“Feeling good through what we do”

Evaluating occupation based workshops on self-esteem for women who use mental health services in Ireland

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Submitted in fulfillment of the requirement for the degree of Master of Science, University of Limerick

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Submitted to the University of Limerick, November 2016
ABSTRACT

Title: ‘Feeling good through what we do’ Evaluating occupation-based workshops on self-esteem for women who use mental health services in Ireland

Author: Niamh Wallace

Background:

Mental health occupational therapists claim to be strongly person-centred and recovery-oriented in their service provision. The design, delivery and evaluation of occupational therapy practice needs to reflect these key features. This study was carried out by a senior occupational therapist in the Irish Mental Health Services. It evaluated an occupation-focused intervention developed for women who use the services. The programme comprised four two-hour sessions over two weeks.

Method:

The conceptual framework guiding this qualitative study comprised Critical Disability Theory, Person Environment Occupation model, and the CHIME recovery framework. This programme evaluation consisted of six pre and five post intervention interviews with workshop participants. Interviews were also completed with two occupational therapy facilitators. The creative pieces designed by participants in the workshops were used to assist the interview process.

Results:

Thematic analysis yielded three core concepts: 1) the importance of responsive service design and participatory facilitation; 2) the potential of occupational engagement in mental health practice; 3) the centrality of peer connections and shared experience in mental health recovery.

Conclusion:

Engaging in creative occupations has the capacity to transform the lives of women with mental health difficulties through reflecting, learning and sharing experiences. Programme design that is responsive to service-user need and participatory facilitation enhances outcomes for participants. Traditional notions of ‘expertise’ in mental health service provision are challenged. The power of shared experience and peer support need to be embedded in service delivery models. Recovery-oriented evaluation of services is essential. Further exploration of ‘shared vulnerability’ is required in relation to recovery-oriented practice.

Application to Practice:

This project demonstrates the value of using creative occupations in mental health practice. Occupational therapists are encouraged to use the value of shared experience and peer connections that are facilitated through this type of participation. The notion of ‘shared vulnerability’ requires further exploration in recovery-oriented practice.
DECLARATION

I declare that this thesis is my own work and has not been submitted to any other university or higher education institution, for any other academic award. Citations of secondary works have been fully acknowledged and referenced.

Signed ______________________
Niamh Wallace
ACKNOWLEDGEMENTS

Firstly, I must thank most sincerely my two supervisors Dr. Nancy Salmon and Dr. Orla McDonnell for your time, sharing your wealth of experience and encouraging me to challenge myself in my learning. It is very much appreciated. Nancy, your dedication and patience knows no bounds and I am eternally grateful.

I would like to express my gratitude to all the participants in this study, the women who freely gave of their time and experiences so that I, and hopefully others, could learn and change mental health practice.

I work with some incredible occupational therapists and mental health practitioners who inspire me on a daily basis. I am also very fortunate to work with colleagues who use their personal experience to facilitate enhanced service provision for others. Thank you one and all for your support, inspiration and friendship.

My thanks goes to the Department of Clinical Therapies in the University of Limerick for providing the opportunity to avail of funding to complete this research.

To the best student peer I could have had to help me through this process. Catherine, you are a star!

To my lovely and fantastic friends and family. I am eternally grateful for your encouragement, understanding and support. Dad, what can I say, you are amazing always.

And Michael, for your kindness, patience and love, for all of that and more, thank you.

Finally, I would like to dedicate this thesis to the memory of my Mum.
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List of Abbreviations

HSE       Health Service Executive
DOH       Department of Health
DOHC      Department of Health and Children
MHS       Mental Health Services
MWMHS     Mid West Mental Health Services
CHO       Community Healthcare Organisation
MHC       Mental Health Commission
CBT       Cognitive Behavioural Therapy
AOTI      Association of Occupational Therapists of Ireland
Chapter 1 Introduction

1.1 Introduction & Background

Mental health services in Ireland are in a time of change and transition. As services struggle to become more person-centred and recovery-oriented in their delivery they are better resourced in terms of multidisciplinary capacity than ever before. Those who use services, however, continue to be critical of the biomedical model of service provision that remains. The criticism focuses on the apparent lack of organisational commitment to the development of person-centred services, based on and responsive to assessed service users’ needs. As a specific group of service users, women using mental health services in Ireland face a variety of challenges. These relate to their individual mental health experiences, how services understand these experiences and how their needs are met by the mental health system. This research evaluates a series of occupation-based workshops for women that were implemented in mental health services in Ireland. The provision of high quality person-centred services is central to Irish mental health policy. The translation of this tenet into mental health occupational therapy practice is explored with a focus on the provision of services for women. The workshop series was designed to meet the needs of women mental health service-users through the use of occupation in a group setting.

