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The Impact of Meaningful Activity

An investigation of the personal experiences of users
of a mental health activity centre.

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Abstract

Activity centres are one way that those experiencing a severe and enduring mental illness can spend their time. Whilst there has been some research into meaningful activity internationally, within the New Zealand context there has been relatively little, particularly with this population group. This qualitative study took an Interpretative Phenomenological approach and sought to investigate participant's experiences of one such activity centre. A sample of five participants who used the centre as part of their weekly schedule provided information via semi-structured interviews. From this data a set of five themes emerged; Belonging, Self-efficacy, Identity, Empowerment and Support, these being the key overall factors defining their time with the service. The participants illustrated their experiences with examples that personalised the journey of each. These examples became the sub-ordinate themes of the research and detailed the particular facets of the service and experiences that promoted their engagement and recovery. These included: Socialisation and relationships, Resources and outcomes of classes, Independence, Staff, Enjoyment and fun, Non-judgemental staff/peers/environment, Flexibility & choice, A sense of a journey, Skill building, Personal growth, and Responsibility. These subthemes interacted with a high level of complexity with the themes and across the participants. This highlighted that each participant had a uniquely individual experience at the service. These individualised experiences support research which has been conducted around the concept of recovery in mental health where recovery emerges as an individual experience and journey. Overall experiences of the service were positive and participants reported that the service had been a positive factor in their recent lives and, for some, in the long term. This study was also found to support previous research which found that activity centres have the potential to improve life quality for vulnerable populations.

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Chapter 1: Background

1.1 The Changing Landscape of Mental Health Services in New Zealand.

This section seeks to establish a picture of the mental health sector in New Zealand and provide some context to the environment in which this research has been carried out. It describes chronologically the significant transformations that have occurred within this sector over the past two decades and how this was relevant to, has impacted on, and provided a rationale for this study which sought to investigate the personal experiences of users of a mental health activity centre in order to understand the impacts of their engagement with such a centre

1.1.1 Where have we been?

The mid-nineties in New Zealand Mental Health was a period of transformation, starting with the National Mental Health Strategy which was commenced with the publication of the document *Strategic Directions for the Mental Health Services* in 1994 by the New Zealand (NZ) Government, and was subsequently developed into the *First National Mental Health Plan* in 1997 (New Zealand Mental Health Commission, 1998). This plan had seven key strategic directions including more mental health services, better mental health services, and developing the mental health services infrastructure (New Zealand Ministry of Health, 1997).

One overall outcome of the implementation of this plan was a process of deinstitutionalisation across NZ which culminated in the late 1990s with the final closure of many of the country's large hospital style institutions, which in turn led to the establishment of many community based services and the redevelopment of already existing services (Gawith & Abrams, 2006; Hamden, Newton, McCauley-Elsom, & Cross, 2011; Lambie, Bullen, Rodetz, & Seymour, 1997; McCormick, Funderburk, Lee, & Hale-Fought, 2005). This was the final stage of a long running move towards having a more community based mental health sector which Brunton (2011) asserts started as far back as the late sixties or early seventies.

Such services were aimed at supporting or assisting people with the highest need; that is, those that experience a severe and/or enduring mental illness and, as such, require support from specialist secondary mental health services for often a long period of time. This discernment was based on the second overall outcome; a funding mechanism developed in the 1994 strategy which saw funding for secondary mental

health services aimed at the 3% of the population that had the highest need. This later came to be known as Blueprint Funding (New Zealand Mental Health Commission, 1998; New Zealand Mental Health Commission, 2007)

This was also a time when, as a result of publications such as *The Mason Report* of 1996 (New Zealand Mental Health Commission, 2007), the Mental Health Commission was established to carry out the functions of advocacy, destigmatisation, monitoring the implementation of the National Mental Health Strategy, and supporting service development and research initiatives (New Zealand Mental Health Commission, 1998; New Zealand Mental Health Commission, 2007). This Commission was subsequently reformed into the Health and Disability Commission in 2012 (Health and Disability Commission). This report, the commission development, and the funding reforms discussed above, have been pivotal in developing the mental health landscape in its current form. The period from the mid-nineties up to today is arguably the most definitive and dynamic period of development and change ever for the mental health sector in NZ.

1.1.2 Beyond the Institutions (Early 2000s to today)

Te Tahuhu, the Second Mental Health and Addiction Plan, was created in 2005 by the Ministry of Health (MOH) in NZ to provide a platform for carrying on the work that was commenced when the first Mental Health Strategy came into being, and to provide an overall plan for the now numerous Primary, Secondary and Community based Mental Health Services in the country to work to. When *Te Tahuhu* was produced it was noted that “one in five New Zealanders experience a mental illness or addiction” (New Zealand Minister of Health, 2005, p. 4). This was inclusive of those experiencing illnesses and/or addictions across the full spectrum of severity from mild to acute. These people were by the Ministry of Health’s assertion in 2005, experiencing a significant improvement in health resources in the community, for example, those who may once have been in an institution were no longer required to live this way, with robust community services affording them improved opportunities for recovery (New Zealand Minister of Health, 2005). *Te Tahuhu* also describes a climate of community services meeting community needs in the form of Non-Government Organisations (NGOs), culturally specific service providers and collaboration with families (2005). Some would argue that *Te Tahuhu* was written by the MOH so has the potential to be biased towards a positive outlook of what had been achieved in the decade prior, however it is clear that a significant move forward had been made at this time and the ground work completed for the establishment and progress of effective community

based treatment and support. Evidence of note being that, during this time, the uptake of use of community services was strong; from 2004 to 2007 an average of 90% of service users accessed community services (New Zealand Ministry of Health, 2008).

In 2012 the document *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012 – 2017* was released. This detailed key areas of focus for the ongoing development of mental health services throughout the country. Two of the key initiatives in this document were; making better use of resources and building on positive progress made for the service users who have the most need (New Zealand Mental Health Commission, 1998). This combined with *The Director of Mental Health's Report* of 2014 which noted a steadily increasing rate of secondary service access; up to 3.5% from the estimated 3% noted in earlier discussions of the 'Blueprint funding', provides a picture of the need for services to have a high level of efficacy with regards to their individual service provision in order to fall in line with the needs of the service users and the MOH.

This time period also saw the growth of anti-stigma campaigns such as Like Minds Like Mine (New Zealand Mental Health Commission, 2007), the start of the consumer movement (New Zealand Minister of Health, 2005) which aimed to empower service users to assist with service design, development and staffing, and the beginning and rapid development of 'recovery' based care in the sector (New Zealand Mental health Commission, 2012). The latter is a key factor in this piece of research and which will be discussed in greater detail in section three of this chapter.

This reorganisation of the NZ mental health sector, which has been referred to as the "most restructured in the world" (New Zealand Mental Health Commission, 2007, p. 12), has been the result of the development, implementation and strict monitoring of government policy and strategic documents. This has culminated in the current climate of NGOs providing community based services funded via a robust MOH funding mechanism working in collaboration with District Health Board (DHB) Secondary Services and improved primary Mental Health services to provide care and service for the top 3.5% of the population with the most severe need with regards to mental health issues.

1.1.3 Current research

This shift towards community based care is of significance to this research. Firstly, because the service in which the research has been conducted was started and developed during this time of dynamic change and hence has been aligned to all of the above mentioned strategic documents and legislation which were designed to support

the development of effective and appropriate services. Secondly; with this line of funding and service provision having now been in place for over 15 years, it is important that research is conducted to establish the efficacy of having services that are community based. Doing this from a service user's point of view is key here as services are after all designed to support people and who better to determine efficacy than the people being supported. Thirdly, it is an opportunity to identify what is working well and what is not, in order to drive future direction within the still fluid mental health sector in NZ.

1.2 Research Population

This research has been conducted in a community based NGO which supports people who are current users of DHB based Secondary Services. This section seeks to provide some context around the overall proportion of New Zealanders who experience a mental illness, within the limitations of data available, and further contextualise the Blueprint 3% - 3.5% as discussed above. Definition of the terms utilised in this study is also provided here so as to provide clarity around those who participated and how they fit within the wider setting of the mental health sector in NZ.

1.2.1 Mental Illness prevalence in NZ

Pre 1990 there were few studies related to the incidences of and types of mental illnesses experienced by New Zealanders. Since then the comprehensive study *Te Rau Hinengaro* was completed and was published in 2006 (New Zealand Ministry of Health, 2006). This study attempted to create a picture of the then present situation in the country with regards to prevalence of mental illnesses throughout the population. Though this study is now 10 years old it gives the best available picture of what the NZ Mental Health support needs were at the time of the major shift towards community based mental health services. Unfortunately there were some limitations to the data collected as noted in the document's executive summary, including that the study did not account for those living in institutions or residential care type facilities at the time, and it could also not identify low prevalence but severe disorders. This means that psychotic disorders were not included, however it did cover major mood disorders and anxiety both of which are considered to be severe and enduring for part of the population. Interestingly, what it did show was that in comparison to other countries whose own studies had been analysed, NZ had comparatively high counts of anxiety and mood disorders with only the USA having more (New Zealand Ministry of Health,

2006). Loss of function or ability as a result of mental illness was highlighted by *The Global Burden of Disease*, a study which showed that 10% of all disability or loss of function in society was caused by mental illness with Major Depression “being the lead cause of disability worldwide” (New Zealand Ministry of Health, 2006, p. 88). These facts and figures indicate the level of need within the NZ system as compared to the other countries surveyed via *Te Rau Hinengaro* as relatively high. This, combined with the previously reported (chapter 1.1) statistic that approximately 90% of mental health service users typically accessed only NGO or community based services, highlights the need for continued focus on and development of these services.

For the purpose of this research, the figure which will indicate the percentage of the population with a severe mental illness will be the most recently reported 3.5%. These are the people accessing specialist mental health services (New Zealand Ministry of Health, 2015, p. 28), and are the population which was targeted for this study.

1.2.2 Definitions

It is important here to provide some context to the terms used hereafter to allow for clarity of definition as they pertain to this particular research study.

Severe: Within the research this refers to a major mental health disorder, that is, any diagnosis of Schizophrenia or Psychosis, Bipolar Disorder, Depressive Disorder, or Anxiety Disorder. This diagnosis shall also have resulted in input from specialist secondary services due to the impact it has had on the individual’s ability to maintain their normal life function. *Te Rau Hinengaro* provided a useful definition describing the level of negative life impact severe when it, “interferes with usual life course and opportunities” (New Zealand Ministry of Health, 2006, p. 30). The MOH’s *Blueprint* document discusses this concept in terms of losses, including isolation, poverty, unemployment and discrimination (1998, p. 1). It is to be understood here that the different categories of illness; Schizophrenia and Psychosis, Bipolar Disorders, Depressive Disorders, and Anxiety Disorders, all come with their own set of impacts (The Royal Australian and New Zealand College of Psychiatrists, 2016). This is not the focus of this definition, rather of interest is the level to which it impacts on the person’s overall health, wellbeing and functionality.

Impact: This population often endures ongoing discrimination in their everyday lives and some can find every day activities difficult to complete due to the ongoing experience of their illness’ symptoms and factors such as the lack of adequate finance,

poor personal relationships, or poor physical health (Dingle, Brander, Ballantyne, & Baker, 2012; Thompson et al., 2008). For the technical purposes of this study, 'impact' is defined as inhibited life engagement or loss of usual function. Such inhibition of life engagement and/or loss of function is defined subjectively by the client and their key worker, as well as via the clinical measurement tool, Health of the Nation Outcome Scales (HoNOS) (Te Pou o te Whakaaro Nui, 2016). The HoNOS scale is the accepted national outcome measure for DHB secondary services and measures problems with cognition, physical illness or disability, hallucinations or delusions, depressed mood, relationships, activities of daily living, living conditions, occupation and activities, drinking or drug taking, non-accidental self-injury, and behavioural problems (Te Pou o te Whakaaro Nui, 2016). Research participants were identified as appropriate for this study by their referral to and enrolment in the activity programme (the setting for this study) which occurs via a Needs Assessment process carried out by secondary clinical services and is indicated by moderate to severe problem scores on the HoNOS tool.

Enduring: Refers to chronicity of illness and the above mentioned associated loss of function for a period of more than 12 months, including an inability to work as assessed by the person's General Practitioner.

1.2.3 The current research

From a human perspective it is important to not condemn chronically unwell people to spend their time in boredom and solitude. Ensuring they are able to lead meaningful and fulfilled lives in spite of their illness is of huge importance. Within such a vulnerable population it is therefore vital that these services are designed to improve quality of life. Activity centres appear to do just that (Eklund, 2009; Eklund & Sandlund, 2012). Again I make the point here that it is important to ensure that the services provided are valuable and beneficial from the point of view of those who are utilising them for reasons which will be described further in the next section.

Though research has been and continues to be carried out within the population of adults with severe and enduring mental illness, there will always be more to be researched and learnt. One consideration is the high needs of this population and the consequent financial cost to the government, whilst another is to ensure that services are fit for purpose to ensure the most possible gains for each individual engaged with them. As such there is need for much more research in this area, such as the needs of people who attend an activity group and how they perceive the support they receive (Eklund & Sandlund, 2012) and the general daily experiences of people with mental illness (McCormick, Funderburk, Lee, & Hale-Fought, 2005). These are just two

identified areas of research need, highlighted here to illustrate the value of this research project.

1.3 Recovery

This research study has been carried out in the context of a service that is considered by those who have set it up and run it to be 'recovery based'. As such an important step is to establish a working understanding of Recovery as a concept in Mental Health, particularly as it relates to the NZ mental health sector. This section also seeks to outline the salient themes of recovery that have come to the attention of the writer via her own personal working experiences and also via research having been conducted in this area. The importance of identifying these themes is to provide the reader with some context surrounding possible outcomes of the present research study and how these fit with previously completed research. Finally, as in other sections some rationale is provided as to how recovery fits the overall picture of this present study.

1.3.1 The enigmatic concept of Recovery

Recovery in a traditional medical sense has long been the focus of psychiatric care, with such a process focusing on absence of symptoms as the predominant method of recovery determination (Jose, Ramachandra, Lalitha, Gandhi, Desai, & Nagarajaiah, 2015; Myers, et al., 2016). Whilst this definition and process has a great deal of utility in supporting people through mental illness problems, research shows it has become increasingly clear that there is often a lack of correspondence between a client's and clinician's viewpoint about what defines and contributes to a person's ability to experience optimum health and wellness (Myers, et al., 2016). Such research has in part been a catalyst for changes to the way recovery has been viewed within the mental health realm.

Since the mid-1990s when the NZ government Mental Health Strategy was enacted (New Zealand Mental Health Commission, 1998), recovery as a concept within mental health has undergone a significant transformation. During this time there have been multiple attempts to pin recovery down to a finite concept, or useable set of rules. However, whilst models of care and best practise principles can be developed to assist front line staff with supporting recovery and guide the practise and development of the sector as a whole, the complexity of the concept and the ever changing socio-political

environment leaves some doubt as to whether a final understanding of the concept will ever be reached (Petros, Solomon, Linz, DeCesaris, & Hanrahan, 2016). This complexity is evident in the many definitions of recovery that can be found in the literature, as there has not always been clarity and consensus about the definition of the term (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). For example; it has been described as a complex and individualised journey for those who are rebuilding after or during a mental illness experience (Barbic, Krupa, & Armstrong, 2009; Jose, Ramachandra, Lalitha, Gandhi, Desai, & Nagarajaiah, 2015; Slade & Longdon, 2016). Anthony states that “recovery, as we currently understand it, involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (1993, p. 20). Barbic, Kuupa and Armstrong describe recovery as both a process and an outcome and include, “engagement in activities that hold personal and social meaning” (2009, p. 491) as one indicator of a positive recovery outcome. Closer to home, the NZ MOH has driven the use of ‘recovery’ in the NZ mental health sector and defines it as “the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential” (New Zealand Ministry of Health, 2012, p. 64). Furthermore, it is defined in *Te Hononga* 2015, a NZ MOH document developed in 2007, as a ‘destination’ for the development of MH services to aim for, which was people “living well in the presence or absence of mental illness” (p. 89).

These definitions affirm that the position of recovery in this context is far removed from more traditional definitions of symptom absence and the positioning of the clinician as the professional with all of the recovery knowledge. Instead the focus is now on living well despite symptoms, the knowledge imbalance having swung in favour of the person experiencing the illness. This has been a bold and positive step towards client-centred care which has been described as being of vital importance by Slade and Longden (2016) as the only person who can define recovery for themselves is themselves, a view shared by Macpherson et al (2016) who advocate for the importance of the patient perspective. It has also provided impetus for further research in this field which is very necessary given the aforementioned complexity of not only the concept itself but also the added lens of the individualised experience which compounds the intricacy of the whole subject.

Such definitions also raise many questions, two of the most prominent being; is recovery a process, an outcome or, as Barbic et al (2009) posit, both? Is it about meeting potential or finding meaning, or are these facets of the same journey? Definitions, theories and models of care abound throughout the literature on this subject but there is some commonality; the most salient being the concept of a

personal or individualised experience or journey. A journey implies an individual who is experiencing or who has experienced a period of mental illness moving towards something more. What that *more* is, is ultimately defined by that individual, and *how* the journey is executed and experienced is again defined by that individual. Slade and Longden (2016) support this individualistic notion of recovery. However they also note that it provides a difficulty when it comes to policy. This is because even though there are some generally accepted facets of recovery, the individualistic nature of the movement can make service and policy development difficult. It then follows that the reality of this self-determination can also be challenged in the context of financial, social and service barriers. So whilst identifying parameters for support workers to work within is a wholly logical and appropriate way to proceed in a practical sense, in the subjective world of real life support work, fluidity and a profound notion of one size does not fit all is the reality in recovery based services and systems. Despite this complexity, for clarity's sake the notion of a self-determined and individualised journey is the position taken in the present study.

1.3.2 Recovery in the NZ context

New Zealand occupies a unique place on the worldwide recovery landscape; considered by some to be a world leader in not only committing to recovery as a concept, but doing so governmentally via policy (New Zealand Mental Health Commission, 2007). Following the publication of the *Mason report* in 1996 and the resultant uptake by the government of the recommendations to develop a commission for mental health services and a dedicated funding stream, 'blueprint funding' (New Zealand Mental Health Commission, 2007), recovery which was still new on the horizon was soon to emerge as the new goal of all mental health services in New Zealand (New Zealand Mental Health Commission, 2007). This was in 1996 and in the decade that followed both the New Zealand and international communities experienced the coming of 'recovery'. At this time it was being explored not only as a concept but also as an aspiration for those using services and those providing them (New Zealand Mental Health Commission, 2007). This meant that services started to look at what recovery meant for them and how they worked. Also service users experienced the beginning of education and understanding, and an introduction to concepts such as peer support and de-stigmatisation (New Zealand Mental health Commission, 2012).

At the end of this first decade of utilisation of blueprint funding and oversight from the mental health commission, the documents *Te Tahuhu*, a MH policy framework document, and *Te Kokiri*, the subsequent implementation plan were created in 2005

and 2006 respectively. These two documents firmly cemented recovery as the foundation, building block and mortar of MH service development and provision within the NZ mental health sector from that time forward (New Zealand Mental Health Commission, 2007).

The New Zealand government continued this commitment to a recovery focus, with the document *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012 – 2017*. This means that not only has NZ been a leader in the take up and implementation of recovery based practice, but it is also a concept that has endured within legislation and therefore ground level service development and provision, cementing the NZ MH sector as a prime candidate for recovery based research.

1.3.3 Recovery Themes

I have gone to pains above to highlight not only the individuality of a recovery process, but also discussed that due to the complexity of the concept the process continues to grow and transform even whilst this research is being conducted. Despite these points, within the reviewed literature there are commonalities of themes that may be considered as important parts of an individual's recovery. These are again many and varied but can be broken into some broad groupings. As expected these groupings take on their own special meaning given the individual context for a specific person and can have endless meanings attributed within them. Therefore, for current purposes, these groupings will be discussed in general terms. For example, rather than discussing the merits of a particular social activity on assisting recovery, the more broad theme of having opportunities for social engagement will be explored. However, this may be done in the context of an individual activity to allow for clarifying examples to be used.

