general journey in life" (Simon) "Well one of the things I like about the Recovery Star, is it's about a journey, not a destination...it measures you on the journey not the destination, you know. Because we're all kind of recovering. You never get to a place where you're fully recovered as a human being, whether you have mental health problems or not, you know. We can all strive to be

				good. That's why I think it's an excellent tool, the Recovery Star" (Peter) "I don't discourage them [a client with a criminal record aspiring towards getting a job that will require a record check] because I know time changes, you know. Even those very high goals they are thinking about, there is no limit to what a human being can do but I tell them at this time, what I know is, this goal you'll be asked for this, you'll be asked for that, you'll be asked for the other, but all you want for now is to come out of this environment, be working, feel useful and you can do it with your own hands" (Olive - worker)
		Hindrances to motivation - in the alliance in general and in working with the MHRS	Worker feeling discouraged or frustrated with client difficulties or setbacks	"I think it's why it's so stressful trying to work with someone when we feel we can see something really positive that can change but they're perhaps not choosing to engage and I think that's where a lot of the kind of difficulties come in our work sometimes" (Jennifer - worker)
			Lack of progress on MHRS may be discouraging and/ or frustrating for client and worker	" [ratings on MHRS] Stay the same really" (Will) "people might think, "Oh, I only got one star in all of these things [areas on the MHRS]" so it might not help to think that... if it's making you feel worried that you're not getting anywhere and there's all this pressure around then just leave it" (Albert) "I think it can be difficult if someone feels very hopeless and sees themselves very negatively in all of the areas [on the MHRS]" (Jennifer - worker) "one of the problems that I came across ... is that the star, it kind of can leave us with a feeling that there must be change. That we should be aiming for a 10. ... I think for a lot of clients the maximum they'll get is perhaps lower down on the star ...it would fit with them a bit better if they said, well this is how happy I am with this area, rather than what is there that I'm not meeting that maybe I might never meet because, you know, because of my difficulties. ... I wonder if that leaves some clients struggling a bit, feeling, you know, I don't know, feeling a bit despondent or hopeless about areas that they feel they can't see change in" (Jennifer - worker)

				"They don't want to see it [MHRS ratings] really goes down ... when you tell them this time I have to give you 2 in this area because of 1, 2, 3 they seem to understand and say, "yes it is true"..... So sometimes I feel so bad when I'm talking about it because I know even if we are talking about getting a job and I'm trying to motivate them they can work at the back of my mind I'm just saying, "Oh my God, will this man ever get a job?" So I'm not really, even me I feel depressed more in that therapy for somebody that has mental health" (Olive - worker) "he [client] is very discouraging to motivate because you feel like you are getting somewhere and then when you start you start very well then it will go down the hill and then you look at what position he is in, probably by the time you took him on, he was about a 4 [in a particular area on the MHRS] and now it's like he's 2. And then from 2 you have to struggle, work hard on him until now you find he has gone up" (Olive - worker)
			MHRS can be seen as burdensome (difficult and taxing)	"Some of the wording [on the MHRS] I would change, you know for, for some people who are less intelligent... maybe the Star doesn't work so much for, somebody who's say less intelligent or less able to formulate or articulate their thoughts" (Peter) "I think I lose a bit of interest in the thing [MHRS]" (Keith) "he's [worker's] got the experience it's easier for him to understand the descriptions of each score" (Simon) "I had caseloads of 60 plus. And yeah, I just didn't have time. So they couldn't really fit the star in along with all the other admin stuff" (Jennifer - worker) "I think it's, I think it's a useful tool for staff. I don't think it's a particularly useful tool for clients because I think a lot of the clients I've worked with using it don't really understand a lot of the terminology. So we have a lot of clients who either sort of have learning disabilities, lower average intelligence and also what you find with people with kind of chronic

				mental health is they kind of function as someone with learning disabilities even if they didn't have that when they were younger. So some of the terminology I think is quite complex. So I like that it's clear, I like the structure and it's straight forward in that aspect. I like it for staff, I like it less for clients. I don't think for them it's that meaningful... I have never known of anybody who has managed to do a whole star in one session with clients because I think it's just too much. So then it can become a bit difficult because you can kind of end up taking 6 months to do it and by the time you're finished it you've got to start again" (Sarah - worker)
			MHRS seen as restrictive (formal or inflexible)	"I think it's you can't, I don't want to talk about alcohol within the framework of the Star, things like that... can be bit, a bit more open ended, a few more things, maybe have another Star that says anything else or something" (Albert) I don't like the way it's written for each of the scores from 1 to 10 because ... I sometimes believe my response is in a different way to what the question is saying, to what the statement is saying about that score (Simon) "Just sitting down and [completing the MHRS] it's more basic. With [another worker] it's more, going out to the cinema, it's more personal, more interesting" (Rob) "It's [MHRS's] a bit more serious..I suppose it's just more relaxed when we are just doing activities...It's [MHRS's] not it's not relaxing it's just 'cause I have to put effort into it. It's a bit more serious" (Eileen) "I suppose, the thing is when you are working on the star it's in more of a formal setting so you do work differently, yeah, where as if you're not using the star it's probably more of an informal kind of key working or support. So yeah I think it does make a sort of difference" (Sarah - worker) "Sometimes when you go and you are putting a paper [MHRS] on somebody like this they would not be free to tell you exactly what they