Many of the discussions with my supervisors and colleagues during the design and carrying out of this research project centred on the challenge of changing today’s Irish mental health service. When starting the project I was a passionate mental health practitioner, an idealistic occupational therapist with a clear rationale for my research that involved changing how mental health practice is evaluated and understanding the
potential of occupation in mental health. In the latter part of completing the project my promotion to occupational therapy service manager, with a wider remit in terms of service development, introduced an additional lens that encouraged a focus on quality and the need for change in the broader service. At all points I was keen that the experience of those who use services was to the fore.

Irish mental health services are in a place of flux and transition. The institutional and custodial care of the 1960s, 70s and 80s remains in the cultural mindset, albeit challenged by a policy push towards person-centred and recovery-oriented practice. Although services are expected to change according to the realignment of policies and procedures, the process of change in an institutional system is complex. There is a sense of a spaces emerging, through this change. This transition represents a disruption of the power dynamic between the mental health practitioner and those who use the service. It means that the lived experience of the people who have mental health difficulties is recognized and valued. It behoves us to include service-users and their families as equal partners in the development, evaluation and provision of mental health services.

Along with the disruption that accompanies change is the potential for transformation, where boundaries dissolve and spaces for new possibilities become apparent. This project is situated in a context where a variety of these spaces are evident. In considering the development of the occupational therapy workshop programme and how to evaluate it, four particular spaces emerge between policy and practice in mental health in Ireland. The first of these is the space between the delivery of standardised services and those that are responsive to need. Secondly, how expertise
by experience is valued in contrast to professional expertise poses challenging questions in today’s service. A third space is evident in the void between how services are currently evaluated and what constitutes meaningful evaluation. And finally, occupational therapy is challenged to realise, define and operationalize its relationship with the recovery ethos in mental health. Inherent in these spaces is an absence of discourse on the essential meaning of recovery in mental health and how it is facilitated. This research aims to respond to these spaces in mental health service provision in Ireland.

The programme under evaluation was developed in the space between responsive, person-centred service provision and standardised services. Modern mental health service delivery in Ireland is in a space of flux where service provision has changed dramatically in a period of fifty years. In that time Irish mental health services moved from custodial uni/bi-disciplinary “care” provision to a service provided by multidisciplinary community based teams. Currently the services are based on a community model of service delivery where multidisciplinary teams offer a specialist mental health service to the local population. The services engage in multidisciplinary assessment and care planning, offering a broad-spectrum approach to mental health. While mental health policy promotes person-centred services (DOHC 2006), a focus on generic service provision remains. The notion of a responsive service is lost in the provision of standardised services.

Today mental health services continue to remain anonymous in their communities. This anonymity is in direct contrast with mental health policy that focuses on recovery and a public health approach to service provision. The person-centred
services that are defined in “A Vision for Change” (DOHC 2006) emphasising personal recovery abruptly contrast with the generic service provision observed today.

The influence of a standardised model of service provision is starkly evident in the limited attempts to provide gender specific service in mental health in Ireland. The needs of different groups are catered for by community and voluntary organisations. The Men’s Shed movement is an excellent example of this (Carragher 2013) where the mental health needs of men are met through community and activity based groups. The specific mental health needs of women are widely documented (Kohen 2000), though in Ireland there is little evidence that these needs are considered or met explicitly.

The current study has its foundation in a deliberate attempt by one service to meet the needs of women service-users. The workshop programme under review was designed further to an audit that considered the needs of individuals being referred to the service. The audit highlighted that many of the women referred to the service identified needs relating to self-esteem and self-confidence (Wallace and Shelton 2012). These areas are often considered the domain of clinical psychology in the mental health setting. At the time there was no clinical psychology available to the team. This encouraged the occupational therapist to consider in greater detail the role of occupational therapy relating to these needs and the workshop programme was developed. The programme comprised a series of four two-hour workshops that used creative occupations to explore and facilitate self-esteem.
The second space demonstrates that a void exists in our understanding of ‘expertise’ in mental health. Historically medical personnel were considered the “experts” and held prominence in psychiatric care (Prior 2012). This is slowly changing and in 2012 the Irish government committed to improving mental health services by providing funding to develop multidisciplinary community mental health teams further to the recommendations in the *Bacon Report* (DOHC 2001). This was in response to the recognition of the need for a breadth of expertise to facilitate recovery in mental health. New posts were developed in social work, occupational therapy and clinical psychology in particular, with further clinical nurse specialist posts following.