The social aspects of an individual's life are often identified within studies as a defining factor of recovery (Dingle, Brander, Ballantyne, & Baker, 2012; Jorge-Monteiro, 2016; Jose et al., 2015; Schon, Denhov, & Topor, 2009). Social relationships can be difficult to develop with family or in the community due to a myriad of factors, such as the symptoms of psychosis (Dingle, Brander, Ballantyne, & Baker, 2012) and the residual effects of trauma (Thompson et al., 2008). Activity centres can provide the opportunity for such relationships to develop (Dingle, Brander, Ballantyne, & Baker, 2012; Iwasaki, Coyle, & Shank, 2010). After lives of feeling invisible and/or misunderstood (Thompson et al., 2008), individuals appear to find immense value in feeling accepted and experiencing a sense of belonging in such environments (Dingle,

Brander, Ballantyne, & Baker, 2012). Dingle, Brander, Ballantyne and Baker's (2012) research was based on participation by disadvantaged adults, 89% of whom had chronic mental illness, in a choir group. This study utilised qualitative methods of data collection and analysis, much the same as this current study, and found that belonging socially to this group impacted positively on participants personally (emotionally and with self-perception), socially (social skills and a sense of connection with others), and functionally (health improvement, establishment of routine and employability) This is just one example of an opportunity for someone to experience social contact. Other routes can be more general as long as there is participation in society in a meaningful way; for example, gaining employment, engaging in education or engaging in leisure pursuits (Iwasaki, Coyle, & Shank, 2010). This meaning would, as per an individualised approach, be defined subjectively by the service user. As long as the participation in social activities is meaningful in this way there is likely to be a positive step towards recovery (Jorge-Monteiro, 2016).

Support from others is also important; with appropriate community support, those experiencing severe and enduring mental illness can experience both social gains such as those noted above, as well as health gains (e.g. improvement in physical fitness and resilience) (Dingle, Brander, Ballantyne, & Baker, 2012; Iwasaki, Coyle, & Shank, 2010; Wijndaele, et al., 2007). 'Others' does not necessarily just mean institutional support; individual, familial and societal supports of any kind can have a significant impact if it is tailored for the individual circumstances (Jose, Ramachandra, Lalitha, Gandhi, Desai, & Nagarajaiah, 2015). That is, it is suited to the subjective needs or desires of the person, for example, a small music group or a large regular family gathering at a Marae.

Empowerment is the third salient theme that has emerged in the literature. Piltch (2016, p.79) describes her own experiences with mental illness as "an assault on one's self esteem and self-confidence". She also goes on to discuss how her personal journey of redefining her personal identity and having a first-hand role in doing so was a key factor in her own recovery. Jose et al (2015) also discuss the loss of an individual's power which can occur via mental illness, and express the view that empowerment by the use of individualised goals and developing a personalised subjective definition of recovery can be useful tools. Monteiro (2016) augments this theory with a compelling discussion of an increase in hope occurring alongside improvements in self efficacy and esteem in a service using an empowering model of support. This study found that engagement in high recovery oriented, community based support services resulted in higher levels of empowerment, achievement of personal goals and subsequent community integration for individuals.

These themes; social contact or engagement, support from outside sources and empowerment, are not the only themes of recovery discussed in the literature. However, they are three routinely salient ones, hence the choice to discuss them here. Despite the clear support for these themes individually they would not in and of themselves necessarily facilitate a person's recovery. Rather, given the aforementioned complexity of recovery as a concept, it is suggested here that a variable approach would be more useful. This would possibly include any combination of these three themes. But could also potentially include others that have been noted as useful to a recovery journey, including having hope for the future, learning self-control, experiencing autonomy in life and decision making, engaging in self-help learning and practices, learning and/or undertaking self-responsibility, and having access to resources (Piltch, 2016; Myers, et al., 2016). Meaningful roles and/or activities, flexibility of approach, and access to a broad range of options were also identified by Piltch (2016) as further factors that could positively influence the process of recovery.

1.3.4 Relevance to current study

As noted above, 'recovery' is a major driver of service provision to MH clients in NZ and across the western world (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). It is also a concept that continues to be dynamic. As such it is important that the experiences and effects of recovery focussed service use continues to be researched. Doing so through analysis of individual subjective experiences in engaging with a service, the development of which occurred during the shift to a recovery focus, is one salient point of focus. Indeed, it is important to give careful consideration of the impact of services on recovery of individuals in the NZ context as well as internationally. NZ having been a world leader in the implementation of recovery based policy provides a solid platform for recovery research to occur. As noted in chapter two, it stands to reason that NZ is not only a good basis for research into the recovery movement itself, but also as a base for international research to be compared to. Barbic, Kuupa and Armstrong's (2009) description of recovery as a very personalised and individual process lends support to the use of an individualistic methodology such as that used in this current study. Such research can also build on the body of available literature regarding recovery itself, as well as the effects of recovery services on those who engage with them. There have been multiple pieces of research completed in recent years that have concluded that such research is required as a means of discovering more about defining and promoting good recovery practices (Barbic, Krupa, &

Armstrong, 2009; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Myers, et al., 2016).

Also noted above is the notion that there will inevitably continue to be ongoing development of recovery based theories. The exploration of the personal experiences of those using a recovery based service in the current climate in NZ will help to build the literature base for the contemporary context from the all important client perspective (Macpherson, et al., 2016).

Other aspects that deserve consideration are those put forward by researchers such as Jose et al (2015) who have identified that the client and clinician versions of recovery tend to differ. A hang over from the previously described tendency for clinical staff to rely on a medical model of recovery emphasising deficits, symptoms and cure, rather than a strengths based, holistic and person centred perspective (Iwasaki, Coyle, & Shank, 2010). Myers et al (2016) are of the same opinion viewing the disparity of opinion as a disconnect between the view of the client and others around them. These researchers note that such a disparity can possibly cause a gulf that may never be successfully bridged, but counter this possibility with the hopeful notion that, “we just need innovative rules, roles and relationships to help promote recovery” (p. 748). Innovation that can only be achieved through further study to gain insights via the subjective accounts of individuals from a range of settings and contexts, that is from those who are the real experts of their own lives (Jose, Ramachandra, Lalitha, Gandhi, Desai, & Nagarajaiah, 2015).

1.4 The value of employment and activity centres

This research study has been carried out in the context of a community based day activity program exclusively attended by people who experience mental illness. The following section explores the concept of meaning, defined for this study as a subjective feeling of purpose or satisfaction that improves life quality and overall life satisfaction. This exploration of meaning is couched in both employment and non-employment based activities programmes to offer contrasting research to ensure that the current piece of research is appropriately contextualised. This is an important point to touch on at this time as this study takes the stance that meaningful activity is a tool a person can use to move towards recovery in their life.

1.4.1 The value of employment in recovery and/or meaning making

Much research is available regarding the efficacy of work as a meaningful activity (Dunn, Wewiorski, & Rogers, 2008; Eklund, 2009). Research reviewed that focussed on the experiences of people with severe mental illness who were in employment concluded that participants valued employment very highly and saw this as contributing significantly to their recovery journey through improvements in self-esteem, the development of coping strategies, and instigation of a sense of pride (Dunn, Wewiorski, & Rogers, 2008). This is supported by Eklund (2009) who surmised that paid employment appeared to have some bearing on a positive quality of life. Eklund did however also conclude that enjoyable meaningful activity accounted for a higher proportion of feelings of high quality of life than paid employment. Results of this study showed that participation in a group or activity centre was an important aspect of participant's experience of quality of life. She finally concluded that this

“raises the question whether open-market work really is the most desirable goal for the majority of people with mental illness. This must be an individual judgement for each individual, but the results suggest that meaningful and appreciated everyday activities may be an important goal, too” (Eklund, 2009, p. 169).

1.4.2 The value of engagement in activity programmes in recovery and/or meaning making

Given Eklund's summary that other fulfilling activities may be just as important as work, research regarding non-work based meaningful activity was also reviewed including but not limited to the impact of leisure based activities on this population (Iwasaki, Coyle, & Shank, 2010), attendance at a choir group (Dingle, Brander, Ballantyne, & Baker, 2012), and the impact of exercise as a meaningful activity on this population (Alexadratos, Barnett, & Thomas, 2012).

A theme that was consistent amongst these studies was social opportunities. In comparison to the general population, those who experience severe and enduring mental illness have less opportunity to engage socially with others which can possibly have the effect of intensifying already present social isolation or symptoms of illness, such as lowered mood (Alexadratos, Barnett, & Thomas, 2012). Social identity theory argues that when someone identifies with a group that has meaning and purpose, such groups can have a positive impact for an individual (Alexadratos, Barnett, & Thomas,

2012). This theory was upheld in more than one study that was reviewed; with one study concluding that there was a strong negative correlation between social support and stress perceived by individuals (Wijndaele, et al., 2007). Another showed that the development of social relationships is a key outcome from engaging in group activities (Iwasaki, Coyle, & Shank, 2010).

Another theme that emerged throughout the review was the idea of routine activity being beneficial to individuals experiencing severe and enduring mental illness (Alexadratos, Barnett, & Thomas, 2012; Iwasaki, Coyle, & Shank, 2010). Indeed within NZ, occupation and leisure were identified as far back as 1988 in the first Mason report published by the NZ MOH as being a key factor for personal wellbeing.

There was however some discrepancy amongst the outcomes of the reviewed studies which were of interest to this study. One study concluded that no matter what the activity, an individual will benefit merely from being involved in an activity (Iwasaki, Coyle, & Shank, 2010). In contrast, others concluded that there had to be specific factors associated with activities to ensure benefit was gained, such as the correct measure of challenge versus stimulation and the ability for an individual to master an activity (McCormick, Funderburk, Lee, & Hale-Fought, 2005; Wijndaele, et al., 2007). Another provided a contrasting point of view, suggesting that moving into 'normal' community activities that had nothing to do with mental health services would provide the best level of positive outcome with regards to recovery (Iwasaki, Coyle, & Shank, 2010)

1.4.3 Current research

As noted, there is a body of literature that discusses and affirms the positive value of employment for individuals with mental illness and the positive impact it can have on their recovery and quality of life. However, for those who are unable to work, such as those who are the subjects of this study, the impact of being included in meaningful activity is less well known. Within the literature reviewed as noted in 1.4.2 above, there is consensus that involvement in meaningful activities is beneficial within this population and that involvement in such programmes does indeed have a positive impact on quality of life and, subsequently, mental health. However, the very nature of such impact is less well known, thus this project sought to understand the individual perspectives on which facets of such services have the most impact (either positively or negatively) on the lives of participants, and if meaning is gained from participation of individuals in such programmes how this meaning is experienced. Understanding how the participants have experienced the activity service in contrast to working

environments will also provide collateral information to contribute to the existing body of literature surrounding the value of work and other alternatives in the lives of individuals experiencing a severe and enduring mental illness.

Also, given that such clients are often unable to partake in 'community' activity alternatives, this project aimed to establish whether or not such activity programmes (which are within the mental health sector and not community based by the strictest definition) can have a positive meaningful impact on individuals, an area for which there is currently not a lot of research literature.

Chapter 2: Qualitative Research & Interpretative Phenomenological Analysis

In this chapter the methodological theories and framework of the study will be discussed including; qualitative research in general terms, a discussion of the specific qualitative methodology chosen, and the rationale for this.

2.1 Qualitative research

Qualitative research has, over the past 20 to 30 years, continued to experience a growth in understanding, literature base, acceptance as a valid research approach, and use in research for both student study and publication (Ashworth, 2008; Madill & Gough, 2008; Willig & Stainton-Rogers, 2008). One of its primary concerns is studying, in detail, how a person understands their existence in the world (Ashworth, 2008). If a researcher is concerned with participant interpretation and human experience then a qualitative study should be the orientation of choice. This is in contrast to a quantitative method which in simplest terms is aimed at objectivity and uses a strict systematic experimental design to establish a data set that can then be analysed (mathematically) to gain a quantifiable description of the relationship between the stimulus of the world and the resulting effect in a test subject (Ashworth, 2008).

It must be understood that there are a myriad of qualitative methods available to a researcher in order to achieve the rich detail of personalised information they seek (Madill & Gough, 2008). But at the heart of all of these methods is a universal understanding that all knowledge and subsequent understanding of this knowledge is context driven and therefore cannot ever be purely objective (Coyle, 2007; Lyons 2007). They also account for the fact that the researcher is by the very nature of this contextual theory a necessary actor in the research process and therefore has an impact on the research itself (Coyle, 2007; Lyons, 2007). The difference in available methods results from different epistemological viewpoints about how knowledge is produced and what it is that can actually be understood about this knowledge (Lyons, 2007). This current research utilises Interpretative Phenomenological Analysis (IPA), the theoretical foundations of which will be discussed below.

2.2 - Methodology - Interpretative Phenomenological Analysis

“Interpretative phenomenological analysis is concerned with the detailed examination of individual lived experience and how individuals make sense of that experience” (Eatough & Smith, 2008, p. 179). Indeed in its very name IPA alludes to the theoretical underpinnings which are subscribed to by those who utilise it in their research, these being Hermeneutics, a form of interpretation, and Phenomenology (Smith & Eatough, 2007) which will both be explored in more detail below. The idiographic leaning of IPA will also be explored. Since the mid-1990s IPA has been established as an approach in its own right. However, the underlying principles of phenomenology and hermeneutics have a much longer and more established history (Eatough & Smith, 2008) and as such give a rich grounding for IPA.

IPA is hermeneutic in orientation because of its interpretative facet (Smith, Flowers, & Larkin, 2009). Packer describes Hermeneutics as aiming to achieve description without utilising existing theories or hypotheses and that it takes the stance that “human action is a complex and ambiguous phenomenon” (1985, p. 1081) and therefore requires an interpretative approach to managing data. IPA itself has been described as employing a ‘double hermeneutic’ in that it involves a researcher interpreting the way in which the research subject has interpreted their experiences in the world (Smith & Eatough, 2007). This supports the qualitative stance that the researcher is inextricably tied to the research and process, and that the existence of a person in the world is highly contextual and the very act of research and interaction with the researcher is just another part of this context.

The second theoretical principle underpinning IPA is Phenomenology which aims to understand the unique and subjective experiences of research participants (Willig & Stainton-Rogers, 2008). At its core phenomenology in this context is an understanding that life is experiential in nature, these experiences being interactions with others and objects in the environment of the world, and that these experiences are ultimately meaningful to the individual (Eatough & Smith, 2008). Phenomenology respects the all-important qualitative feature of context, it seeks to ensure that the context is captured rather than controlled and reduced to generalisable statistics as it would be in a quantitative method (Giorgi & Giorgi, 2008). The purpose of this is to develop a deep psychological understanding of a phenomenon and how this has been experienced by the individual.

These two principles are clearly distinct in their orientation; however they become intertwined within this methodology. Because this type of research (IPA) aims to understand a person’s individual subjective experience (phenomenology), it by

default becomes an interpretative process (hermeneutics) (Smith, Flowers, & Larkin, 2009). The two theories work together to produce a methodology that can account for the fact that a qualitative researcher, as noted above, is inextricably a part of the actual research process.

There is one final influence on IPA that requires mention; that it is idiographic in nature (Eatough & Smith, 2008) and seeks to deeply investigate the experiences of one person. Eatough and Smith (2008) discuss Allport's argument that psychological enquiry should very necessarily be carried out with the participant point of view being focal. This is consistent with the idea of establishing individual meaning which as discussed previously is a key facet of IPA. This alludes to the utility of an idiographic methodology. Historically, typical psychological research was nomothetic in nature and the single case nature of IPA diverges strongly from this notion (Smith & Eatough, 2007). This key feature of IPA is concerned with individual detail and points to a single subject or small group research design, and fits nicely with the phenomenological theory of individualistic, context specific experiences (Smith, Flowers, & Larkin, 2009). This single and small 'n' design assists the researcher to develop a deep understanding of an individual and the phenomenon being studied, and once individual cases have been analysed in significant detail, using across subject analysis this can also be taken further to develop themes and general statements (Smith, Flowers, & Larkin, 2009). Themes will have rich and detailed information resulting from such close engagement with the data.

2.3 Qualitative research in Mental Health

There are many things to be considered when choosing how to go about conducting a piece of research. The research question or aim of the research, and the research population are amongst the most important as these factors can guide a researcher towards the epistemology and methodology that would best suit their particular scenario.

Harper (2008) discusses the need to ensure a methodology is matched appropriately to the research question being asked. It is not just a matter of deciding on your favourite methodology and launching forth into a research design. For example; if the question is one of cause and effect, or is looking for comparisons, a quantitative methodology would be wholly appropriate. However if meaning, and detailed subjective experience are desired as in this case then a qualitative methodology is much more appropriate.

With regards to the research population, this particular piece of research sought to engage with a cohort of people who have been diagnosed with a serious and enduring mental illness. Also the activity centre which has been the focus of this project seeks to support this cohort with recovery, related to their losses or difficulties that have resulted from their clinical mental health diagnosis or presentation. Whilst neither of these points makes this a purely 'clinical' research project it certainly places the research within the clinical psychology field, so discussion of qualitative research in this field would be prudent here.

Despite clinical psychology historically being a medically driven and subsequently a realist and quantitative discipline, Harper (2008) reports that qualitative research continues to become more popular and thus has grown in usage within the clinical psychology field. He noted a 10% increase in articles published in journals between 2001 and 2005 utilising qualitative methods with a clinical psychology question. This shows that there is now value being seen in using both qualitative and quantitative methods within this discipline. As research conducted within clinical psychology continues to branch out into different methodologies, it gives opportunity for research projects such as this one to build on the burgeoning literature base utilising qualitative research and design, and offers a complimentary research style to build on knowledge which has already been established via quantitative methods.

The health field is the other area in which mental health sits, and qualitative research in mental health from a health perspective paints much the same picture in that it is starting to move more towards utilising qualitative methods (Peters, 2010). Though it is occurring, the field of mental health has been slower to move towards using qualitative methods than other health disciplines (Peters, 2010). However it has gradually become more understood that within mental health the idea of cause and effect is not always helpful for answering research questions generated in this field (Peters, 2010) (Peters, 2010). For example, it is not overly useful if you are trying to understand the experience of a person who has just had their first psychotic experience to set them up in a controlled laboratory setting and subject them to a rigorous experimental design. What would be of greater utility would be to allow them the opportunity to describe the experience in their own words in an environment that is going to make them feel safe and comfortable.

The value that is being seen within health research using qualitative methods is that they have the ability to influence thinking, assist with development and/or evaluation of programmes or other interventions, and possibly support the resolution of clinical dilemmas (Hutchison, 2001).

2.3.1 Qualitative methodology and the current project

Qualitative methodologies aspire to give detailed accounts of the experiences, understandings and perceptions of an individual or homogenous group rather than looking to generalisable statements, showing a dedication to detailed and specific analysis (Peters, 2010). Therefore in utilising a qualitative methodology this study will be able to develop a detailed report regarding these particular participants and their experiences at this particular activity centre, but not activity centres in general. The value in this case is in the depth of detail and how this allows for deeper understanding of concepts that the individuals found important. Peters puts this nicely stating that, “understanding what stakeholders value about a service and what barriers exist to its uptake is another evidence base to inform clinicians’ practise” (2010, p. 37). This is entirely relevant to this study. Other possible outcomes are; identifying and defining themes relevant to activity centre use, understanding the nature of positive or negative experiences to enable tailoring of services but also, as discussed in further detail below, being able to understand the differences in experiences between working and attending an activity centre for the individuals participating in the study. Qualitative research has also been noted as being useful for developing or redeveloping therapeutic interventions and giving insight into the experiences of a particular group of people (Harper, 2008), both of which are features of this study.

For these reasons, as well as others discussed within this chapter, I believe that a qualitative study has the opportunity to do justice to the data and capture the essence of this complexity more so than a quantitative method.

2.3.2 IPA and the current project

For this piece of research, it was decided that a phenomenological epistemology would be most appropriate. IPA was subsequently chosen as the preferred phenomenological methodology. There are many different facets to IPA, all bringing their own unique reasons for why it was selected, these being discussed in detail below.

Firstly that, “IPA is particularly well suited to exploring topics within health, social and clinical psychology where there is a need to discern how people perceive and understand significant events in their lives” (Smith & Eatough, 2007, p. 36). This highlights the phenomenological aspect of the methodology and a significant reason IPA was chosen in this case. This being that the methodology was chosen to suit the research that was being conducted rather than the methodology dictating what the research question was going to be.

Secondly, Harper (2008) notes that IPA has been identified as quickly becoming a popular methodology within clinical psychology, a field in which this project is located. He posits that this may be due to clinical psychology judgements often being made using a qualitative style method to make sense of the presentation of the patient (Harper, 2008). Using such a research method is then not such a major jump in thinking as it is likely to be in other disciplines. Smith and Osborn also support the link with clinical psychology noting the concern IPA and clinical psychology both have with mental processes, particularly cognition (2008).