				are feeling, you can still work on this without putting a paper in front of them, and you cover and achieve what you want... because when they are doing it [MHRS] formally, you do one then they say, "ah I don't want to do it, I'm tired"" (Olive - worker) "in an ideal world you would use it as it is set up but I think for some clients it can be helpful to say, well let's break it down, let's have three or four scoring scales, let's have pictures instead of the points on the star. Let's change the name of some of the areas on the star to make them a bit more understandable. And I think it depends on the client though. So for me, being able to use it flexibly would be helpful. The fact that you can't access it, we used to have free access to the LD Star [version of the Star designed for people with learning disabilities] and the other stars and I know you can't do that now without training and I can understand that but I think actually it would be really helpful to use the star that is most applicable to that client" (Jennifer – worker)
			MHRS seen to play a peripheral role in client experience	"I don't mind doing it [MHRS] but I don't think it adds much... But I don't know if it stays with me for much longer after I've had the, you know after I've been talking about it ... Can see it both ways.... I mean we do set goals but I think it's something I had in my mind anyway before I had the Star" (Albert) "I can't remember using it.. we were ticking things up, average, poor, bad, alright. I was ticking them which ones. I remember that, yeah" (Will) "It [MHRS] don't make no difference" (Rob)
	Service Context in which working with the MHRS takes place - frequency and way of using MHRS varies		Variable frequency of using MHRS	"We'll review it [MHRS] every so often, then we'll do like activities together in my sessions" (Eileen) " [we will do MHRS] in another 2 months" (Peter) "every 6 months" (Albert) "every 3 months" (Keith)

	across services and workers			"We just gone through it every 2 weeks" (Jake)
			Variable ways of completing the MHRS in a session	"we usually do all ten [ladders]. Yeah, it's very heavy but we usually cover, I think we've always covered all ten in one session... then we do three or four goals" (Simon) "We went through the whole Star but we didn't do all of the plans [goals] as we went along....we did a few yesterday but we're going to finish it off when we type it up" (Eileen) " [we do the MHRS every 6 months] for 10 or 20 minutes" (Albert) "their concentration span is likely to be a lot less so it needs to be done in a very different way. You can't kind of go through it in a couple of sessions. It would take quite a long time and I think the key workers find that quite difficult" (Jennifer - worker) "I have never known of anybody who has managed to do a whole star in one session with clients because I think it's just too much. So then it can become a bit difficult because you can kind of end up taking 6 months to do it and by the time you've finished it you've got to start again" (Sarah - worker) "We do part of it today. Probably a part of it the next day or the day after that but you get there in the end" (Miriam - worker)
			Variable ways of using the MHRS in the service – as a therapeutic tool and outcome measure completed by numerous professionals in the multidisciplinary team	"Well, I'll read, 1, 2, 3, 4 and it's got a little comment rate saying what that number represents, so I'll read, look up what I had last time and maybe it was 5 before and now 6, you'd say a bit better. So I can see whether I've improved by reading the little manuals. It describes what each one was. Each level would be representing what's going on with you, so that's how I moved up to 7 and I'll tick 7" (Albert) "But he [worker] will evaluate [me] based on your [client's] notes and the fact that he is your keyworker, he gives you the marks and then his evaluation will be brought in front of the staff team... they're all

				[multidisciplinary team] going to be there, in the meeting and everybody is having an input" (Jake) "the aim was to get key workers to use it with their clients to structure conversations. It kind of structures some of the ward rounds input and the CPA [Care Programme Approach] input in theory it should bleed into those, which is good but I think it needs to be used flexibly with these clients as well" (Jennifer - worker) "So it's either done by the client on their own, with the key worker and the client or, if the client doesn't want to be involved in it then it will be the staff team ...So we'll sit down as a staff team. We'll have a client in mind and we'll sort of discuss it between us, or talk through the ideas and then I always ask people to score independently and then we look at it later so they're not influenced by what I've scored" (Sarah -worker)
			MHRS used as therapeutic tool in a biweekly group setting	"the smallest group we had was probably 3, went up to 7 or 8 ... What was interesting at the start of the group, we asked the clients to think about which areas of the star they might find harder to talk about and which might be easier and so we kind of ranked them and then we did the group in that order" (Jennifer - worker) "[the group was] just over an hour... you get told what time to go, what time it happens. It's just like a class in school, doing history or something" Ron [in response to asking how the group worked:] "Say, for example, with relationships we'd have questions about what kind of relationships exist, you know between family, friends and work relationships. We get the topic and put it like say in the middle like that we would just drop anything you can think of related to the topic. And then after that there's questions which, say, the psychologist's prepared, I can't think of any at the moment, which delve into the topic even further" (Jake)