IPA has also been described by Harper as allowing a researcher to work in a semi hypothetico-deductive manner (2008). This again locates IPA in what has historically been a typically quantitative research field. Although there is no hypothesis as such attached to this piece of research, I am interested in noting the contrasting experiences in using an activity centre as opposed to working. Having a particular interest such as this within a qualitative study could be seen as a limitation; indeed Smith and Osborn (2008) note that in IPA testing a hypothesis is not a goal, rather flexibility and exploration of detail are key. However, whilst there appears to be a hypothesis driven area to this study, this is not a true comparative study, and using IPA will allow for this to be explored due to its semi hypothetico-deductive capacity, which will provide a stronger base from which to approach this particular part of the data analysis than other methodologies might offer. Furthermore, Peter's (2010) notes that it is appropriate in some cases to test a priori hypothesis in qualitative research as long as an appropriate methodology has been chosen.

IPA also allows for development of themes across participants to add further depth to the resulting understandings. Further research questions can also be developed to explore the particular area of study further. When starting this research the intention was never to generalise beyond this individual activity service or these subjects, rather it has always been the aim to obtain and analyse detailed, personalised information about the participants' experiences in order to understand as well as possible how they experience and make meaning from their engagement at the service. Though this information is not generalisable in a quantitative sense, the value of carrying out thorough and concentrated individual analysis is supported by Smith and Eatough (2007), who go as far as saying that this level of detail means that information can theoretically be projected out to humanity as it can be analysed in such detail and reported in a very pure form.

IPA is not useful for testing hypotheses (though as noted above there is some room to move in this regard), rather it is better utilised for exploring a phenomenon to look for the differences, nuances and processes of the individual experience (Smith &

Osborn, 2008). This provides a depth of understanding and context unavailable from quantitative studies.

Another facet of IPA is that it locates the researcher very much in the research process (Smith & Eatough, 2007). This has the potential to be seen as a significant flaw from a quantitative point of view, given that this negates any possibility of removing bias from the analysis. This being said, the mere fact of being able to place oneself in the position of the participant, as far as this is possible, allows for a clearer understanding from their point of view. This combined with the ability for the researcher to then step back and analyse the data critically from their own point of view allows for a breadth of data analysis otherwise unavailable via other methodologies. IPA also acknowledges the client as the expert on their life and experience (Harper, 2008). This is the crux of this type of research and enables depth and breadth of contextually rich information. These two factors combine to offer a methodology with an analysis which utilises as much of the person's subjective experience, as well as the phenomenon in question, as possible.

Smith and Eatough (2007) provide a history of IPA development which has seen various themes emerge within published IPA research, including but not limited to meaning making and identity. Meaning making and identity are facets of the client experience that are of core interest to this particular study, lending further weight to the appropriateness of the decision to use an IPA research design.

On a practical level, small n designs that are a hallmark of IPA are more attainable subject wise than quantitative methodologies which require a high number of subjects in order to ensure statistical robustness when it comes to generalisation. Within the field of mental health there are many factors that make obtaining large numbers of subjects difficult, including but not limited to issues related to active symptoms of mental illness, the sensitivity of the information being obtained and ethical access to subjects due to vulnerabilities.

2.3.3 Summary

Whilst it may appear that I have made an effort to disqualify quantitative methods as being useful in psychological research this is not the case. Rather I have argued that qualitative methodologies, whilst not better or worse than quantitative ones, are ultimately more suitable to the understandings this study has been carried out to develop. Hutchison (2001) supports this by noting that detailed description is typically obtained via qualitative methods that would be otherwise unobtainable quantitatively. Evidence has also been provided to support the choosing of the particular methodology

to ensure absolute clarity around not only why it was selected but to add validity to the project overall by ensuring the appropriate fit of methodology to project aim, scope and participant group.

Chapter 3 – Method

3.1 Current study description

The main aim for this project was to examine the individual lived experiences of engaging with a non-work based activity centre for people with a mental illness diagnosis via analysis of their personal subjective accounts. This was to establish what, if any, the meanings are which they attributed to attending the activity service and obtain a personalised insight into their experiences of such a service. It was also hoped that themes might be apparent across these accounts which would allow for a broader interpretation of the impact such services have on the lives of individuals with severe and enduring mental illness.

Within such a vulnerable population I believe it is vital that these services are designed appropriately to enhance the experience of life. It is even more important to ensure that the services provided are valuable and beneficial from the point of view of those who are utilising them. From a humanist perspective it is important to try to prevent chronically unwell people spending their time in boredom and solitude; ensuring they are able to lead meaningful and fulfilled lives in spite of their illness, as is the focus of recovery as discussed in chapter one. To this end, this study aimed to establish if and/or how the experience of attending the activity centre has had any bearing individually on these factors.

3.2 Ethical considerations

Ethical concerns were one of the foremost considerations when I embarked on this research process. I started by consulting the Health and Disability Ethics Committee. Subsequent consultation of the Massey University Human Ethics Committee (MUHEC) web information and completion of their screening questionnaire process established the need for a formal ethics application given that the subject participant group was considered a vulnerable group. Subsequent discussions with my academic supervisor allowed me to complete the formal MUHEC application process. Ethics approval was sought via the MUHEC Northern committee and approved via letter on 23 October 2014; approval number MUHECN14/042 (attached as Appendix A)

Possible ethical issues, as well as the implications of, and solutions to minimise or remove these issues were identified through the above processes and are presented in Table 1.

Possible ethical issue	Identified mitigating / removal solutions
Conflict of interest due to power relationship; I am a tutor at the service where the research was carried out.	Explicit detail in the information sheet stating that non participation or withdrawal will not affect access to the service.
Vulnerability of client group given their status as being diagnosed with a severe and enduring mental illness.	Ability to postpone interviews should clients be experiencing an increase in symptoms which would impact on their ability to safely participate in an interview.
Possibility of harm from questioning about experience of illness and current life meaning.	Clear information and plan in place for accessing support should there be a need to do so. Information provided in the 'information form' about options for reducing or minimising unintended distress. Reminder of details of free services for clients to access should they feel the need to. Reiterated immediately prior to interview. Observation by interviewer during interview to identify possible signs of distress in order to be able to suspend the interview, provide verbal reminder of supports available, or support to make contact with supports.
Researcher safety; interviewing alone	Interviews being carried out at service where a panic alarm is available and will be located on the person of the interviewer at all times. Location of the researcher in the interview room for ease of exit if required.

Table 1: Ethical issues identified and mitigating measures

3.3 Cultural considerations

Despite this not being a project aimed specifically at a Maori cohort it was acknowledged early on that the city in which the research was being conducted, has a high percentage of Maori within the demographic. This meant the possibility of having Maori people in the cohort of participants was quite high and therefore cultural considerations were of much importance. To ensure cultural safety for this project the following steps were taken:

1. A discussion with a Kaumātua (Maori elder) from a local Hapu (subtribe) who represents the Marae closest geographically to the activity service was conducted, he is also a member of the largest Iwi (tribe) in the district. The outcome of this was that he voiced no issue culturally with the project which was presented to him in terms of the project aims, research process and analysis processes. Agreement was also obtained that if a participant requested and gave permission for his presence, he would attend that individual's interview. He also gave the following recommendations:
 - a. A kaumatua should be present pre interview with Maori clients to ensure proper protocols are followed and to carry out karakia (prayer) if the participant indicates they want this. Also he recommended that the kaumatua be present

for the interview itself if requested. This is to ensure that should there be any discomfort or feeling of whakama (shyness) or intimidation this will be able to be minimised by the kaumatua.

b. There should be coffee and/or tea available for the client and all possible factors should be looked at to ensure that the client is comfortable and relaxed.

c. It is also important that should the client wish to stop or reschedule the interview for any reason they should be given the opportunity to do this without question.

As a result of these discussions, all participants who identified as Maori at the pre interview discussion were offered the opportunity to have a Kaumatua present, and to be able to carry out tikanga (protocols) practices chiefly by way of karakia. All declined the offer. Tea and coffee were made available for all participants, and all participants were reminded at the start of their interview that they could stop the interview at any time.

2. I obtained, read and applied the Massey University code of ethical conduct for research, teaching and evaluations involving human participants (2013) to the project.
3. I obtained, read and applied Te Ara Tika – Guidelines for Maori research ethics: A framework for researchers and ethics committee members (2010) to the project
4. I attended an ethics symposium on 27.06.14; 'Ethical Best Practise – Challenges in the Maori Context' presented by Dr Barry Smith, Dr Polly Atatoa-Carr and Professor Sir Mason Durie.
5. I myself am Maori and have been raised around Tikanga Maori and therefore have an understanding of the protocols relevant in such a situation and how to apply these.

3.4 Accessing participants

Participants were identified by way of an advertisement (attached as Appendix B) placed on the notice board at the activity centre, the only non-work based activity service in the area specifically dedicated to those with mental health difficulties. Those who showed an interest in the advertisement and subsequently approached me were listed in the order in which they came to see me, and the inclusion and exclusion criteria were checked to ensure the client had applied appropriately. These criteria, as

listed below, were clearly outlined in the initial advertisement to ensure that there was minimal chance individuals would be confused as to their suitability for the project and therefore reduced any chance of disappointment resulting from omission from the study. Following being checked against these criteria those who aligned were then given the information sheet (attached as Appendix C) and the opportunity to discuss the project face to face with me and have any questions answered before agreeing to participate in the project. If there was an excess in numbers the participants would have been chosen by their original approach order, however this did not occur.

Inclusion criteria included:

1. Being in receipt of the supported living payment that is an indication that the participant is deemed unable to work by a medical professional
2. Having attended the day activity centre for at least six months
3. Engaging in more than one type of activity, for example, art and craft or exercise, within the centre
4. Being diagnosed with what is considered a severe mental illness, such as Major Depressive Disorder, Schizophrenia or Bipolar Disorder

Exclusion criteria included:

1. Those currently involved in or seeking paid or voluntary employment.

The above information was reported by the participant during this initial discussion. Other information gathered at this time included age band and ethnicity. Information regarding advocacy services was given verbally at this point and the participants were encouraged to discuss their decision with family, support persons or an independent advocate. Also the discussion was had with those who identified as Maori as to whether or not they wanted a kaumatua present or tikanga practices followed.

For those who fit the criteria and subsequently agreed to participate, a consent form (attached as Appendix D) was given to them and explained.

3.5 Final participants

Seven people responded to the initial advertisement, five of which fitted the inclusion and exclusion criteria. These five subsequently went on to sign up for the project and complete the research process. At the first meeting with each participant, demographic

and diagnostic information was gathered and subsequently analysed. This analysis showed that:

- Two of the five participants were male and three female
- Two identified as Maori, a further two identified as NZ European/New Zealander, and one identified as Australian
- Two reported a diagnosis of Schizophrenia (paranoid type), One Bipolar Affective Disorder, and Two Major Depressive Disorder
- One of the participants had been with the service for approximately one year, the other four reported being with the service for at least two years

3.6 Participant involvement

The process of participant involvement commenced at the initial meeting where the project was discussed in detail, an opportunity offered to ask questions, and the information sheet was provided.

A subsequent meeting with each participant was held during which they were given the opportunity to ask questions regarding the consent form. Once they were satisfied they understood the form completely it was signed. At this point further demographic information including their gender, their diagnosis and the amount of time they had been enrolled with the service were formally collected.

The formal interview was completed at the activity centre. This was done for two reasons. The first was that it was a place where the person would feel comfortable as they attended there regularly. They were also used to seeing myself there, again ensuring comfort. The second was safety; the building is equipped with a safety alarm system with a panic button remote which was available to be used during the interviews. There were also staff available in the building should support be required. Confidentiality was maintained as there are two entrances to the building and the interviews took place after class times so participants were not required to pass by anybody on their way to or from their interviews. The interviews were completed in a semi-structured format and were audio recorded. All interviews conducted took under an hour. At the start of the interview participants were reminded that the recorder could be turned off at any time, that they could cease the interview at any time, that their privacy would be maintained at all times through the research process and their rights reinforced as per the information on the initial information sheet and consent form.

After transcription of the interviews the transcript was given to participants to read to ensure accuracy from their point of view was achieved. The transcript was read

fully to one of the participants as they had a low level of literacy and were therefore unable to read the transcript themselves. Once the transcripts were returned with approval from participants, analysis of the data was carried out.

The final contribution made by participants was via return of analysed data and individual theme table for their comment. This was only able to be achieved for three of the five participants. One participant had moved from the district during the analytic process and left no forwarding address, and the second declined to have the information returned to them for their input as they felt they were too vulnerable at the time to read through the information due to a relapse of some of the symptoms of their illness they were experiencing at the time. This information was returned in person and opportunity given for discussion and questions, with notes being taken during this process.

In the interests of confidentiality participants were allocated pseudonym names within the final written thesis.

3.7 Process

To summarise, the research process itself was completed via the following steps;

1. Research proposal completed and agreed with academic supervisor
2. Ethics approval gained
3. Letter sent to Trustees of service where research was proposed (attached as Appendix E)
4. Meeting held with Trustees and questions from them answered, consent to proceed obtained
5. Advertisement placed on notice board at activity centre
6. Advertisement answered by participant
7. Assessment against inclusion/exclusion criteria
8. Information sheet given and discussed, questions answered
9. Consent form given and explained then signed if participant willing to go ahead
10. Data collection – Semi structured interviews, sound recorded
11. Data transcription
12. Transcripts returned to participants for editing
13. Data Analysis – IPA
14. Return of data information to the participants, and discussion of research outcomes
15. Completion of written thesis
16. Submission of thesis

17. Dissemination of information to interested parties; the local mental health sector, other activity centres, the activity centre used for the research, and consultation parties.

3.8 Number of participants

The final number of participants that took part in this project was five. The main reason a small sample of participants was chosen is due to the use of IPA as the methodology which typically utilises small participant groups (Ritchie, Lewis, McNaughton-Nicholls, & Ormston, 2003; Smith & Eatough, 2007). This is due to the fact that it interested in the lived experiences of individuals rather than with sampling 'populations', and ensuring that there is a sufficiently in-depth analysis of this individual information. There were also practical reasons that had a bearing on the number of cases chosen. The first was time available for the completion of this project. This impacted because it was of the utmost importance to be able to do justice to the analysis of each individual's information as the depth of context and individual experience is what is first and foremost being sought. As a result it was important to limit the number of participants to one that was able to achieve this within the limited time available. Secondly the final number of participants was also governed by the number of people who applied to be part of the study who fit the criteria and gave consent to participate. The final reason for the number of participants is that there is evidence to suggest that this is an appropriate number of participants for such a study. Smith and Eatough state that, "there seems to be some convergence in clinical and health psychology post graduate programmes that six to eight is an appropriate number for an IPA study" (2007, p.40). Smith and Eatough also point out that there is no fixed formula or 'correct' number of participants (2007) and after consideration of the literature and due to being bound by the practical restrictions as noted above I decided that five was an appropriate number of participants for the scope, timeframe and subject matter of this project.

3.9 Sampling method

Purposive sampling is typically used with IPA (Smith & Eatough, 2007) and was done so in this case. This was due to the need for a relatively homogenous group of individuals who would all have in common attendance at the activity centre and personal experiences stemming from this attendance. Because the intention of this project is not to form generalised statements against the population, purposive sampling is not only acceptable but necessary to ensure that the research question is

able to be targeted appropriately. Smith and Osborn note that this type of sampling has its strength in being able to identify and recruit a sample of people for whom the research question is important (2008).

3.10 Data collection

Interviews are accepted as a cornerstone data collection tool within qualitative research (Ritchie, Lewis, McNaughton-Nicholls, & Ormston, 2003) and indeed in IPA itself (Smith & Eatough, 2007). This is because it is a flexible method of data collection and allows for rapport development and collection of rich data (Smith & Osborn, 2008). Despite semi-structured interviews tending to be the method of choice, it is worth noting that there are many other qualitative methods of data collection that are utilised depending on the skills and needs of the researcher and the type of study being completed. For this study however I did decide to utilise this type of interview for the following reasons. Firstly, as noted above, interviews are the most widely used form of data collection in qualitative research. The second reason being that other commonly utilised collection tools such as diaries or questionnaires (Smith, Flowers, & Larkin, 2009) had the potential to not only put participants at risk, but also may have had a negative impact on the quality of the data collected. The target participant group for this project had the potential to have a high level of vulnerability. Because of this, leaving them to complete diaries or measures about potentially distressing topics was too high a risk. Conducting interviews so there was someone present to support the person if required and initiate a predetermined safety plan was deemed more appropriate.

The use of semi-structured as opposed to fully structured interviews was also a decision to be made. Whilst structured interviews are more controlled and allow for specific detail to be targeted, the strict nature of such a technique would have meant that the deep level of description required for an IPA analysis, and the ability to follow a potentially important strand of conversation would have been lost. Using a semi-structured format with guiding questions and prewritten prompts allowed for the interview to flow at the pace of the participant in an order suitable to them, and allow them to have as much opportunity as possible to tell their story (Smith & Eatough, 2007). This of course minimised the control I had as researcher in the overall outcome of the information gained, and meant that I played a significant part in the interview. However IPA as a methodology overtly acknowledges the researcher as an integral part of not only data collection but also analysis. As per guidelines provided by Smith and Eatough (2007), I produced an interview template (attached as appendix F) prior to starting which included some questions to ensure that the topic I wanted to target was

indeed targeted. This template also included some prompts which served the purpose of giving me as the interviewer a reminder of what was trying to be targeted in the interview and which I could use to assist a participant to find their flow if required. Prompting was intended to be used only if required in order to not inject too much structure into the interviews that had been so deliberately made semi-structured. With consent from the participants the interviews were audio recorded, and participants told via their written consent forms that they could ask for the recorder to be turned off at any time during the interview. They were also verbally reminded of this immediately prior to the interview.

3.11 Analysis

IPA does not have a specified and concrete method of approaching analysis (Smith & Eatough, 2007), though there are guidelines available to guide a researcher. This is a factor that has the potential to make it very difficult for a novice researcher to carry out the process, however this is outweighed by the fact that it allows for flexibility of method to allow for the dynamic analysis which is required in IPA due to the multitude of different types of research that can be carried out utilising this methodology.

Because IPA is idiographic in nature, any analysis first takes the single case into account, with an in-depth reading of one set of data (Smith & Eatough, 2007). The researcher then moves on to individually carry out a detailed reading and analysis of each individual case (Smith & Eatough, 2007). This allows for the analysis to take two forms; each individual case is analysed for depth and complexity and presented to the reader for its own merits. Then generic themes across the individuals are also explored (Smith & Eatough, 2007).

Table 2 contains a general guideline proposed by Smith and Eatough (2007, pp. 45-48) which was utilised for the analysis of this project, applying it to each of the written transcripts in turn.

Phase of analysis	Process	Important points
During transcription	Noted initial thoughts or potentially important points that came up whilst listening to and transcribing the data	
In-depth reading of transcript	Multiple readings were completed and the left hand column used to note any interesting or prominent information	This is a free analysis of all aspects of the text including but not limited to type of language used, actual words used and any points of difference or similarity with other parts of the text
Second round of reading	Used the right hand column to pull comments or ideas in left hand column into loose themes whilst re-reading the transcript	This is a more proscribed phase and requires the use of psychological ideas to make sense of the data and emerging salient points. This is a significant point in the process and requires the researcher to not lose sight of the participant's voice during the interpretation process.
Data reduction	Clustering of identified themes into appropriate groupings by identifying sensible connections between them	There is a possibility that some themes will be left out at this point if they do not 'make sense' within the context of the rest of the data
Table	A table is produce of the theme clusters and each cluster titled appropriately	
Narrative	A final narrative is completed for each participant	This again forms part of the analytic process in that if done well it identifies and describes in-depth the interplay between the data and the researcher's interpretations
Analysis across participants	A table of themes is created across participants	This is only attempted after the researcher is fully confident that each individual data set has been appropriately analysed

Table 2: Analysis process

For the purposes of this study several tables were created and will be included in the results chapter or appendix. These tables were created in the following order. As each participant's transcript was analysed a theme table was established which detailed each theme, each subordinate theme and how this was experienced for the participant (attached as appendix G). Following this a narrative was completed for each participant which was designed to capture the essence of the interview and give an illustrative view of the data table. Once this process was completed a table was created of all of the themes and subordinate themes of all participants (attached as appendix H), this was also created in matrix form (attached as appendix I) as another way of being able to view and make sense of the data. Utilising these data templates, a final table of themes and subordinate themes was created which is presented in chapter 5 which

accounted for the most salient and sensible themes present across the entire group of participants.

The themes were discerned via the following process: Initially all individual participant's themes identified during analysis were grouped under relevant headings. This process established the first set of themes and subordinate themes. After this, a process of consolidation occurred in order to reduce the subordinate themes into a more manageable subset.

This consolidation was achieved via the following means: Firstly, the subordinate themes that were present for three or more participants were transferred over to the final table without change. Secondly, where there were similar subordinate themes these were grouped together under a more global heading. For example, in the theme of belonging, 'relationships with staff' and 'staff support' were drawn together under the heading of 'staff'. Finally, subordinate themes that looked to be outliers within one theme, that is they did not fit ideally with the other items, but were captured under another theme were excluded from the theme group in which they were not an ideal fit. Also of note is that some of the subordinate themes are present in more than one theme due to their contribution to each theme being different, and therefore including them in more than one theme ensured analysis was full and complete.

3.12 Validity

Due to this project not being quantitative in nature it stands to reason that traditional methods of ensuring strength and quality of the research such as internal validity, external validity, objectivity and reliability will not be useful in assessing the quality of the work. Yardley (2008) describes validity in qualitative research in the context of ensuring that research findings can be trusted and in the quality of the research process. Other researchers also concur with this measure of validity (Guba, 1981; Shenton, 2004). These authors also agree that it is difficult to give a proscribed set of trustworthiness measures within qualitative study for several reasons. The most salient being the sheer number of different methodologies and styles this type of research can utilise.

In order to develop and maintain a high level of validity within this project the following processes were used, which align to the factors of trustworthiness as suggested by Guba and presented by Shenton (2004), being credibility, transferability, dependability and confirmability. These factors are popular amongst qualitative researchers (Shenton, 2004) hence the decision to use them here. In the interests of clarity these factors are defined by Guba (1981) and Shenton (2004) as follows:

- Credibility: Checking the credibility of the data, that is “how congruent the findings are with reality” (Shenton, 2004, p.64), and subsequent analyses with those who were the subjects of the data.
- Transferability: Identifying themes that may be applied to other similar situations, and noting possible limitations for such transferability.
- Dependability: How reliable the results are for this particular project and the context in which it was carried out. This also entails the variability or differences that can possibly be attributed to particular contextual factors.
- Confirmability: An understanding that the researcher has an undeniable effect on the process so the data itself needs to be confirmable; findings are as much as possible the product of the experiential data received from the participants and not impacted by the researcher’s beliefs or biases.

Credibility is described by Shenton (2004) as the foremost criteria for ensuring trustworthiness and has been applied to this project via the following methods which he identified. In some cases these methods have been corroborated by other researchers as noted throughout the list.

1. Understanding, and appropriate use, of methodological practices that have been generally accepted as appropriate for the type of project and research question being investigated (Shenton, 2004). The use of IPA for this project has already been justified and the methodology applied rigorously throughout the entire project.
2. Ensuring a good understanding of the environment or context in which the research is to take place to allow for rapport building and a deep understanding of the contextual environment (Shenton, 2004). For this project I utilised a service in which I worked so already had trust built with those participating and an in-depth understanding of the environment, philosophies and practices of the service. This working relationship did have the potential to create a power imbalance, however this was managed via clear communication with the participants about their confidentiality, and reiteration of the fact that the research project was independent of the service itself and that I was in a research role not a staff role.
3. The above factors, as well as the opportunity for participants to pull out of contributing being offered immediately prior to the interview, and at other meetings after the data collection phase were utilised in an effort to ensure that participants were as truthful as possible with the information they gave

(Shenton, 2004). It was ensured that all information was given clearly and opportunities offered for advocacy and support when making the decision to participate. These multiple opportunities to withdraw ensured that those participating were doing so without duress and therefore willingly, and therefore the information contributed would be given as freely and truthfully as possible.

4. Comparison of coding as outlined by Yardley (2008) was also utilised. This was carried out by having a second person (academic supervisor) go over the annotated transcriptions to critically evaluate the identified important data and subsequent themes and give feedback from their point of view. This offered a method by which the coding could be rigorously evaluated for understanding, clarity and faithfulness to the participant experience. Regular feedback was also obtained during the 'writing up' phase of the project to ensure critical review of the findings from someone a bit further removed from the data. This was to ensure the participant story was not lost through the analysis process due to the researcher's depth of immersion in the data.
5. Participant feedback was also identified by Yardley (2008) as a strong method for increasing validity. Willig (2013) supports this notion, noting that validity can be considered to be present if the participants agree with the findings of the study. Guba (1981) describes this in terms of its contribution to credibility. He goes so far as to say this is the most important act a qualitative researcher can carry out within their work as it is being checked for accuracy by the participants who have had the experience themselves. This is the very definition of credibility in this type of project. This feedback was obtained at two different stages, the first being that the transcripts were returned to participants prior to analysis. This was to ensure that the transcript was a true account of the interview from the participant's perspective and that it captured their intent appropriately. Notes of the meetings were kept and referred to during analysis. The second opportunity for participant feedback was when the data had been analysed into themes. These themes were presented to the individuals for comment, and again notes were kept of the meetings. This second process was only carried out with three of the five individuals as one was unavailable to have this information returned to them, and another felt that they were too unwell mentally at the time to have it returned to them but was happy for the information to continue to be part of the study without them seeing it.
6. Other similar qualitative projects have been sourced and examined as part of this research project.

7. Due to the nature of the analysis process, the data has been read and re-read many times, each time providing a more in-depth understanding of the experiences of the individual. If done well this allows for the researcher to put themselves as far as possible into the experience of the individual. As these readings were completed for this project, the analytic process as outlined in table 2 was carried out. This has provided a process by which I was able to track the analytic process and the path that has been taken to move from the original transcript data to the final thematic table. Smith and Eatough (2007) describe this as a type of audit process that is carried out throughout the analysis. This type of paper trail was also identified by Yardley (2008), Guba (2012) and Willig (2013) as being a good tool for maintaining a high level of trustworthiness as it not only allowed for internal audit but also external audit if necessary. Folders were kept for each participant containing not only the annotated transcripts but also notes of all meetings carried out with the individual participants.
8. Working under the principle that the intent is not to reduce the influence of the researcher but to allow the researcher, who is accepted within qualitative research as inevitably being a significant part of the research process, to utilise this influence to increase participant engagement to allow for the production of detailed and descriptive data (Yardley, 2008).
9. Not striving for reduction of error or bias but rather encouraging the participant's individual context, experience and personalised account to take precedence. Again allowing development of an in-depth set of data for analysis which is required for IPA analysis in order to have the best chance of gaining an intimate insight into the experience of that person, which is the goal of this research project. Guba (1981) suggests that no human experience is free of context and the variations are as important as the parallels when trying to come to an understanding of a phenomenon.

The following processes have been carried out with the intention of achieving a high level of *transferability*:

1. Looking at generalisability in a different way than it has been considered traditionally, Yardley (2008) points out that typically all researchers would like their findings to be generalisable in some way, however this looks different in qualitative and quantitative methods. She refers to qualitative studies considering this not from a population based angle but rather that the information or understandings developed would be able to be replicated or

applied in similar contexts. This means that the research findings can be adapted to situations that may be similar and therefore have a level of flexibility unattainable in quantitative studies. This viewpoint was adopted within this project, as it is hoped that the findings will not only add to the body of literature focused on those with severe and enduring mental illness, but also that it may help guide those developing, auditing, or modifying activity programmes for this population group.

2. Offering enough information about the service in question, the research question, participants, research method, and participant involvement within the results section of this project to allow those reading to have as clear as possible understanding of the context in which it has been conducted. Shenton (2004) asserts that the above noted process will allow the best opportunity for the research findings to be transferred to other contexts, hence increasing its utility as an information source.

The following processes have been carried out with the intention of achieving a high level of *dependability*:

1. Rigorous application of the chosen methodology providing a clear, detailed description of its application throughout the project (Shenton, 2004)
2. Reflective practise in relation to the entire research process carried out regularly (Shenton, 2004). This information will be detailed in the 'limitations' section of this project following the discussion.

The following processes have been carried out with the intention of achieving a high level of *confirmability*: Several of the points noted above assist towards ensuring confirmability and have been utilised within this project; these include ensuring the participant experience is captured fully and faithfully, utilising a reflective process, having the audit process available, and providing a detailed methodology description (Shenton, 2004)

Chapter 4 – Participant Narratives

This chapter includes a narrative for each participant. The purpose of the narratives is to give a rich description of the participant's account of their experiences at the centre, in an effort to provide a transparent way of showing where the later reported themes emerge from. Each narrative contains a brief description of the participant and then moves into an at length description of the interview and how this was interpreted.

4.1 Participant 1 - Robert

Robert is a Maori man in his mid-forties. He identifies strongly with his Maori culture, however when asked if he wanted a Kaumatua present or to initiate the interview with a karakia he declined both. He has a self-reported diagnosis of Schizophrenia (Paranoid Type) and engages in ongoing active medical treatment for this. He supplements this treatment with attendance at the activity centre. He states that he has used the service for 15 years where approximately ten of these will have been with the service in its current format. He has in the past, and continues to, engage in several different types of courses but these are dominated by courses with a physical activity component. Robert spent a brief period as a young man completing what he calls access courses, which appear to be training courses for those who were unemployed at the time. This involved a period of training and working with peers in a farming environment. He did not spend much time speaking of these experiences apart from to say that he enjoyed the learning and peer engagement in that environment.

Initially during the interview Robert appeared a little nervous. Early in his dialogue he expressed feeling like he had a lack of skill expressing himself verbally (pronunciation). This admission went some way to explaining these initial nerves given it was an oral interview. It appears he initially felt a little pressure given the formal nature of the discussion. This was one of the reasons it was chosen to have the interviews at the centre itself, to reduce any intimidation from the situation as much as possible. I also made sure to engage with Robert in as relaxed a manner as I could given the circumstances. These mitigating measures were successful and as the interview progressed he became less concerned with his use of language and expressed himself openly and fully. He felt comfortable to express issues related to his culture and physical disability which ensured that a detailed picture of his experience was able to be gained as these are quite significant defining factors to his sense of self.

Throughout the interview Robert described a journey of significant self-discovery and personal growth which will now be discussed in further detail.

Robert started by discussing an early life that was dominated by difficulty. He expressed this particularly in terms of his lack of education. He discussed that his siblings had all done well with their education but he had not managed this, failing his school certificate and spending a lot of time truant from school. This early mention of education and its importance to life went on to become a dominant theme for Robert throughout the interview. The recurrent return to this theme appears to come from an early age where it was instilled in him that education is a valuable life tool. This belief has persisted and has been one of the factors that has guided his decisions to initially engage in and subsequently continue use of the activity service.

During this early discussion Robert spoke of the fact that physical activity at school was the only reason he would attend and something he found to be enjoyable and achievable, "I really liked the sports activities (at school), that was the only good effect on my life". This high level of physical ability which he was able to define himself by and gain some satisfaction from was interrupted when as a young man he lost the lower part of one of his arms in an accident. This was a significant traumatic experience in his life and an apparent antecedent to his loss of self-esteem, described within the interview by the term "embarrassment". He goes on to describe himself as "grouchy" and "aggro" as a person socially, a behaviour that appears to have established itself post-accident. At about this time he also had a young family, however his relationship deteriorated and he "lost" his wife and family. His life has also been punctuated by drug and alcohol use, a factor which he appears to believe had an impact on the development on his mental illness, and in particular the psychotic component of this illness. These combined factors resulted in an angry, unwell man who was set apart from family due to his lack of achievement, had lost his young family, and had also lost his ability to engage in physical activities which he had previously enjoyed and had been a defining part of his identity.

Robert's entry into the activity centre commenced a period of regaining his identity. He found himself with the opportunity to express and rediscover himself. Due to his overwhelming sense of embarrassment and self-confessed aggressive attitude towards others, a significant factor in his ability to join and remain engaged with the activity service was the non-judgemental attitude and environment created within the service. He stated that he was apprehensive initially as he was unsure how his mental illness and disability would be received. He thought his self-stigma related to these two issues would likely be replicated by those who he met once he started attending. He instead found social acceptance greeted him from both peers and staff which allowed

him to overcome this first barrier. This acceptance from peers and staff also appeared to begin and foster an acceptance of self in spite of his mental and physical challenges.

The second factor which supported Robert in his redevelopment of his identity were the opportunities, both informal and formal, for skill building and personal development. He was able to engage in a variety of courses in an effort to again find what he enjoyed and what he was capable of. Ultimately this led back to his preference and enjoyment of physical activity pursuits. The service is structured in such a way that he has been able to engage in a range of physical activities that have not necessarily relied on his use of both arms. The ability to adapt his programme of courses to suit the disability allowed him to regain the pleasure of again engaging in physical activity. He has been able to make this an achievement based activity also by setting his own goals of what he would like to achieve physically in each program. He mentions this sense of achievement as an important factor in feeling good about himself. He also views the service as an educational establishment, and his ongoing engagement and achievement of goals is meaningful in that it allows him to fulfil his childhood value based goal of success in education.

More informally Robert has developed more appropriate social skills and subsequently fulfilling peer and staff relationships, via ongoing engagement with both parties whilst attending his courses. He appears to have developed a high level of comfort with who he is and this has resulted in a level of social comfort he appears to not have experienced in either his young life or early adult life. This redefinition of identity and determinants of life success have had a flow on effect and the impact of increasing Robert's self-esteem and confidence, a point he mentions several times throughout the interview. This confidence and self-esteem has also flowed over into his personal life and he describes that he now has the confidence to take up the place of Koro (grandfather) to his now grown children's children and share his life knowledge with them. He ultimately feels his mana (prestige, influence, status) has been restored.

Other factors that have impacted on Robert's experience of the service have been the ability to develop self-efficacy and the support he has received from peers and staff. As mentioned earlier the acceptance from staff was a key factor in his comfort in attending the service, he also described learning how to ask for help and how doing so has been helpful. Finally he spoke about how the staff have been "useful" in regards to assisting him to develop his knowledge and engaging in a recovery process. His level of self-efficacy has improved not just within the service but also within his personal life. He has more confidence to engage with and support his family, he is able to make choices about how he manages his overall wellbeing, and he also now has confidence to engage well with those who support him socially and clinically.

And, on a more practical note, attending the service regularly allows him to work towards a goal of being around drugs and alcohol less which is one part of his life he still struggles to manage. Having the choice to attend the centre offers him respite from a difficult peer environment in which drugs and alcohol are readily available but which he knows are detrimental to his overall wellbeing.

This journey of growth and achievement for Robert has been achieved via a myriad of interconnected themes, however there has been one factor that has overarched them all and allowed the previously mentioned themes to become evident in and impact on Robert's life. The experience of empowerment has been a powerful catalyst in assisting Robert to develop a sense of hope that he was able to overcome his barriers and live a life of meaning and achievement. This empowerment has been achieved via and is interwoven with many of the factors already discussed. For example, the acceptance Robert experienced from staff and peers allowed him to develop socially which flowed over into self-confidence and self-esteem. These growths have subsequently allowed him to take control over a life in which he felt little control early on as he felt he did not fit in or achieve what he should have. This personal growth was not only marked by a reduction of embarrassment, and significant increase in confidence and self-esteem, but also by a development in understanding of his past self, and the need for maintenance of a positive lifestyle. He has also made the move to use the support available to learn about and to accept medication as a part of wellness, as well as the knowledge and understanding of how to remain well and accept support to achieve this.

The final empowering factor was the previously mentioned flexibility of the service. Robert has been able to choose courses that are useful to his recovery stage at any given time and weigh his programme heavily towards physical activity, an area in which he finds particular value, meaning and fulfilment. This flexibility is complimented by the fact that the service is not time limited. This has been particularly valuable for Robert as he has had a long journey through his recovery and had this been time limited he would not have been able to make the continuous positive progress he has made. All of these factors have combined to allow Robert to move into his own support role as a role model to new clients entering the service and to his children and grandchildren. This is something that he is able to derive mana and fulfilment from.

Robert has spent the last 20 years engaging in a long and difficult recovery journey. The last 10 years of this has been particularly positive for him. He has been able to develop a sense of identity and love of himself that he was unable to fully achieve as a young man. A challenging childhood and a traumatic young adulthood led

Robert to feeling embarrassed, angry and lacking knowledge or value. He has described in his interview a challenging process of self-discovery, learning, and perseverance which has resulted in a positive overall life outcome for him. He feels that he is stable with regards to his mental illness and has achieved this through a combination of self learning, medication support and lifestyle change. He has overcome the barriers of self-doubt, self-stigma and what he describes as mental and physical disability to achieve some personally significant accomplishments that he was unable to achieve earlier in his life. These include but are not limited to engaging successfully in a form of education, a clear and positive definition of self, a sense of pride (mana) and a good level of self value. He feels he has a voice, one which he is now confident to share with not only those at the service but the wider community and his whanau.

4.2 Participant 2 – Lyall

Lyall is a man in his mid-forties who has identified himself as Australian. He has a self-reported diagnosis of Schizophrenia (Paranoid Type) and was raised in Australia after having been born in New Zealand. He has lived with his parents his whole life and continues to do so. Prior to moving back to New Zealand in his early thirties, Lyall spent some time studying at a TAFE (Technical and further education institute) after he finished his schooling and then worked different seasonal jobs as a young man. He has been with the activity service for what he believes is approximately seven years. Over the course of this time he has completed many of the different course types available and currently engages predominantly in groups with physical activity and physical health as the primary focus. Lyall has described a life that has been “good” in the past and indicated that he feels that his life at present is also “good”, with attendance at the activity centre being one of the key elements of his current feeling of contentment with his life. Throughout the interview Lyall established himself as a man of few words who utilised language that established him as an easy going person in the form of words such as “yeah”. Though he was not prolific orally, his responses had a high level of clarity and provided data that overall showed that use of the activity centre was a positive experience for him.

“I love being here, so I enjoy it”

“so I like (name of service), so I’ll be here forever”

Lyall's narrative commenced with an unsolicited discussion regarding his past employment and study. When asked about his life prior to attending the activity service he spoke of his "wellbeing" being "pretty good" and discussed this feeling of wellbeing in a sentence that also included a reference to study and work that he undertook when living in Australia. This gave the first indication that Lyall found meaning or value in, and referenced his 'good' life, against working and studying, things a person would usually do in the course of their life. He confirmed this thought of 'normality' or convergence with the general population when he immediately went on to describe his life at that time as being "pretty general", the use of the term appearing to refer to being the same as the general population or others. Lyall showed a sense of pride in his study at TAFE, going on to express to me how he achieved well in his courses. He also expressed that he enjoyed employment, particularly in terms of the fact that it enabled him to learn new skills. When asked to reflect on his working life and draw a comparison between this and his use of the activity centre he stated that he found the activity centre enjoyable and satisfying to attend with little other detail. However throughout the interview there was evidence that Lyall utilised the service almost as mimicry of his early adult life of study and work. He referenced learning new skills as one of the key reasons he chooses to attend the centre. He also made parallel comments regarding opportunities for being social being important in both environments.

The above observations indicated that education or skill building were a key part of Lyall's identity. Other factors that were identity based and became apparent during the interview were personal responsibility, choice, and self-improvement. Lyall expressed that he had experienced improved physical health (reduced smoking and reduced asthma) and an increase in motivation as a result of attending the service. This increase in motivation was evidenced later in the interview by his assertion that he would like to attend more days per week than he presently did. He also referred to choice of courses as being important. This factor allowed him to not only express his identity via doing courses he enjoyed, but also to further establish factors of his identity by learning new skills and experiencing new activities. The final factor was personal responsibility. Lyall referred to this with the statements, "I do what I have to do so I come here to (name of service) each day and do what I have to do" and "I feel yeah, like responsible for myself". Not only is this another correlation to the expectations of work but also indicates a part of his identity lies in having a sense of responsibility.

The above mentioned factors of personal responsibility and being able to choose, that is having autonomy over the construction of his programme, has provided Lyall with a sense of personal efficacy and independence. He actively chooses physical

activity courses which are more suited to him rather than doing other things. He has undertaken other courses at the service in the past and had not liked them and therefore values the opportunity to engage in things meaningful to him personally. He also refers to being actively engaged in something outside of his personal life, “doing something, being out of the house” which alludes to independence of his home environment where he lives with his parents, and the value this has for him as an independent adult. With regards to personal responsibility, it is an expectation of the service that a client is responsible for their attendance or notifying staff if they are unable to attend. This is a ‘real world’ expectation and supports the building of independence and autonomy. All of these factors offer empowerment, particularly the ability to choose courses.