Appendix 21: Letter to Ethics / R & D
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Appendix 22: Letter to Participants
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Appendix 23: Summary Report

How do clients experience the alliance when working with the Mental Health Recovery Star in Rehabilitation Settings? A Grounded Theory

1. Introduction

The Mental Health Recovery Star (MHRS) is a therapeutic tool and outcome measure used widely across mental health services in the UK, particularly in rehabilitation settings. Over the years, research into mental health treatment has increasingly highlighted the importance of the relationship between clients and workers (or "alliance"). The MHRS is designed to reflect recovery principles in practice, including facilitating joint-working between clients and workers, which may help the alliance. This study sought to explore client experiences of the alliance when using the MHRS in rehabilitation mental health services.

2. Methods

Grounded Theory Methods (GTM) were used in the research design, data collection, analysis and interpretation. This involved interviewing ten clients and four workers from three rehabilitation services to obtain a wide range of views to enable a fuller understanding of the subject matter. The participants were asked about their experiences of the alliance when using the MHRS and how this might or might not affect the process of recovery. Transcripts of interviews were analysed using Grounded Theory Methods, which focuses on identifying and conceptualising key elements across the data and linking them to explain how they relate to each other.

3. Results

The findings highlighted important interpersonal processes that are seen in the alliance in general and when using the MHRS. An explanation of these is depicted in the attached theoretical model of the Grounded Theory.

There seems to be important processes between a client and a worker that are evident both when using the MHRS and in general interactions. The main overarching category that incorporates these can be summed up as 'Engaged in working together towards improved wellbeing'. This is made up of the following three processes:

3.1. Collaborative working - This involves both worker and client participating towards an agreed goal. There are important general alliance processes that seem to help this: clients taking an active position in making decisions, and workers being seen as likeable, trustworthy and providing emotional and social support. Participants highlighted that they particularly value the informal, social interactions they have in the alliance. Having a strong alliance was also seen to support the work with the MHRS, making it more enjoyable as well as more meaningful.

What seems to hinder collaborative working is when client involvement is minimal – either in a passive compliant position or in an oppositional position, particularly seen where the client felt pressured by the worker into doing something, including work related to the MHRS. According to the workers, this apparent lack of client involvement tends to result from the level of clients' mental health needs and other cognitive difficulties. A leading example of this is staff completing a separate version of the MHRS for a client because the client is considered not to have the required insight to record an accurate representation of themselves.

3.2. Negotiating new /shared perspectives - As described above, where clients and workers were seen to hold fixed conflicting views, this was seen to hinder a process of negotiating new or shared perspectives. However, there were also numerous examples of how the MHRS seems to help clients and workers develop new perspectives that enable better working together towards improved wellbeing. These included considering a holistic view of the client; helping clients to focus their thoughts; and challenging client views of themselves and their recovery, in particular clients trusting and appreciating worker's views of clients' MHRS scores and goals.

3.3. Motivation towards improved wellbeing - Clients acknowledging difficulties, a need for change, and working towards this was seen to reflect a process of motivation towards improved wellbeing. This appears to be helped by the structure of the MHRS with its focus on assessing numerous life areas for the client and, with the help of the worker, enabling the client to notice progress they have made. Furthermore, there were also examples of clients describing an indirect positive influence of the MHRS, even when not worked on MHRS goals directly. This included it being a positive experience in itself (enjoyable or interesting).

A key element of maintaining motivation in working together was accepting recovery as an ongoing journey with setbacks and limitations. There were certain possible limitations in relation to using the MHRS that were identified that could hinder such motivation. These included clients and workers possibly feeling discouraged if no progress was noted on the MHRS; the MHRS being perceived as burdensome (difficult or taxing); too restrictive or inflexible; or peripheral to the client's experience.

4. Clinical implications

The MHRS appears to be a promising tool in being able to support alliance-building processes and recovery principles in practice. However there are also ways it can potentially harm such processes if not used sensitively. Those involved in the use of the tool should perhaps consider how best to negotiate a more flexible approach in its use to safeguard against such hindrances, particularly in terms of being able to adapt to the complex difficulties presented by those in rehabilitation settings. To this end, perhaps staff involved in work with the MHRS could benefit from further support in terms of training and supervision to help them address the difficulties and challenges presented to implement a truly person-centred approach.