The theme of commonality with others, initially noted with regards to his study and work, was evident throughout the interview. Lyall spoke of an important feature of his attendance at the activity centre being that, “everyone attends, not just me, but everyone attends”. This showed a sense of belonging to be important to Lyall. Belonging for Lyall was experienced via the following processes; positive and supportive relationships with staff, social acceptance, inclusion with the rest of the population, and experiencing fun and enjoyment whilst participating in the courses. The theme of socialisation was prominent in his discussions throughout the interview; he noted a second point of enjoyment and importance when working which was being around other staff, he then went on to state that this was the same as being at the activity centre with his peers. This again strengthened the correlation between his experience of work and a positive experience of life as a young person, and attending the activity centre and a positive experience of life as an adult. Lyall did not give a lot of detail in his references to staff support and relationships, therefore a high level of understanding behind the rhetoric was unable to be gained. Despite this lack of depth the fact that he made reference to staff three times in the interview highlighted it (staff relationships) as an important factor. One occurrence was during a discussion of the term ‘meaningful activity’ and his personal definition of this, and subsequent threads being followed regarding enjoyment. He spoke of the staff in the same way he did his peers; “being amongst you guys, yeah, being around everyone yeah”. This is inclusive language and it could be inferred from this phrase that he considers the staff to be less in a power based relationship but rather more of an inclusive relationship reducing the concept of difference between staff and clients and therefore promoting a feeling of inclusion in an accepting and ‘normal’ peer group.

Lyall’s overall experience of the service, as described during the interview, has been positive. He has been able to utilise the service in a way that has mimicked his

early life which was positive by his determination. By having flexibility and autonomy within the service he has been able to recreate an environment in which he has been able to experience key meaningful factors that punctuated his early life and therefore established themselves as important for him. These include a feeling of belonging within the environment and group, and learning new skills. These factors have in turn allowed Lyall to develop a high level of self efficacy, and strong identity which have allowed him to experience a positive life both within and outside of the service. And a final simple but not unimportant point is that he really enjoys attending the service.

4.3 Participant 3 – Rita

Rita is a Maori woman who is almost 50 years old. She has a self-reported diagnosis of Bipolar Affective Disorder and was raised in New Zealand in a large, supportive and very loving family. She currently lives independently in a unit that is family owned and whose purchase she has contributed to financially. Rita has had a great deal of life experience which includes high schooling in America, at least two different instances of employment, engagement in adult education, at least one period of acute mental illness resulting in inpatient care, being the victim of and leaving a physically abusive relationship, and being part of a close knit family unit. This life experience allows Rita an excellent vantage point from which to reflect on how the use of the activity centre has impacted on her life. She expressed herself openly throughout the interview and unreservedly discussed the aspects of the service that she found both positive and negative. She spoke openly and lovingly about family relationships and was clear on how these had shaped her self-perception (which was positive and self-affirming), identity and values. Rita also appears to have had little stigma placed on her by family and has therefore embraced supports she has received from Mental Health services both at a secondary and tertiary level, having used community mental health services and inpatient care. Her lack of self stigma and positive upbringing have ensured that she has had a strong sense of self throughout her journey through life and she has therefore been confident to ensure that services have been suitable to her needs. She has generally found the experience of attending the activity centre to be a positive one and when discussing her attendance stated, “oh gosh, really it’s wonderful coming here”. There were several themes and subordinate themes that emerged during her interview which illustrate her positive experience.

Rita has used the service for an indeterminate but lengthy period of time. This has established a strong sense of belonging for her. This is predominantly in terms of the longstanding relationships she has established with staff members which have in

turn allowed for the development of a high level of trust. Peer socialisation and subsequent friendships has also contributed to this sense of belonging. The level of trust with some staff is demonstrated in that throughout the interview she was willing to discuss some very personal experiences she has had and understood that not only was this confidential because of the fact that it was part of a research project, but also because she trusts that this information will be treated respectfully anyway. She also expressed that some of these relationships have become an important part of both her history and her present, as they form part of the supportive network that she finds valuable to her wellbeing. The friendships she has developed have also become a valuable part of her life both at and away from the centre. She has been able to express her Christianity openly and this has allowed her to meet likeminded people and establish relationships that have moved beyond the service and become part of her life in the community. This ability to attend a service with no experience of being judged for beliefs and differences has enabled her to develop a sense of belonging and a sense of value in attending.

People appear to hold high significance in Rita's value system. She spoke at length of her family and friends during the interview. She has experienced a loving and giving family which has in turn established family as a prominent and valuable feature in her life. She has expressed these values in her early adult life by helping her parents financially when able, spending a period of time assisting with the raising of her younger brother, and living in and caring for an extended family member. These values were also apparent in her description of her working life where she acted as supporter, carer or helper for others. This very important part of her identity has been preserved in her use of the activity centre. She has been able to assist others using the service through her friendships with them and contact with them outside of group hours.

She has also been able to create and give gifts to cherished family members despite financial constraints resulting from her inability to work. Not only are these gifts that she has been able to create, they are much more; a point she illustrated very well with the statement; "I don't just 'make' them, there's a lot of love goes into what I make, and that's pretty meaningful".

Attending the service also gives Rita the opportunity to engage with the community via the different activity groups that she enrolled in with the service that were carried out within the wider community, as well as with her peers within the centre. This allows her to be part of something bigger than just herself and her family, allowing her enact her identity as someone who values and engages with people.

The other aspects of the service that allow Rita to develop a sense of identity following drastic life changes are the flexibility of the service set up, the ability to be

responsible for one's self, and the fact that Rita is able to engage in this part of her life journey on her own terms. The first point is that she is able to choose courses that suit her needs at any given time, whether this be self-care and relaxation or physical activity. During the interview she discussed a particular class that she found difficult; though she did not enjoy it as much as she might have this did not dissuade her from continuing with the service as she was able to choose to move to a more suitable course. This allowed her to express her sense of self. The second point is that Rita appears to view her attendance at the service as a natural part of what she has accepted is her individual life journey. This acceptance based way of thinking about her life not only supports her sense of belonging, as she views the service as the place where she should be and therefore belongs, but also because she accepts that the centre is an integral part of her journey and therefore makes up part of who she is. The final point is that of personal responsibility. She is a person who has from a relatively young age been responsible for herself and often for helping others. The service allows her to continue to experience a sense of responsibility towards herself and beyond.

Several of the above mentioned factors also blend into other areas for Rita. For example, the concepts of responsibility and flexibility of the service allow Rita a high level of autonomy leading to a sense of self-efficacy. She expressed feeling empowered by being able to choose her own courses and being able to change these as required. Accountability and responsibility for attendance and making decisions regarding service use also support autonomy. One further aspect of self-efficacy for Rita was the opportunity available at the service for self-care. She discussed that she has learnt through her life experiences that caring for herself is extremely important. This was evidenced when she discussed working more than she was capable of mentally, and supporting others at the expense of her own needs. The opportunity for self-care not only allows for her to ensure that she remains well but also allows her to be able to continue helping others in which she finds a great deal of value and meaning.

Finally, Rita is empowered and supported via the trusting and respectful relationships she has developed with staff and others who use the service. Staff support appears to be valuable for ensuring her positive engagement with the service. She spoke of having fun with staff and inferred that this makes for a positive environment. She appeared to appreciate staff behaving in a relaxed and fun manner, and aligning themselves with service users so as to normalise the relationship and reduce the staff–client differential. The importance of appropriate staff engagement and support was also noted when Rita discussed a staff member who had at times reduced the enjoyment of a particular course. A further example was where Rita felt a staff

member did not respect her autonomy to make decisions about her attendance. She appeared to almost find this disrespectful. This example further illustrates that Rita finds being allowed to exercise personal responsibility very important. A supportive staff member who has developed a good relationship with her would be able to recognise this and be able to support appropriately. She also described the significant positive relationship she has had with a different staff member. Her references were in keeping with the high value placed on helping others; she described the staff member by saying “she has been so good to me” and “every time I ask her to help me with something she helps me”. The discussion highlighted how a positive client experience relies on the genuine support and the desire of staff to help.

Rita’s overall experiences at the service have been positive, although she also highlighted some areas that she found made it less enjoyable. These involved a particular staff member and supported her description about how her sense of autonomy and self-efficacy are important to her, and how staff relationships and rapport are an important. Rita is using the service to support her wellbeing as she has found that she needs balance in her life between her desire to help others and the need to look after herself. By using the service she has been able to develop and maintain a high level of self-efficacy, be empowered to develop friendships with others, have the opportunity to ensure time for herself, and have an opportunity to make gifts for her family. The latter allows her to continue to participate in reciprocal relationships with her family that would otherwise be very difficult to sustain.

The final point that comes across for Rita is that she has been able to merge the use of the centre into her existing life and so they have become complimentary. This is via the friends she has made, friendships which have transitioned into the community and her personal life. As noted above, it also allows her the opportunity to maintain the type of relationship with her family that she has had in the past, maintain her sense of personal identity, and allow her to remain ‘well’ in order to be able to continue to engage in her helping role she carries out with friends and family in the community. This complimentary aspect means that Rita can progress in her life journey on her own terms and in a way that allows her to be herself and live a life that she herself considers meaningful as it has been in the past. By way of describing where she is at present and where she wants to be in the future Rita told me, “I’m just happy that now my life is actually on track” and later, “I want to stay on track”, this highlighting for a final time the value the centre has as one facet of her current life.

4.4 Participant 4 – Amy

Amy is a woman in her mid to late forties who identified herself as a New Zealander. She has had more than one diagnosis during her life, however at the time of the interview her lead diagnosis and the one which initiated her enrolment at the activity centre was Major Depressive Disorder. She estimated her time at the centre as approximately twelve months. Unfortunately a lot of this time has been punctuated by significantly poor physical and mental health. She described herself and her life pre activity service as, “boring because I was on my own all the time, quite unwell, quite depressed, unmotivated, isolated”. During her life Amy has been employed and as an adult has predominantly lived independently in rented accommodation, as she was doing at the time of her interview. Amy provided little further about her life prior to her engagement with the activity service. What was clear from the very beginning however was that she was experiencing a life of solitude in which her main contacts with the world outside her home were her community mental health team, a neighbour she saw “very occasionally” and a friend she spoke to overseas.

She initially appeared quite nervous about the process and was reassured that she could end the interview at any time and also that the recording could be stopped if she needed this which assisted in reducing her nervousness. She took advantage of the opportunity to turn off the recorder once during the course of the interview as she required time to think of a response. As the interview progressed she acclimatised to both the recorder and the interview itself and was able to complete the process without any incidences of anxiety or distress.

Early on in the interview, Amy made it clear that socialisation was a key goal for her with regards to enrolling in and attending the activity service, with her ultimate ideal being to be able to transfer this socialisation to her home life. She also repeatedly expressed a very strong desire of wanting to be in the ‘real world’. For example, Amy wanted to regain and develop her social skills in order to be able to more fully integrate into her community and in order to develop friendships that would reduce the isolation in her life. The service helped her progress towards these goals but also presented challenges for her. She noted that she had built the confidence to give her contact details to someone within the service in order to establish a relationship outside of the service. She also found that the social aspect of the activity centre allowed her to redevelop her social skills. A concern for her was that although when she was at the service she had ample opportunity to be with others, when she returned home for the day her isolation was more pronounced due to her having been able to socialise all day. This had the effect of increasing her loneliness in her home environment and at

times resulted in lowered mood. A second paradoxical effect she experienced with the social aspect of the service was that there were times that the sheer volume of people around her had the potential to cause elevations in anxiety. Initially with support and then more independently she was able to manage these incidents, however it provided an extra avenue of stress for her when attending. For the most part Amy was able to manage these contradictory social effects with an understanding that she now had hope for reducing isolation in the long term if she could manage the increase in loneliness and anxiety in the short term. Her continued attendance at the service alluded to the fact that she found that the positives outweighed the negatives.

This social aspect of the service, combined with the supportive environment she found there, allowed Amy to develop a sense of belonging which increased her self-esteem and confidence, and allowed her to grow personally. This supportive environment was discussed by Amy in terms of staff support, peer support and the expectations of the service. She made more than one comment about feeling safe and comfortable to use staff and sometimes peers as a sounding board. She felt her own thoughts and responses to the social environment had the potential to be skewed and so asked staff to give feedback on this to support her in developing more suitable thoughts or confirm that she was correct in what she was thinking or feeling regarding a particular situation. She also spoke of feeling comfortable enough to ask staff if she could leave groups when she was feeling overwhelmed and that this flexibility and lack of judgement within the service supported a growth in confidence and self-esteem, both of which she has experienced in the past year. She also gave a specific example where a staff member had taken time to be with her in a moment of extreme anxiety. This was done without pressure or judgement. The format of the course at that moment was changed and the staff member supported her to work through the experience and go on to complete the course session. This flexibility and unconditional support were prominent features of the service for Amy. This worked in conjunction with what Amy described as a no pressure environment, one in which she could work at and experience the courses at her own pace, thus creating a place where she could safely explore her social capacity and begin to rebuild herself.

During her time with the service, Amy was also looking to redefine herself. She did not go into a great deal of detail but did express that her life had undergone some significant changes; changes that have meant that she no longer felt as though she knew how she fitted into the world. She expressed this by saying she was “looking for who I am now”. One attempt she made to redefine herself was socially as outlined above. The others were by pushing herself to reintegrate with the community in which she lived and developing herself personally. The first was achieved via accountability to

the service to attend. One part of the service procedures is that a person is responsible for attending or letting staff know when not attending. It was apparent that due to low self-esteem and lack of motivation Amy was not prepared initially to do things if they were only for herself. When she became accountable to the staff at the service for her attendance she grew in her resolve to ensure she did what was required of her. This helped ensure that she did not just avoid things and continue to isolate herself. As her self-esteem and confidence grew, she started to do things for herself and not only because she 'had' to. This flowed over into her personal life; once she had developed a better routine, she was also less likely to avoid going to town in order to carry out tasks that required doing. This had a twofold benefit; she reduced her anxiety as she was completing things, and she was also entering her community more. The second part was personal development which for Amy happened in multiple ways. As noted above she was required to manage anxiety symptoms and use previously learnt strategies to do so which she did successfully. Also noted above was her drive to develop socially. Other opportunities she had were not so much via the particular courses she chose but naturally occurred with her ongoing attendance. For example, she spoke of planning skills being a key outcome for her. She now had to plan her week and develop a routine rather than just put things off. She also spoke about not being able to be complacent about when she gets up in the morning.

As mentioned earlier Amy was asked if she had any experience of working, which she did. When subsequently asked if the activity service gave her the same experience, her reply was consistent with what was expected from the content of her interview. She mentioned throughout the interview that she valued achievement. For example, she completed a mosaic project at the service on her own and in the midst of physical illness. She viewed this as a significant achievement and experienced a growth in confidence and self-esteem as a result, saying that this type of success helped provide her with a sense of purpose and assisted with her journey of self-discovery. She has had more than one such an experience during the past twelve months, in her mind however it seems this is still not that same as existing in and contributing to the 'real world'. She spoke of when she was working as being able to achieve something every day, and not being on a benefit. Conversely she stated that she found the expectations and commitment required in a workplace overwhelming. Whilst these things (expectations and commitment) were present at the activity centre they were couched in a supportive and accepting environment so were not only acceptable to Amy but became valued parts of the service.

Amy has had both positive and challenging experiences within the service. She has grown in confidence, motivation and has developed her social and self-

management skills, and has been able to achieve these things via the processes and experiences outlined above. Though she has encountered some difficulties at the service these became opportunities for personal growth. The service was also able to offer achievement based activities that suited Amy's need for achievement. The flexibility of programmes allowed for individual planning to suit her particular needs at any given time, and she experienced a supportive and accepting environment allowing her to develop greater acceptance of herself and redefine her identity. She has experienced poor physical health and felt that if she had not had access to the support available at the centre this may have had significant negative consequences for her, including the possibility of self harm or complete isolation. All of these experiences have culminated in some positive life changes and outcomes for Amy. She however believes she has a significant journey ahead of her. She still feels that she has a lot of work ahead in regards to improving her sense of self and moving into and participating more fully in the 'real world' which she feels would provide her with a real sense of purpose and meaning and allow a more fully rounded social engagement with her community. Her concluding remarks summed this up, "I'm pleased about when I do make it here, particularly on a hard day, and that helps. I know it's helped my trust in people but I'm still pretty negative about myself and my life, I still have no real sense of purpose in life at the moment so it's quite hard".

4.5 Participant 5 – Luke

Luke is a man in his late fifties who has a diagnosis of Major Depressive Disorder. He described himself as a European when asked his ethnicity. Luke's interview was the shortest of the five as he answered all questions briefly. When efforts were made to redirect the questions or illicit further information he occasionally gave a little more but otherwise stuck to his concise, to the point, responses. Throughout the interview Luke presented himself as a man who experiences an ongoing low mood which appears to be related in large part to loneliness and low sense of self-worth. When it comes to determining whether or not he has a high quality of life, Luke appears to place high value on what people think of him, his ability to have relationships with others, and the volume of social contact he has with others. He also experiences chronic pain which impacts on his ability to maintain motivation and a stable mood. Luke has utilised the service for approximately two years and engages in physical activity, art and education based groups. Despite his use of the varied groups and the apparent value some of these have had for his wellbeing, it was clear that his use of the service was predominantly about having a social outlet and opportunities to feel included and

valued. Prior to service engagement he experienced extreme loneliness and low self-worth describing it as follows, "It just feels like, just empty, nobody wants you".

Socialisation was relevant to Luke's relationships with both staff and peers. It contributed to a feeling of belonging for Luke. This is because, as mentioned above, Luke highly values social relationships, so social engagement in this environment allows him to feel valued and part of something. This feeling of belonging was in part achieved via the support given to him by staff. Luke has had the experience of using another activity centre. He reported that this service placed him in a group with a lot of others. This did not take into account his learning disability and he failed to thrive with regards to learning to read and write which is why he had enrolled there. Conversely staff support is given on a one-to-one basis as required at the service that is the focus of this study. This allowed Luke to not only start making progress with his learning, but also allowed him to feel like he was not just another face in the crowd. Another facet of these social relationships that Luke found allowed him to feel comfortable was the fun he was able to have. He described being able to "have a laugh" as a valuable part of his experience at the centre. This engendered comfort, a feeling of friendship with peers, and allowed him to experience some positivity when he was experiencing a low mood.

The second important aspect of socialisation for Luke was that it helped him to develop and maintain a more positive sense of identity. During his interview he detailed a life of difficult relationships with those close to him. He had experienced a divorce and has trouble getting along with his adult children who he feels do not value him as a person or in his role as a father. His longing for and enjoyment of personal relationships was evident when he discussed a recent visit with his granddaughter and during the interview stopped to show me photos of her on his phone. He described his grandchildren as "something to live for" and he was obviously proud of her and enjoyed the contact, but noted that such visits are few and far between which often leaves him feeling bereft. It became apparent that use of the service was not just to develop a social network but an effort to gain friends and be able to enjoy a more personal relationship with others. This has also been a difficult exercise for him as he stated he sometimes has social difficulties at the service and does not know what has gone wrong. What he has been able to do however is maintain attendance and confidence and allow the difficulties to sort themselves out which is something he has in the past been unable to achieve in his private life. Given that his family roles had effectively been disestablished, attendance allowed him to begin to redefine himself and develop more appropriate social skills. Having social success, even though it has at times been difficult, has also allowed him to gain confidence. This has led him to develop the goal

of returning to where he was raised and re-establishing his relationships with his family of origin.

This improvement in confidence and self-esteem has not just been attributed by Luke to his social success but also to his skill building. He has worked through adversity to make some small improvements in his reading and writing. These small successes have slowly built confidence and a sense of self-worth. As a result Luke has been less likely to fall into bad habits when faced with a difficult situation or a return of low mood. His past pattern was to go to bed and try to sleep through his low mood and self-loathing. This created a negative cycle for him with further deterioration of mood. Now that he has more confidence and motivation he is less likely to do this and makes more of an effort to counter his negative thoughts. As a result he has been able to start fixing his house in an effort to move towards his goal of selling and moving back to family. It appears that this is a big achievement for him as he spoke of this in depth. This increase in self efficacy has fostered a sense of empowerment and an ability to start making decisions that would allow him to move towards the future he has been thinking of but has lacked the motivation and self-worth to strive for. Luke's self-improvement was not confined to his psychological health but he has also experienced improvements physically. He reported an increase in fitness as a result of attending groups at the service. This also worked in his favour as it supported his ability to achieve physical tasks at home meaning he had another tool to reduce his likelihood of falling back into his negative coping cycle.

Throughout Luke's interview his focus inevitably returned to the social aspects of his life. Even when asked to compare his experiences of working to attending the activity centre, he described the most important aspect of working for him as the companionship and having someone to talk to.

His experience at the activity centre has been one of learning and perseverance. What he has achieved through this is a stronger and more positive sense of self and what he would like to achieve in the future, and an increase in motivation and confidence. He expressed this by saying "I don't feel I'm just nothing and all that. I feel a bit more confidence in meself".

Chapter 5 – Results

This chapter outlines the study findings in terms of the five themes which are presented in the table below. They will be discussed in terms of their subthemes and derive from the narratives provided in the previous chapter. There will also be a short section on how the participants who had an experience of working felt the activity centre was similar to or contrasted with their time working. Whilst this is not a study that is hypothesis based, when I was completing my literature review for my research proposal it became apparent that studies about work and the meaning this provides in people's lives is common. This led me to think about those who I have supported over the course of my career who are unable to work for reasons related to their acute and/or chronic mental illness. As such there was a part of the interview schedule that briefly touched on this area of interest and the comparisons or contrasts participants were able to make against their experiences at the activity centre.

Theme	Subordinate Theme
Belonging	<i>Socialisation</i>
	Staff
	<i>Enjoyment / fun</i>
	Non-judgemental / supportive environment
Identity	Flexibility / choice
	Journey
	<i>Skill building</i>
	<i>Personal growth</i>
	Social / peer engagement
Self-Efficacy	<i>Responsibility / accountability</i>
	<i>Flexibility / choice</i>
	<i>Independence</i>
	Personal growth
Empowerment	<i>Flexibility / choice</i>
	Resources / course outcomes
	Relationships
	<i>Skill building</i>
	Personal growth
Support	<i>Relationships with staff</i>
	Non-judgemental / unconditional
	Socialisation

Table 3: Themes and subordinate themes across all participants

Note: The items in italics denote subordinate themes that were present for three or more participants.

5.1 Overview

A severe and enduring mental illness has the potential to be a debilitating experience. This study has sought to gain insight into the experiences of five people who live with such an illness and, more particularly, the experience of their use of a mental health activity based recovery centre. Following the completion of semi-structured interviews held with each of the five participants of the study, an analysis of the interview content was conducted as specified in the Methods chapter. Below are the results of this analysis which are illustrated with direct quotes from the participants' interviews.

5.2 Belonging

The theme of *belonging* was one that stood out in the data. All of the participants expressed a high level of comfort with the service and indicated that they felt that they belonged within the service, although this was indicated as being due to several different experiences. These experiences constitute the four subordinate themes; socialisation, staff, enjoyment/fun, and a non-judgemental/supportive environment.

Socialisation was the most significant subordinate theme. It was expressed in discussion by participants around feeling socially accepted, included, and having an opportunity to be social. All participants felt that their experience of mental illness had isolated them in some way. For both Amy and Luke this was an acute issue with the mere opportunity to have social contact with others appearing to make the service valuable to them. For Rita social opportunity was also a key factor as she described herself as a naturally sociable person and has tended to seek out social relationships throughout her life. These three participants found that being able to have access to peers and possibly develop friendships, gave them a sense of being a part of something and not just existing in their own small bubble.

For Robert and Lyall socialisation seemed to be more about acceptance. Lyall wanted to be the 'same' as others with the group aspect and the social aspect available between groups allowing him an experience of commonality with others. Robert's experience indicated that he possibly found that acceptance from his peers and the staff allowed him to start considering himself in new terms. He initially had a very negative sense of self and was "aggro" towards others, but he indicated that an experience of acceptance and belonging at the service allowed him to foster personal acceptance.

I've found being amongst everyone has been really good, like everyone attends, not just me but everyone - Lyall

Companionship (is positive); you can talk to people and all that, and you're not home on your own, and all that sort of thing, that's the biggest thing - Luke

Staff as a subordinate theme was relevant for three of the participants. These experiences were all very different but all based themselves around staff behaviours and attitudes that fostered a sense of belonging. Luke experienced this via staff ensuring that his individualised needs were met. As he has literacy issues, staff were required to assist him more than some others in classes which allowed him to remain engaged and part of the programme, achieving some measure of success along the way. Lyall's experience was based around staff interacting respectfully with him and reducing the staff/client imbalance that has the potential to be present in this type of service. He seemed to find that this acceptance by staff as just another person, rather than a 'client being supported', allowed him to feel comfortable in the environment and fostered a feeling of belonging. This was consistent with him also indicating, as previously mentioned, that acceptance by his peers was a valuable outcome for him. For Rita, belonging was engendered simply by the fact that the staff at the service had been stable for a long time and she thus knew the staff well and felt comfortable within the environment. She had also had dealings with some of the same staff outside of the service in previous years so appeared to be comfortable with them right from the outset.

Enjoyment at the service and having fun with staff and peers emerged for three of the participants. All three referenced this as facilitating a high level of comfort in the setting. This was particularly salient for Luke who was prone to experiencing significant bouts of low mood. Being able to "have a laugh" at the service supported him during these low periods which allowed him to feel like the service was there for him and that he belonged.

There's always a bit of humour aye, everybody's so happy here you know, it makes the world go round aye, happiness - Rita

Joking around and having fun!! - Luke (positive points)

The *non-judgemental and supportive environment* is the final subordinate thread within this category. This was described by two participants and the impact on these participants was significant enough for this theme to be included. Both participants experienced this as a level of acceptance which not only supported the feeling of belonging but also promoted personal growth, a subordinate theme that also emerged as salient in three other themes. For Robert it was predominantly the lack of judgement he felt within the service that was valuable. As mentioned earlier, he had a negative sense of self and was whakama (shy) as a result. Support was received that was not based on his physical impairment, his mental health diagnosis or his lack of educational achievement. This assisted him to feel a high level of comfort and a sense of belonging and supported him in reducing his self-stigma. For Amy it was about not feeling judged but also that the support was forthcoming in any way she required it and, most importantly, she was able to access this support without feeling any pressure to conform to an ideal or timeframe. For her what appeared to be valuable was that she felt safe to check her social behaviour and gain feedback from staff and peers to ensure she was interpreting or reacting to situations appropriately. Knowing that feedback was going to be given objectively and not coloured by subjective judgement assisted her to learn and grow and have the courage to make such requests of others.

I enjoy that I can come and there's not pressure on me here, um I can throw ideas about stuff that's happening in my life at staff members, sometimes other clients, and get feedback to show the way I'm reacting to stuff is relatively normal - Amy

5.3 Identity

This theme was one of the most salient with the initial reduction of data showing 19 experiences of factors that impacted on identity across the five participants. Once these were condensed, five sub-ordinate themes were discerned. These were flexibility or choice, life journey, skill building, personal growth, and social or peer engagement.

Flexibility and choice was articulated by two people. It also emerged in relation to two other categories making it one of the most salient subordinate themes. In this category its importance was in terms of participants being able to pick and choose courses that suited their individual needs and personality (that is, having a sense of choice). This meant that for Rita and Lyall they could express themselves and their own personal sense of who they are. Rita also appreciated the flexibility which allowed her to change or pull out of courses that she did not enjoy or felt were not useful to her.

Journey: Life journey was a particularly prominent notion for Rita and Robert. Rita had a common thread throughout her interview in that she appeared to view her life as a journey and that every part of it was meant to be and was therefore an accepted part of her life. Because of this, she felt that the service was a natural part of her current life and therefore intrinsically part of her identity at the time and important to her not only as a service to use but as part of her life as a whole. The journey metaphor was also used by Robert in terms of a journey of recovery. Whilst this change and growth through a journey process moved across several themes for Robert, its relevance here is with regards to him being able to rediscover who he is as a person. He was able to reduce his self-stigma and concentrate on developing the parts of his identity he was unable to as a youth due to educational difficulties, physical trauma and the eventual onset of his mental illness. The recovery journey was also a factor for Lyall; though his was about regaining past parts of his identity rather than developing them as in Robert's case. Lyall was able to use the service to mimic parts of his life (education, work, social opportunities) that he found meaningful earlier in his life prior to experiencing his mental illness. Amy added a third facet to the concept of the recovery journey; she was wanting to develop or redefine her identity and utilised the service to find out who she felt she was after significant changes in her life.

For Robert the journey subtheme spilled over somewhat into the next one which is *skill building*. He was able to fulfil his family value of gaining education and to learn about himself and his illness. All of these factors contributed to his growing sense of self and new personal identity as an adult working towards recovery and developing a self that has not been possible previously. Skill building for Luke occurred by way of improving his literacy skills. His lack of ability to read and write has been a defining aspect of his identity during his life, so being able to address this held great value for him. For Lyall it came down to his already established identity as indicated in the journey subordinate theme. In this case Lyall placed value on and marked his identity by being able to learn new things and incorporate them into his life, something he was able to do via the service and the large variety of programmes available to him.

Personal growth was also a subtheme within the identity category. Though this was similar to skill building, participants drew a distinction between practical and educational learning and growth of personal self. Within this category personal growth was relevant for Lyall, Robert and Amy. Lyall experienced health and motivation improvements whilst Robert reported an increase in both self-esteem and confidence. For Amy the improvements were more complex. She experienced some difficulties at the service including an increase in anxiety initially when around a lot of people and also feelings of extreme loneliness when home on her own. Though these were difficult

times for her, they produced opportunities for her to utilise her previously established management skills and further develop her sense of self via the learning that occurred from managing these situations.

My motivation and everything to do with motivation and everything in myself has generally improved since I've been here - Lyall

It's boosted me up and made me feel like I'm just as good as anybody else cause I'm doing something - Rita

The *social* aspect of the service again surfaced within this theme category. For Luke and Robert it again came back to their own personal themes of defining self via social relationships and acceptance of self respectively. Both were able to either develop or maintain their sense of identity through the positive relationships they developed with peers at the service. For Rita this was relevant as she was able to be part of the community and have her own social identity outside of her close family network.

5.4 Self-Efficacy

Self-efficacy theory as introduced by Bandura (1982) relates to a person's belief in their ability to successfully undertake an activity and their subsequent decision based on this belief to undertake said activity or not. It is also a determinant of how they will possibly approach an activity if they do indeed decide to carry it out. Not only is self-efficacy a relevant theme because it naturally established itself as such within the analysis process, it has also been discussed in research literature in terms of its central relevance to mental illness recovery (Thomas, Muralidharan, Medoff, & Drapalski, 2016). For this study *Self-Efficacy* is a theme comprised of four subordinate themes, three of these described by three participants. These were responsibility/accountability, flexibility/ choice, independence, and personal growth.

Responsibility was relevant to both Lyall and Rita in the identity theme also. It was expressed there as a personal value or way of being, that is, a core aspect of their identity. In this theme (self efficacy) it appeared to be more about their experiences at the service allowing them to express and build upon this part of their sense of self. For both the idea of personal responsibility is something they have always had. Because this service also promotes this same value, for example a person has to contact the

service if they are not going to attend their group; it seemed to fit well with their core values and drive to be accountable. They are also given the opportunity to choose their own programme and the amount of time they utilise the service for each week, creating a sense of autonomy which again was something valuable to these two individuals. This process also ensures best fit of the service as it is individualised to each person. Amy experienced the sense of responsibility in a slightly different way, more in regards to accountability; she found having something or someone other than herself to be accountable to, improved her self-efficacy as she was more likely to attend than if she was just accountable to herself. When she became accountable to others for her attendance, her sense of responsibility meant that she did what was required of her. As her self-esteem and confidence grew, she started doing things for herself since she experienced an increasing sense of responsibility and accountability towards herself. This was also because she had a feeling of being capable as she had attended successfully for a period of time.

I can't be as complacent about when I get up in the morning. Having somewhere like this to come has been helpful, you know, organising my week instead of putting things off - Amy

Flexibility and choice was articulated by three participants. For Rita and Lyall it intertwined with the responsibility thread as it again related to their ability to choose their programme and how much they used the service to suit themselves. This was the same experience that Robert expressed in his interview and one that again fostered a sense of autonomy for all three, supporting growth of self efficacy.

Sometimes it's nice to do something for you, to keep something for you. Cause it's when you start giving too much that you start losing part of yourself and that's when you start getting unwell - Rita

Independence was the third subordinate theme that emerged and though experienced by three participants this was again in differing ways. For Lyall it was more about having a place where he could express and develop himself independently of his family whom he lived with, again supporting his sense of autonomy, in this one facet of his life at least. For Robert it was about development of the right set of skills for him to be able to move through the world independently, and for Amy it was regaining the independence she once had. Independence and autonomy in this analysis take on two

views of a similar concept. For purposes of reader clarity, Independence has been defined as not relying on others, and autonomy having personal control of choices and relevant facets of life. An example for illustrative purposes can be found within Lyall's case. He no longer has to rely on his parents and family for all of his social needs and as such he now has more personal control over how he engages socially.

These gains in independence are intertwined with the final subordinate theme of *personal growth*. For these three participants, growth in self-esteem, confidence, and mental wellness allowed for independence to flourish. For Rita it was about self-care, a factor of life that she had learnt was very important. Personal growth for her was about taking time for herself to do things, such as attend the service and continue to learn and grow and keep herself well mentally. Luke's personal growth was quite profound; his growth in confidence established a more positive sense of self which in turn allowed him to feel comfortable to start making decisions for his future and look towards goals he had set a long time prior but had never previously worked towards. Once he grew personally to a point where he felt he was worth the effort, significant positive progress was made. For Luke this was the only subordinate theme he had within the self-efficacy theme but an extremely meaningful one nonetheless.

I've actually got more confident, and it's good to feel confident because you will have a voice, and you know confidence comes with achievement and overcoming barriers -
Robert

I now don't feel like I'm just nothing, I feel a bit more confidence in meself - Luke

5.5 Empowerment

Empowerment is defined as the process of becoming stronger or more in control, and comprised of a number of subordinate themes; flexibility/choice, resources/course outcomes, relationships, skill building and personal growth. Whilst this could have the potential to bleed into self-efficacy, it is important to indicate that the two are different in that self-efficacy can be considered a *destination* (that is, an improved sense of capacity), where as empowerment is the *journey* of attaining this. This means that I have considered self-efficacy in terms of an overall *outcome* for a participant or capacity to do something, while, in contrast, empowerment is classified in terms of the *process* that participants have been through to gain this capacity. This is a similar contrast to that between empowerment and autonomy. Again autonomy can be seen

as the end product of having power over personal choices, such power having been gained via an empowerment process.

Again *flexibility and choice* featured highly and, though simple in their application, had a significant impact with four participants expressing empowerment via this factor. Again having the ability to choose a programme suitable to their own individual needs with a good range of options, allowed the participants to gain some sense of control over their lives. Choosing what suited them personally gave them an opportunity to continue on their path as they saw fit. For Amy it was even more in depth; she appreciated the choice but the flexibility was what empowered her the most. She was able to leave groups when overwhelmed and change her programme at any time to suit quickly changing needs, this allowed her to remain engaged in the programme no matter her health status.

Resources and course outcomes was only present for one person, however as it was such a salient aspect of their experience, it is important that it is included. This was so valuable for Rita as it allowed her to continue to contribute to her family of origin in a meaningful way. She was able to use things she had made at the service to give to her family so she was able to engage in the family tradition of reciprocity without impacting negatively on her stretched financial situation.

I don't just 'make' them, there's a lot of love goes into what I make, and that's pretty meaningful – Rita

Acceptance by peers and staff, role modelling, and trust and respect were drawn together into a subordinate theme of *relationships*. For Robert, particularly, empowerment was a strong theme and relationships were a strong thread within this. He developed socially once he started to feel accepted and subsequently accepted himself which flowed into an increase in confidence (that is, a sense of being able to act in his life). He was eventually able to gain some control over his life which he had previously not experienced. He also started to rebuild his relationships with his family and further develop positive relationships at the service. He expressed this in terms of being a role model to his family and other clients of the service. Trust and respect were experienced by Rita from staff and peers at the service and this allowed her to feel confident in her use of the centre and to utilise the resources and flexibility to her best advantage.

Skill building is again present; here working with other factors towards empowering participants through an increased sense of self-efficacy and/or autonomy. Increased skills included social skills, planning and routine development, literacy,

physical health and strength, verbal communication and understanding and management of illness.

Gradually I found out that using the activities, coming here actually brought back my self-esteem and I was striving to learn more - Robert

Personal growth again emerges here: For Robert and Luke this was a twofold process; experiences as recounted in other theme sets assisted them to improve confidence and self-esteem. Such experiences included social acceptance, personal achievements, and re-defining a sense of self. These improvements in turn appeared to produce an increase in motivation and the drive to move forward. Practical achievements such as increased fitness level and confidence to make decisions were also experienced. For Amy it was a little more abstract; through her personal growth she developed hope for new and more positive experiences in her life, particularly socially; hope which continued to drive her forward even through difficult times mentally and physically.

I've had some changes; like when I first came here I was in a shell, I came out of my shell and it's picked me up - Luke

It's been really good doing something that I know I've completed on my own. I guess I'm quite proud of it, it's quite an achievement to finish something - Amy

Empowerment via the methods illustrated here have been an apparent catalyst for improved self-efficacy as described in the previous section.

5.6 Support

Support focuses predominantly on social factors. This theme needs to be distinguished from *Belonging* in that in *Belonging* the environment was conducive to maintaining attendance and experiencing a level of comfort, whereas *Support* enabled growth and movement towards personal goals. The constituent subordinate themes are relationships with staff (experienced by all five participants in one way or another), non-judgemental/unconditional support, and socialisation.

Engagement or relationships with staff was prominent within this theme. This was mostly experienced and valued in terms of staff supporting them unconditionally

and respectfully, ensuring support is always available, tailored to the individual's needs and increased during tougher times. It is apparent that participants experienced a high level of trust that staff would support them appropriately. It was also noted that staff are such an important factor that their support, whether positive or negative, can have a profound impact. Types of impact noted from staff support included; maintenance of progress when difficult times meant there was a potential to slip backwards, helping drive personal success and self-improvement, and maintaining positive engagement with the service. Rita also noted that staff can potentially have a negative impact, noting some incidents where inappropriate staff support had negatively impacted her enjoyment and feeling of autonomy. Finally identified was the deliberate choice of staff to try to reduce the power imbalance. Being treated as an equal rather than a 'client' of a service and treated in a consistent manner no matter the circumstances or person, appears to have allowed for many of the positive developments, such as improved confidence and skill development, to occur.

I've used the system and been in it for 20 years. At first, the first 10 years were hard, I thought I couldn't accomplish things being not too much educated. But now as I get along I find things more easier and with the good people around me; clients and staff have really helped me make a difference and impacted on my decisions and accomplishments – Robert

The importance of a *non-judgemental environment* was apparent throughout references to staff relationships but also qualifies as a standalone factor due to its experience in relation to both peers and the environment in general. One thing that made it stand out was that for some it was the lack of judgement from their peers that made them feel supported and encouraged. The other was with regards to Robert who felt that this type of general environment was the key to his engagement and ongoing success. This has been mentioned earlier in other themes, however it remains relevant here too. Robert's self-stigma was what was causing a good portion of his lack of engagement with services and withdrawal from the community as a whole. Feeling understood and accepted within the service helped him turn his self-concept around.

I completed the walk (despite significant anxiety) and staff came back and walked with me, so it made it easier for me to handle it because I was really going into panic mode, so that was good – Amy

Yes, nice and positive, (environment), because without the environment and the people you know things wouldn't be accomplished - Robert

These peer and staff relationships relate to the final subordinate theme, *socialisation*. This was described distinctly by two of the participants. For Luke being at the service in a social environment and feeling supported within that environment addressed one of his biggest needs; having friends and having social contact. This helped him feel valued and assisted him to build his self-esteem. For Amy this was also a key factor, not merely related to having social contact but also objective support and feedback from staff and peers when she requested it. This assisted her to monitor her social responses and hence build her skills in this regard and also to check the validity of her thoughts. This is the support she had not been able to find in the general community and something she would only feel comfortable to undertake in the centre's safe and unconditionally supportive environment.

It means a lot to sit with people even if I don't talk, just a bit of human interaction - Amy

5.7 Activity Centre vs Employment

Four of the participants had experiences of employment and one of doing what he described as 'access courses' which were work based training programmes.

The three men drew a more comparative picture when asked to differentiate between their work and activity centre experiences. All three referred to the key areas of how working created meaning for them in the same way it did at the activity centre. For Luke this was social opportunity and chance to experience commonality with others, whilst for Robert they both allowed skill building. Lyall pointed to both of these as important and appeared to be using the centre to mimic all that he found positive in his pre-illness life.

Amy and Rita had more contrasting experiences. Amy found that both working and attendance at the activity centre had their pros and cons with neither being of much more use than the other, but rather each being useful in their own way. If she had to lean in one direction with regards to acquiring meaning in her life this would have been working. She found that at work she was able to fulfil her achievement based standards which made her feel good. She also referred to working being part of the real world which is something she values highly. Unfortunately in her experience

the two things that she valued about working also worked against her; she felt pressure to perform at work and also that the 'real' world is not as tolerant of her mental and physical difficulties. Interestingly these are the two things she valued most about the activity centre; lack of pressure and lack of judgement. What she found difficult though was that although there were opportunities to achieve (which she did do when independently completing a craft project), these were not as valuable as she had experienced when working. For Rita, she had found that through her working life she had given so much of herself that she had become unwell. So working for her was now no longer a priority and at the centre she was able to fulfil her need to help others and have access to social opportunities whilst still looking after herself and maintaining her wellness. Thus for Rita it was not the same experience or outcome but part of her current journey so is relevant and meaningful.

Chapter 6 – Discussion

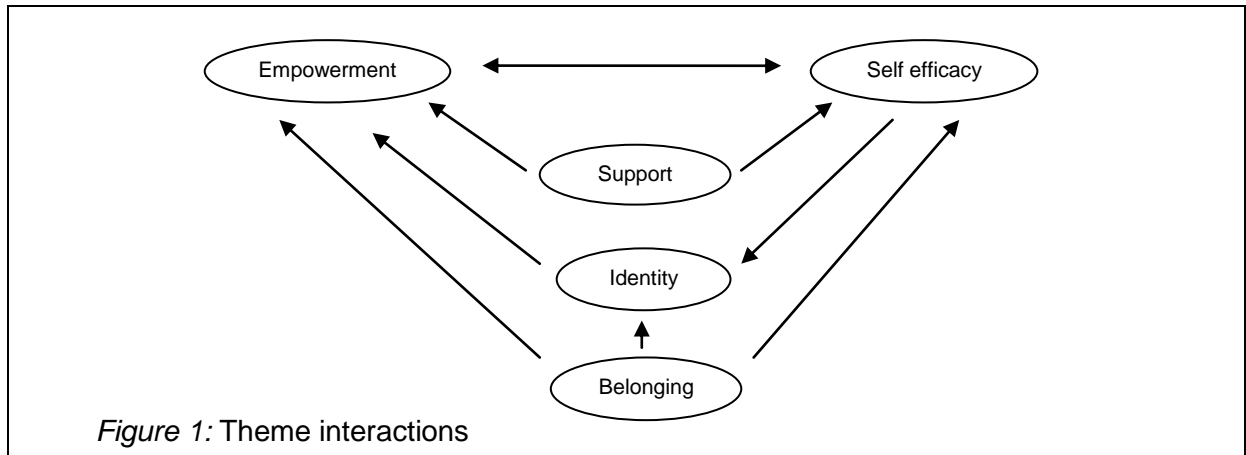
6.1 Overview

Living with a severe and enduring mental illness brings with it some challenging life situations. All the participants of this study noted that they experienced significant social loss such as estrangement from family or loss of friends or workmates as a result of their circumstances. Other noted struggles included lack of self-esteem and confidence, and a disruption in perception of self; for example one participant found she needed to understand what her identity was now and what she wanted her life to be like following a period of significantly poor mental health. These losses and struggles have been a very real part of their mental health and life experience and it was important to establish whether or not the community service they attended, aimed at assisting them in ‘recovering’ from their illness and living a ‘good’ life, was able to support them as they needed.

The study has identified and discussed a set of five main themes and ten subordinate themes. Of interest is the way in which the themes and subthemes interact with each other. There is a high level of complexity present due to the overlapping nature of some of the subthemes. This interlinking of the subthemes adds depth to the individual contributions that each theme and subtheme makes on its own. I have had to map out these complexities as themes in order to highlight certain concepts which unavoidably reduced the singular definition of the individual aspects. The Table 4 illustrates this complexity by matching the subthemes against the themes in which they were significant and also against the participants where these emerged in the analysis of their overall experience. As indicated, this complexity of experiences has made final analysis for discussion a tricky endeavour, however, as will be shown useful findings have been made.

Another point to note whilst discussing theme complexity is that some themes at times are more important than others and can also be an antecedent to the others even happening. For example, the experience of empowerment as described by one participant was the catalyst for him being able to achieve all the other aspects highlighted through the other themes. This means that there is potential for the themes to be relevant to all users of the service but in different sequences, combinations and with different priorities. This is supported by way of an example in that a sense of belonging was achieved for all five participants despite their varied backgrounds, experiences and needs.

Figure 1 is a pictorial representation of the most salient theme interactions that emerged from transcript analysis



Throughout the supplementary results tables (appendices G, H and I) it is noted that the participants often have the same subordinate themes as others but under different theme headings. It shows that within a service it is possible for users of that service to experience the same things but in different ways, ways that are relevant to their own individual needs, history and personality. There is one subtheme that appears as an apparent anomaly; resources/outcomes is only relevant overtly to one participant but still made the final table. This is because it was so very relevant to their individual experience. This subtheme was also a contributor to the Empowerment theme which was one of the strongest themes.

There are also instances where participants have the same subordinate theme but under several different headings within their own data as this subordinate theme served multiple functions for them. Managing the dynamic nature of the themes during analysis of the multiple narratives whilst also managing the individual facets was a further intricacy that I was cognisant of during this process.

Participants who experienced subordinate theme	Subordinate theme	Themes that subordinate theme contributed to
Rita Lyall Luke Robert Amy	Socialisation / relationships	Belonging Identity Empowerment Support
Rita	Resources / outcomes of classes	Empowerment
Lyall Amy Robert	Independence	Self-efficacy
Luke Lyall Amy Rita Robert	Staff	Support Empowerment Belonging
Luke Lyall Rita	Enjoyment / fun	Belonging
Amy Robert	Non judgemental	Support Belonging
Lyall Amy Rita Robert	Flexibility / choice	Identity Self-efficacy Empowerment
Rita Robert	Journey	Identity
Luke Lyall Amy Robert	Skill building	Identity Empowerment
Luke Lyall Amy Rita Robert	Personal growth	Identity Self-efficacy Empowerment
Lyall Amy Rita	Responsibility	Self-efficacy

Table 4: Subordinate themes relative to themes and participants

6.2 Recovery

One valuable facet of this study was that despite the fact that sampling was purposive there was enough of a degree of difference in diagnosis, gender, culture and personal history that findings were able to highlight two valuable points. Firstly it supported the individualistic notion of Recovery (Slade & Longdon, 2016). It also showed that if a service is set up in a way that promotes and supports individual journeys, is reflexive to changes in need, and is provided in a non-judgemental, fun environment, with staff that

utilise specific behaviours and strategies for support, that there is potential for a wide range of service users to benefit from their service engagement. The high level of flexibility and individualised programming and support allowed for five very individual journeys to occur and be supported positively within one service. This is reflected in the five participants as follows:

- Robert experienced a journey that was about developing his identity as a person. He knew he had certain likes and dislikes but his identity was defined by his lack of success at school, his mental illness diagnosis and his physical disability which was the result of an accident in his early twenties. So for him his experiences have been about developing a sense of identity he had never had before.
- Rita's experience was that of moving through the natural path of her life and being able to maintain aspects of that life that are important to her.
- Lyall regained aspects of his life that he found meaningful in the past and utilised the service as a means of experiencing this 'good' life once more.
- Amy sought to find out 'who she is now' following a period of significant upheaval in her life. For her it was about redefining herself in her current circumstances and what that meant for the future.
- Luke was focussed on specific goals and looking for support that would match his ideal which was having friends or social acceptance.

Therefore the findings have highlighted that this particular service has provided an appropriate environment and support to promote experiences that have been consistent with a recovery focus. It thus supports research which indicates that not only is recovery an experience individual to the person, but that it is also best self-determined (New Zealand Ministry of Health, 2012), and a process of moving beyond the effects of illness towards new or redefined meaning/purpose (Anthony, 1993).

In chapter one it was established that there are many differing definitions of recovery and also some tension as to how to implement these practically given the individualistic nature of the concept. One of the strengths of the service in this study that was noted as a key factor in supporting clients in their recovery journeys is the flexibility of the programme. This flexibility allowed individual recovery journeys to occur despite the participants' very different situations. It also allowed the intricacies that come from ongoing and often fluctuating experiences of symptoms of mental illness to be present and be supported accordingly.

The social aspect of the service has also been noted several times as being a key factor to ongoing participant engagement with the service, a point which also

supports the existing literature which notes that socialisation is a key recovery factor (Barbic, Krupa, & Armstrong, 2009). This will be discussed further below.

6.3 Theme/subordinate theme interactions and contributions

The themes that were produced via the analysis process were belonging, identity, self-efficacy, empowerment and support. Despite the overall themes being of global interest and used for categorising purposes, what is apparent is that the subthemes are where the experiences for each participant are best articulated. The overall analysis utilised these specificities of context to allow for understanding what has been useful for the participants. Appendices H and I are tables to provide illustration of these interactions to assist reading and understanding of the intricacies contained in this section.

One salient subtheme was that of *Socialisation* which contributed to four themes, two being *Belonging* and *Empowerment* which were the two strongest themes, and was noted across all five participants. The importance of social opportunities and acceptance supports previous research studies which have identified these as key factors in recovery (Dingle, Brander, Ballantyne, & Baker, 2012; Jose et al., 2015). Importantly, in each of these themes socialisation makes a different contribution. It was most apparent in the *Belonging* theme; where it allowed participants the opportunity to not only meet new people in a safe space but also for some to feel accepted which allowed them to feel they are part of the service and comfortable within the space. Within the *Empowerment* theme the participant experience was also about feeling accepted, but here it supported the development of self-esteem and confidence. *Identity* and *Support* were the other two areas: The experiences within the *Identity* theme were around using the social opportunities to define or redefine aspects of self. For example, Luke had developed a sense of self around his family and workmates however these relationships were no longer available to him. Having the social aspect at the service allowed him to develop new relationships and redefine his sense of self in the context of these new relationships. Support experiences included a sense of not being judged; allowing engagement with others in a way that involved the whole self rather than an edited non mental health version. This enabled feelings of acceptance and support and of feeling valued. This reflects a study which found that such environments can engender a sense of value, acceptance and belonging (Dingle, Brander, Ballantyne, & Baker, 2012).

Whilst *Socialisation* did not contribute directly to the *Self Efficacy* theme it did so indirectly. As shown in figure one all of the four other themes can be seen to contribute either directly or via other themes towards self-efficacy within this study. This supports

the research conducted by Thomas, Muralidharan, Medoff and Drapalski (2016) whose conclusions showed a positive correlation between self-efficacy and recovery from mental illness and that social support from peers and professionals can be a key factor in this process.

Staff was the second most salient subordinate theme, again being experienced by all five participants and occurring across three themes. Within all three themes the contributions were similar to those noted with regards to acceptance by peers. However staff relationships were also noted to have the potential to contribute to a negative experience of the service. It highlighted that acceptance and non-judgemental support from staff were of high importance. Staff were also seen as part of the 'normal' population and their acceptance noted as important due to this distinction. Previous research has tended to consider this relationship from a medical patient/doctor point of view and has often found a disconnect between the views of either party (Myers, et al., 2016). This research contributes to this discussion albeit from a community non-clinical perspective, which can provide impetus for further research into how such a relationship can be modelled to provide the best potential for a positive outcome.

Personal growth was also described by all five participants and plotted across three themes; *Identity*, *Self-efficacy* and *Empowerment*. This subordinate theme may be conceptualised as a journey through the three themes. Participants reported experiencing improved confidence, motivation and self-esteem, moving towards a clearer sense of self, and opportunities to utilise and develop personal self-help strategies. The journey is one which sees the improvements as an empowering factor which enables self-efficacy and as a result allows a person to have a clearer understanding of their identity. This is almost a mini depiction of a recovery journey. This idea of a *Journey* is present as a subordinate theme and fits here as part of this overall passage defined through personal growth and the very experience of life.

6.4 Other key factors and interactions

The above section notes the most salient contributions and connections between themes and sub-ordinate themes. This section serves to outline the lesser contributing sub-ordinate themes and other factors that have been noted during the analysis process.

Skill building was a factor in the experiences of four of the participants across two themes; *Identity* and *Empowerment*. What is to be distinguished here is the difference between personal growth and skill building. At times throughout the research process these two factors converged but as an overall outcome their divergence was

the dynamic that was more useful to capture. Personal growth emerged more as an emotional process with noted experiences being improvements in motivation, confidence and self-esteem. Skill building on the other hand was more related to practical gains such as improvement in health and fitness, reading ability, planning and routine development, and social skills. These tangible improvements in skill appeared to contribute to the growth of self-esteem and confidence and provided opportunities for overall personal growth to occur.

The structure of the service and overall environment played a significant part in the experiences of the participants. This was shown in the subordinate themes; resources/outcomes, staff, independence, enjoyment/fun, non-judgement, and flexibility/choice. Overall what was found was that, whilst the content of the courses has the potential to be important for meeting particular needs, it seems that the structure of service and staffing are more the key. There was only brief mention by two of the participants about the outcomes of particular courses being useful. All other comments and experiences were related to the environment, staffing and service structure. The flexibility noted by participants allowed for individual needs to be met, and the environment was reported as supportive and non-judgemental. This finding references the discussion in chapter one where findings from different studies had noted different outcomes. One viewpoint noted that no matter the nature of the activity, just being part of an activity programme is valuable (Iwasaki, Coyle, & Shank, 2010), with the opposing view being that there needed to be specific characteristics of an activity in order to achieve a positive outcome (Wijndaele, et al., 2007). This research has noted findings that support the first viewpoint; participants indeed did not place an extremely high value on the particular activity whilst at the service. The second point however also garners some support from this research, though this is not related to the activity itself but more the structure or characteristics of the service as noted above, including but not limited to; flexibility of service delivery, a non-judgemental environment and the provision of unconditional support. These are factors present within this service independent of the activities themselves that appear to have made a significant contribution to the positive experiences and journeys the participants have reported.

Another overall factor was that all of the participants have moved towards a self that has 'more'. All participants reported social losses as a result of their mental illness and all found the social aspect of the service a key part of their experience. There were also other avenues of growth towards some feeling of 'more'. For Robert, for example, this was in the form of having a better sense of self and developing his identity. For Amy, this was about having an avenue to further develop personal skills and engage with peers and reduce her significant isolation. This finding reflects the discussion in

chapter one about recovery and how despite the many different definitions there are of this concept, one commonality is an experience of moving towards something better or 'more' than what one presently has.

Identity as a theme is comprised of five sub-ordinate themes. The salience of this theme is supported by Wisdom et al (2008), who noted that not only is a strong sense of identity important in recovering from a mental illness but that responses from others to such an illness have the potential to have a significant negative effect on a person's identity. This is mirrored in the findings of this study which noted that participants valued positive social engagement and personal growth amongst the key factors in this theme group.

6.5 Work vs activity programme

As noted in the results chapter, this was not a hypothesis based research project; however there was a point of interest that was explored as part of the project. This was to establish whether experiences participants had at the activity centre were comparable to their previous work experiences. The reason this was of interest was because there is a high likelihood that those experiencing a severe and enduring mental illness will not be able to work in paid employment for long periods in their lives or may never work again. This being said, if they are unable to engage in employment is there any value for them in attending an activity centre such as this one? The research reviewed for this study concluded that activity centres are useful, the context of which has already been discussed. The studies reviewed also concluded that being in paid employment had a positive impact on recovery journeys and feelings of quality of life could be attributed in part to being employed (Dunn, Wewiorski, & Rogers, 2008; Eklund, 2009). Eklund (2009) also noted however that activity centres contributed as much if not more to a feeling of quality of life.

For this study, participants were asked to draw a comparison between their past working experiences and their experiences at the activity service. What was highlighted was that all five had different experiences and viewpoints. However, for four of the participants their experiences at the activity centre were described to be as meaningful as working. The one exception was Amy who felt that working was more meaningful as it was a 'real world' activity. What is interesting about this difference in experience is that, of all the participants, Amy had been at the service for the shortest time and had also been experiencing acute symptoms for the shortest time. It is possible that the other four participants had become accustomed to the idea that they would likely not work again and therefore were able to see the value the activity centre held for them

while Amy was more focussed on a return to 'normal' life rather than integrating into the activity centre 'permanently'. Amy did however report that what she valued about work (achievement based, engagement in wider community) were the very things that she currently struggled with and some of the reasons she was using the activity centre. The complexity of this relationship with her vocation was overall outweighed by her report that each had pros and cons with each (work / activity centre) being relevant to her dependent on her situation.

What these findings have shown is that this experience is as subjective to the individual as all others that have been noted throughout the study. It seemed to me that what each individual sought from the service was what their experience was based around and therefore the meaning ascribed was relative to this. For example, Lyall values being with others and social interaction in his life and partially attributed his positive experiences at the centre to this. Interestingly, when Lyall was asked about work, his comments were based around being able to be with people and the social aspect of employment.

6.6 Limitations

This study was designed so as to capture the real life experiences of the participants. One limitation noted is the inexperience of myself as an interviewer. I had experience with formal clinical assessment but this did not transfer to the interview process as readily as I would have liked. What I noted upon reviewing the interviews and during transcription was that there were threads of conversation that could have been followed up further to possibly gain a fuller insight into the participant's experience.

There was also opportunity during the design phase to add in a quantitative measure of quality of life, having participants initially code such a measure for their pre service life and then again for their current situation would have provided a second source of data with which to match the qualitative data in order to strengthen any findings from the study.

Although the interviews elicited a rich data source, the study was only conducted via a single interview session with each participant. Despite there being no time limit placed on the actual interview process, having only one session in which to collect the required information only allowed for a very brief window into this person's experiences. Subsequent interviews could have been useful for again adding depth to the data and further delving into the participant's experience.

This study had a limited number of participants which was entirely suitable given the methodology used. These participants however were accepted on a voluntary

basis and those who were experiencing active symptoms of illness at the time were excluded from the process. Other exclusions included those who were working and those who had only been at the centre for a short amount of time. Whilst these exclusions assisted in ensuring that the particular population I was interested in was included in the study, it meant that there are facets of the participant experience and service that I was unable to explore due to this deliberate narrowing of the participant group. Voluntary participation meant those who participated were more likely to share openly due to their voluntary status; however those who have had negative experiences of the service or other useful data may not have come forward to participate.

As is inherent in this type of research, it is the researcher's interpretations of the data which are ultimately presented. Whilst every action has been taken to ensure that the final results reflect the meanings and intentions of the participants, it must be acknowledged that there is an interpretative process that takes place and that this will undoubtedly in some way have an impact on the final results.

6.7 Future research / implications

This research has focussed on the experiences of people with a chronic and enduring mental illness attending an activity centre. What has also been highlighted however is that there is a great deal of variation in not only the acuity of mental illnesses, but also variation in the support services available to assist those experiencing such a mental illness. Whilst this study has added insights to the literature, continued research of the general daily experiences of people with mental illness is still an under researched area and one where further studies would be beneficial (McCormick, Funderburk, Lee, & Hale-Fought, 2005).

Ongoing research into 'recovery' based mental health services of a different nature could assist in supporting findings found in this study and continue to develop the understanding of recovery as a concept and its utility as a model of care now that it has been used in practise nationally for several years.

I propose also that any ongoing research with this population and in the New Zealand specific context is valuable. As was highlighted during the literature review, New Zealand specific studies in mental health continue to be thin on the ground and we often need to rely on international literature and attempt to map this onto our own unique population. Further research of any kind with this population would grow our literature base and understandings specific to our unique demographic and cultural idiosyncrasies.

Further research into the client/staff relationship and the impact this has on recovery, client engagement in service, and the efficacy of services would be beneficial. It was highlighted in this study to be a significant factor and of interest would be research to support, contextualise further or challenge this finding. Based on the experiences of the participants from this research study it is noted that staff with the following practices supported positive experiences.

- As far as practical reducing the power imbalance inherent in the staff/client relationship
- Acceptance of individuals, and engaging with people in a non-judgemental way
- Supporting unconditionally, and fluidly changing supports to reflect changes in need
- Encouraging autonomy and accountability
- Having a sense of fun as appropriate when supporting individuals

6.8 Conclusion

This study sought to engage with users of a community based recovery service that provides activity programmes for people with a severe and enduring mental illness. The purpose was to investigate their experiences of the service. Overall this study was found to support previous studies, such as that by Eklund (2009), which found that activity centres improve quality of life for vulnerable populations. The experiences of the participants were varied and individual, findings which supported the individualised notion of recovery that has come to be the norm in thinking. Participants reported experiences that included belonging, empowerment, identity, self-efficacy and support as the key factors defining their time with the service. These were illustrated by examples that personalised the journeys of each. These examples became the subordinate themes of the research and detailed the particular facets of the service and experiences that promoted their engagement and recovery. Overall experiences of the service were positive and participants reported that the service had been a positive factor in their recent lives and, for some, in the long term.

Despite the limitations noted above, this study has provided evidence that if a recovery service possesses particular characteristics it has the potential to provide appropriate and meaningful support to a wide range of people and needs. These characteristics include flexibility, a non-judgemental environment/attitude, individualised support options, staff who are accepting, unreservedly supportive and minimise power imbalance, an environment of fun and happiness, and the opportunity to engage

socially with others. These facets were described by participants in varying combinations and with varying emphasis on different points. This implies that their experience was personalised in a true recovery manner, which supported the overall sense that their experiences were individually meaningful.

This study has also supported previous studies which have highlighted socialisation and empowerment amongst the key factors for promoting mental health recovery and has also highlighted further areas for research with this population and within this general topic.

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Appendix A



MASSEY UNIVERSITY ALBANY

23 October 2014

Theresa Harvey
c/- Dr Clifford van Ommen
School of Psychology
Massey University
Albany

Dear Theresa

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 14/042

The impact of meaningful activity: an investigation of the personal experiences of users of a mental health activity centre

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Andrew Chrystall
Acting Chair
Human Ethics Committee: Northern

cc Dr Clifford van Ommen

Te Kunenga
ki Pūrehuroa

Research Ethics Office
Private Bag 102 904, Auckland, 0745, New Zealand Telephone +64 9 414 0800 ex 43279 humanethicsnorth@massey.ac.nz

Appendix B



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Would you be interested in taking part in my (Theresa Harvey's) research project?

I am carrying out a research project focussed on the experiences of people utilising a mental health activity centre and the impact it has on their lives. I am looking for people to interview that are willing to share some of their experiences with me.

Your identity and information will be kept confidential in accordance with Massey University's Ethical Guidelines.

To be able to participate, you must have been diagnosed with a severe and enduring mental illness (for example, Schizophrenia, Major Depressive Disorder, Bipolar Affective Disorder).

You must also have been using the activity centre for a period of at least 6 months, be receiving Supported Living Payment, be attending at least two different types of classes at the centre and not be engaged in any paid or voluntary work.

If you are interested in taking part it will involve undertaking an interview with me of between 1 and 2 hours.

Please feel free to come and see me at any time to discuss whether or not this is something you would like to take part in.

Appendix C



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

The impact of meaningful activity: an investigation of the personal experiences of users of a mental health activity centre.

INFORMATION SHEET 20 August 2014

Hi.

As you know my name is Theresa Harvey and I am a tutor at _____. I am currently seeking your support to carry out a research project that will form part of my assessment for my Master of Arts in Psychology which I am currently pursuing through Massey University.

I have chosen to do research at the Centre as meaningful activity is an area of significant interest for me. Also, I very much enjoy learning anything I possibly can about living with mental illness and the information that can be gained from those who live with such illness is the most valuable of all.

How can you help?

As a person who experiences a severe and enduring mental illness and attends _____, I would like to invite you to participate in this study.

I am looking for volunteers who would be willing to attend a one-on-one interview with myself that would take between 1 and 2 hours. During this interview we will discuss your experiences of your illness and specifically of the activity centre and the Centre's overall impact on your daily life.

The interview would be held in a private room at _____ and is intended to be a relaxed process. With your permission the interview will be sound recorded so that it can be referred to after the interview to allow for it to be transcribed.

Te Kūnenga
ki Pūrehuroa

Massey University School of Psychology – Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442 T +64 6 356 9099 extn 85071 F +64 6 350 5673 www.massey.ac.nz

All information received from you will be kept confidential and only myself, a transcriber (who will have signed a confidentiality agreement) and my supervisor will be privy to any information that may identify you. A pseudonym will be given to you in written documentation to ensure you cannot be identified. Your details will be kept in locked storage at all times and your transcript returned to you at the end of the study should you want it. If not it will be kept in locked storage and destroyed after a period of 5 years.

Outcomes

I would like to present a summary of the outcomes of the research to you either verbally or in written format, whichever is your preference. You will also be given the opportunity to read and edit the transcripts of the interview prior to any analysis of the information taking place.

A thesis will be prepared from your information and that of other participants and this will be submitted to Massey University for assessment.

I would like you to consider taking part in this study with the understanding that it is entirely voluntary and that you can withdraw from the study at any time. Your participation in this study and information provided by you for this study will not impact on your access to and use of the service at _____.

While it is not expected that the interview will make you feel uncomfortable, it is possible that talking about your illness and talking about personal thoughts and feelings may cause some unintended discomfort. Should you believe this may be an issue it is recommended that you do not progress any further in this process. If you decide to progress and at any time discomfort or distress occurs you will be given the opportunity to immediately cease the interview. If you would like to participate but are unsure about any unintended impact perhaps you may wish to discuss it with your key worker first. If you choose to progress you will also have the right to refuse to answer any question. Should you experience any distress as a result of the interview you will be supported to make contact with community mental health, Voice Advocacy or Ngati Pikiao Health Services to seek support during office hours. You may also seek free support from the CATT team on 0800166167 for personal after hours

support, or contact Lifeline on 0800543354 or The Samaritans on 0800726666 who can provide phone support.

Your rights

- To receive this information sheet and be able to still decline to be in this study
- To withdraw at any time up until two weeks after submitting your edited transcript back to the researcher
- To have a support person of your choice and/or kaumatua present at the interview should you want this.
- To ask any questions about the research
- To refuse to answer any questions or stop the interview and / or ask that the voice recorder be switched off at any time
- Receive a written or verbal summary of the findings once completed

If you have any concerns these can be directed to

Researcher: Theresa Harvey

Theresa.lean.harvey@gmail.com

0273184621

Research Supervisor: Clifford van Ommen

c.vanommen@massey.ac.nz

(09)4140800 ext43114

Health & Disability Commission: 0800 112233

Ethical Approval

This research project has been submitted to the Massey University Ethics Northern Committee and has been approved to progress; approval number MUHECN 14/042.

Acting Northern Ethics Committee Chairperson: Dr Andrew Chrystall
School of Communication, Journalism &
Marketing
09 414 0800 ext 43317

_____ Trust has given permission for the study to progress at the _____ Service.

I am happy to answer any and all of your questions, all of which will be dealt with confidentially and respectfully.

I thank you for taking the time to read this information sheet and consider my research project and await your confirmation or decline of my request to take part.

Yours Sincerely, Theresa Harvey

Appendix D



The impact of meaningful activity: an investigation of the personal experiences of users of a mental health activity centre.

PARTICIPANT CONSENT FORM – INDIVIDUAL

I have read the information sheet dated 20 August and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I also acknowledge that I am taking part in this project voluntarily and am aware that I can withdraw at any time up until two weeks after my interview transcript has been finalised and / or decline to answer any questions in the interview. I agree to provide information to the researcher on the understanding that my name and any other material which could identify me will not be used in any reports regarding the study. All data gained from the interviews will be kept securely in locked storage for a period of 5 years before being destroyed.

I agree / do not agree to the interview being sound recorded. I have been advised I have the right to ask for the recorder to be switched off at any time and I understand that the recording will be transcribed. I wish / do not wish to have my recordings returned to me.

I would / would not like to receive a summary of the overall results of the project once it has been completed and submitted. I would like to receive this in a written / verbal format.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ Date: _____

Full name (printed): _____

Te Kunenga
ki Pūrehuroa

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Appendix E



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

30.09.2014

To the Trustees of _____ Trust

Re: Permission to conduct research on premises

I would like to request the permission of the Trust to carry out my research project at the _____ Service. This project once completed will form the final part of my Master's Degree which I am currently studying towards with Massey University.

My research focusses on the experience and impact of attendance at the activity service at _____ for individuals with severe and enduring mental illness. My project will be overseen by a supervisor from Massey University; Clifford van Ommen who can be contacted by phone by the following means; C.VanOmmen@massey.ac.nz, (09)4140800 ext 43114.

If the Trustees are in agreement the project would involve the placement of an advertisement on the notice board at the service, and the carrying out of individual interviews on the premises with up to eight participants. Interviews will be timed so as to not interfere in any way with the running of the service. There will also be measures in place to protect the rights and confidentiality of the participants; this will include written information for staff about the project and the precautions that will be taken by myself to protect participant confidentiality. This project has been reviewed and approved by the Massey University Ethics Committee (Northern).

I would also like to notify the Trust that, although not specifically named, the _____ service, given its unique position in the Lakes community, may be identifiable in any final documentation created as a result of this research. I am very willing to discuss any questions the Trustees may have and look forward to your response.

Yours sincerely

Theresa Harvey

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ki Pūrehuroa

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Appendix F

Interview schedule

Semi-structured interviews will be carried out with the following.

Housekeeping;

1. Welcome (and Karakia if participant indicates this is wanted)
2. Discussion of role as researcher throughout this process to separate this and work role and provide a clear boundary in this respect
3. Discussion of appropriate forms of engagement after the interview and reminder of appropriate contact times, i.e, out of work hours to keep roles separate.
4. Discussion of protocols that will be followed should they become distressed and discussion of support options available should this occur. Reminder also that they may cease the interview or request the voice recorder be switched off at any time

Demographic information;

5. Please tell me what ethnicity you identify with.
6. Can you tell me what your life was like before you started at the activity centre?
Focus - activities participated in
- relationships with others
- overall health and wellbeing
7. Can you tell me what has changed since starting at the centre?
Focus - relationships with others
- overall health and wellbeing
- personal growth or regression
8. Can you describe for me some memorable experiences you have had at the activity centre?
Focus - can prompt for both positive and negative experiences
9. What does the phrase 'meaningful activity' mean to you?
10. Can you tell me what you most enjoy about attending the activity centre?
11. Can you tell me what you least enjoy about attending the activity centre?
12. If you have ever worked before how does coming to the activity centre compare to this?
13. How has attending the activity centre changed the way you think and feel about yourself, if at all?

Appendix G

Individual Themes Robert

Theme	Subordinate Themes	Expression of subordinate theme
Belonging	Social acceptance	Despite “aggro” behaviour, negative sense of self, still felt acceptance from peers and staff
	Non-judgemental environment	Able to feel comfortable to attend despite “whakama”, understanding by others of mental, educational and physical impediments. Reduction of self stigma
Identity	Self improvement	Developing positive sense of self; increase in self esteem and confidence
	Recovery journey	Reduction of self stigma, activity centre as part of a whole life change, ability to engage in long process of recovery (not time limited). Ability to gain what he was unable to as a youth; education, clear definition of self, mana, sense of pride, achievements
	Skill building / education	Understanding of self and illness, fulfilling family value of education
	Social / peer engagement	Ability to engage positively with others, comfort in own skin within a social environment
Self Efficacy	Independence	Gained wellness / confidence; now able to confidently make way in the world
	Programme flexibility	Can do courses which suit him individually
Empowerment	Personal growth	Reduction of embarrassment, significant increase in confidence and self esteem. Understanding of past self and the need for maintenance of a positive lifestyle. Overcoming obstacles and achieving personal accomplishments
	Acceptance by peers and staff	Developed socially which flowed over into self confidence and self esteem. These growths have allowed him to take control over a life in which he felt little control early in life as he felt he did not fit in or achieve what he should have
	Skill building	Social, verbal, physical, mental, educational
	Role model	Centre (new clients) & family (children, grand children). Able to move into own support role and feel mana and fulfilment from this. Especially as his early life with his young family was disrupted and significantly challenging.
	Illness management	Support to accept medication as a part of wellness, knowledge and understanding of how to remain well and support to achieve this
	Flexibility of course	Able to choose courses that suit needs, enjoys and that give personal fulfilment
Support	Unconditional support from staff / peers	Supported his goal of self improvement
	Non-judgemental environment	Allowed him to feel good about self and gain confidence. Able to feel comfortable to attend despite “whakama”, understanding by others of mental, educational and physical impediments. Reduction of self stigma

Individual Themes Lyall

Theme	Subordinate Themes	Expression of subordinate theme
Belonging	Social acceptance / inclusion	Engaging with peers and feeling part of the group / service, being the 'same' as other people
	Relationships with staff	Staff being supportive and respectful and not separating themselves out from those who use the centre for support
	Enjoyment / Fun	Experiencing an enjoyable atmosphere enabled him to feel part of something and comfortable in the environment
Identity	Regaining past	Being able to use the service to mimic experiences from early life which he found meaningful
	Education / skill building	Values being able to learn new things and utilise these skills regularly. Has been able to experience different programmes and therefore learn a variety of information and skills
	Flexibility / choice	Is able to choose courses that fit his personality and needs, and which therefore allow him to express and consolidate his identity
	Self improvement	Has experienced improvements in health and an increase in motivation
	Responsibility	Has a personal sense of responsibility to attend and be accountable. Expresses this as something they ensure they try to do.
Self Efficacy	Independence	Has the opportunity to be away from home which belongs to his parents and have some autonomy. He can make his own way in this part of his life.
	Responsibility	This is an important part of his identity so fits into self efficacy also as he is responsible for himself and therefore makes his own decisions as to what he needs and how the service can best support him
	Flexibility / choice	Has autonomy over course choice and how he uses the service
Empowerment	Flexibility / choice	Is able to choose what suits him best following experience of different courses
Support	Engagement with staff	Positive engagements not based around a power model (staff / client) rather engagement as a peer (treating all people the same)

Themes Rita

Theme	Subordinate Themes	Expression of subordinate theme
Belonging	Social opportunity	Has developed friendships at the service
	Life journey	Views attendance at the service as part of her life journey and therefore it is a place where she belongs at this point in time
	Relationships with staff	Has long standing relationships with staff
	Enjoyment / Fun	The fun that she describes at the centre makes the environment comfortable and enjoyable to be at
Identity	Participating in 'something'	Being part of the community or something more than just herself or her family.
	Resources / course outcomes	She is able to continue to give as she did financially to her parents when she had a job. This giving is in the form of things she has made herself.
	Flexibility / choice	She is able to choose courses that suit her to ensure she is able to express herself truly. Is not expected to continue with courses she does not enjoy or find useful
	Life journey	She appears to view her life as a journey with particular parts to it. She accepts that in this part of her life the centre is where she fits and therefore it is an integral part of her journey and therefore makes up part of who she is
	Responsibility	She is a person who has always been responsible for herself and often for helping others. The service allows her to continue to have a responsibility to something and herself. She has also been able to help others via friendships she has made and continue to express this part of her identity.
Self Efficacy	Self care	She has the opportunity to practise self care and do something for herself which she has learnt is very important, especially if she wants to continue to help others.
	Responsibility	Accountability and responsibility for attendance and making own decisions regarding service use allow for personal autonomy
	Flexibility / choice	Can choose own courses and to use the centre how she feels fits with her needs.
Empowerment	Flexibility / choice	Can choose own courses and to use the centre how she feels fits with her needs.
	Resources / course outcomes	Is able to participate in family gifting where she would not otherwise be able to
	Trust and respect	Experienced from staff and others who use the service.
Support	Engagement with staff	Staff support a valuable tool for their positive engagement with the service. Also noted as a possible source of reduction of enjoyment.
	Trust and respect	Experienced from staff

Individual Themes Amy

Theme	Subordinate Themes	Expression of subordinate theme
Belonging	Supportive environment	No pressure environment, felt safe to ask staff and peers for feedback on social behaviour to enable learning and personal growth
	Social opportunity	Made friends at the centre, one of these in the process of becoming a community based relationship
Identity	Learning about 'new' self	Life has been through significant change and she needed time and opportunity to rediscover who she was personally within her new life
	Personal growth	Encountered some difficulties at the service; these personally became opportunities for personal growth. For example utilising anxiety management techniques learnt in Psychology treatment to manage anxiety related to business of the centre.
Self Efficacy	Accountability	Is responsible for attending or letting staff know when not attending. This helps ensure that she does not just avoid things and further isolate herself
	Redeveloping independence	Growth in self esteem and confidence
Empowerment	Flexibility	Ability to utilise service as needed for own personal goals and challenges. For example she could leave a group at any time if she felt overwhelmed. Service also able to offer achievement based activities that suited Amy's personal achievement based way of thinking. The flexibility of programmes allowed for individual planning to suit her particular needs at any given time.
	Accountability	It was apparent that due to low self esteem Amy was not prepared initially to do things for herself. When she became accountable to others for attendance at the service she grew in her resolve to ensure she did what was required of her. As her self esteem and confidence grew she started to do things for herself also as well as because she 'had' to
	Skill development	Redevelopment of social skills, planning and routine development
	Future possibilities	Amy developed hope for new things and positive things in her life, particularly with regards to her social life
Support	Staff	Unconditional support from staff. Support enabled personal successes
	Feedback from others	Valued feedback from staff or peers and utilised this to monitor personal responses to social environment and check validity of own thoughts

Individual Themes Luke

Theme	Subordinate Themes	Expression of subordinate theme
Belonging	Social opportunity	Luke places a high value on social relationships so being able to engage socially in this environment was important to him and allowed him to feel valued and part of something
	Staff support	Has had experiences at other services where he was left to his own devices. Staff 1:1 support when necessary allowed him to feel like he wasn't just another face in the crowd
	Enjoyment / fun	Experiences significant periods of low mood, having fun and "a laugh" at the service allowed him to feel comfortable
Identity	Gaining friends	Redefining himself following estrangement from family via new social networks
	Education	Learning to read and write helped him in his efforts to develop himself as a different person to the one who he feels is disliked
Self Efficacy	Improved sense of self	Improved in confidence and established a more positive sense of self allowing him to start to make decisions for moving forward as he felt he was worth the effort
Empowerment	Self improvement	Improved in confidence and established a more positive sense of self allowing him to start to make decisions for moving forward as he felt he was worth the effort. Improvement in fitness allowed for physical activity level to be higher meaning he could get more things done. An increase in motivation meant he was able to do more things to work towards his goal of relocating to be near family
	Education	Learning new skills both socially and with regards to literacy allowed for boost in self esteem and motivation
Support	Staff engagement	Having staff available to support through tougher times helped maintain progress.
	Social opportunities	Having social contact was the most important aspect of the service for Luke. This aided him to feel valued and therefore develop a better self esteem.

Appendix H

Initial Group Themes

Theme	Subordinate Theme	Number of participants with sub theme
Belonging	Social acceptance	2
	Inclusion	1
	Relationships with staff	2
	Enjoyment / fun	3
	Social opportunity	3
	Life journey	1
	Non judgemental / supportive environment	2
	Staff support	1
Identity	Participating in something	1
	Resources / course outcomes	1
	Flexibility / choice	2
	Life journey	1
	Responsibility	2
	Regaining past	1
	Education / skill building	3
	Self improvement / personal growth	3
	Social / peer engagement	2
	Recovery journey	1
	Learning about new self	1
Self Efficacy	Responsibility / accountability	3
	Flexibility / choice	3
	Self care	1
	Independence	3
	Improved sense of self	1
Empowerment	Flexibility / choice	4
	Resources / course outcomes	1
	Trust / respect	1
	Personal growth	2
	Acceptance by peers and staff	1
	Skill building	3
	Role model	1
	Illness management	1
	Accountability	1
	Future possibilities	1
Support	Relationships with staff	4
	Trust / respect	1
	Unconditional support	1
	Non-judgemental environment	1
	Feedback from others	1
	Social opportunities	1

Appendix I

Matrix

	Robert M	Amy W	Lyall C	Rita N	Luke W
Belonging	Social Acceptance	Social opportunity	Social acceptance	Social Opportunity	Social opportunity
	Non-judgemental environment	Supportive environment	Inclusion – same As others	Part of journey	Staff support
			Relationships with staff	Relationships with staff	Enjoyment / Fun
			Enjoyment / Fun	Enjoyment / Fun	
Identity	Self improvement	Personal growth	Regained past pride	Participating in something	Gaining friends
	Recovery journey	Learning about new self	Education / skill building	Life journey	Education
	Education / skill building		Choice (of Courses)	Resources / course outcomes	
	Social engagement		Self improvement	Choice (of courses)	
			Responsibility	Self improvement	
				Social opportunity & helping	
Self efficacy	Independence	Independence	Independence	Responsibility	Improved sense Of self
	Flexibility / Choice (of courses)	Accountability	Responsibility	Choice (of courses)	
			Choice (of courses)	Self care	
Empowerment	Personal growth	Flexibility	Choice (of courses)	Choice (of Courses)	Self improvement
	Acceptance by Peers and staff	Accountability		Resources / course outcomes	Education
	Skill building	Skill building		Trust and respect	
	Role model	Future possibilities			
	Illness management				
	Flexibility / Choice (of courses)				
Support	Non-judgemental environment	staff	Engagement With staff	Trust and respect	Staff engagement
	Unconditional support	feedback from others		Engagement With staff	Social opportunities