In spite of these increases in staffing, services struggle to become recovery-oriented as is outlined in mental health policy (DOHC 2006). Community mental health teams continue to grapple with the notion of mental health recovery and how to shape responsive service by accessing the expertise inherent in the experience of those who use services and their families. The value of professional expertise has not been balanced by the recognition of service-user and family expertise (McDaid 2014). Attempts to include service-users and their families in service development initiatives are the exception rather than the norm with the experience of the mental health practitioners remaining the acknowledged expertise.

The intervention central to the current study and the methodology used to evaluate it aimed to recognise the expertise of the participants at a number of levels. It acknowledges the potential of peer connection in mental health recovery while also ensuring meaningful evaluation of the programme. Each of the occupations used in the programme promoted reflection, shared experience and the use of personal talents.
Participants were continuously encouraged to support each other. The value of personal expertise was consistently to the fore. The occupational therapists who facilitated the programme also participated in each element of the programme promoting an equality not typical in therapeutic encounters.

The third space that transforming services has opened relates to what constitutes an effective evaluation. *A Vision for Change* (DOHC 2006) recommends that meaningful research into recovery in mental health is required. It acknowledges the lack of high quality data available on mental health in Ireland that could inform service delivery. The policy identifies that information to support service development is critical for improvement. Although there have been changes, services continue to be evaluated using crude methods. For example, numbers attending out-patient medical appointments and waiting times are used to offer a view on how a service is performing as demonstrated in national service operational plans (HSE 2016). This is far removed from the outcomes focused information promoted in national policy. While counting numbers attending service answers questions about “how many” and “by whom” it does not address issues of quality and experience of service-users. *A Vision for Change* (DOHC 2006) seeks high quality research that focuses on outcomes and can create an evidence base for mental health service provision in Ireland.

In response to this transformative space, this research project aimed to use a methodology that would provide meaningful outcomes that resonate with recovery-oriented service delivery. As a result the research centralises the experience of the participants in evaluating the occupational therapy programme in question. The key
areas for consideration in designing the research were how the methods facilitated an
evaluation of the programme in terms of recovery oriented practice, the role of
occupational therapy in mental health and the centrality of the experience of the
participants.

The fourth space identified exists between the practice of occupational therapy and
recovery in mental health. As members of community mental health multidisciplinary
teams occupational therapists are a key discipline in mental health service provision
(DOHC 2006). The number of occupational therapists working in mental health in
Ireland has increased significantly, almost doubling in the past five years (AOTI
internal document 2016). In spite of this recognition, Irish mental health occupational
therapists face pressure to become increasingly generic in their working. This is
similar to patterns in the UK where occupational therapists faced pressure to become
generic mental health care coordinators rather than using their core occupational
therapy skills (Pettican and Bryant 2007). There is limited evidence available to
support occupational therapy in mental health in the Irish context. Research that
meaningfully considers the experience of those who participate in occupational
therapy from a recovery perspective is required.

Mental health is a natural setting for occupational therapy, a profession whose origins
lay in the humanist traditions of using creative occupations to aid recovery and
promote well-being (Creek and Hughes 2008). However, evidence for occupational
therapy practice in mental health that focuses on the perspective of service-users is
limited, particularly in an Irish context. The emphasis on generic working in mental
health services puts pressure on a discipline that lacks confidence in its potential to
facilitate recovery. In this project creative occupations were used as therapeutic tools. It is difficult to ignore the tension that exists between the dominant biomedical model of care and the use of creativity as a means of self-expression and exploration. Further exploration of the meaning and usefulness of these types of interventions is needed.

The design of the programme itself was important in terms of promoting and exploring occupational therapy practice. Occupational therapists working in Irish mental health services often find themselves facilitating education and discussion-based interventions at both group and individual levels. It was important that occupation-focused practice was evident at all levels of this occupational therapy programme and creative occupations were central to the design. With the needs of women in mind the chosen occupations were used to facilitate exploration of self-esteem. They were also used to promote esteem and to encourage shared learning and experience. The focus on occupation-based work was vital given the pressure on occupational therapists to become more generic practitioners.

1.2 Structure of the thesis

The project addresses these spaces that exist in Irish mental health service provision today through evaluating the service in a meaningful manner. The lack of service provision for women is in direct contrast to policy that centralises person-centred services. Designing a service to answer specific needs aims to be responsive as opposed to standardised and generic in nature. In this project the needs of a specific group, women with mental health difficulties, are foregrounded. The programme recognised both the expertise of service-user participants and that of the occupational
therapist facilitators. This programme aimed to maximise the recovery potential of the therapeutic encounter. Using a methodology that centralised service-user experience to evaluate the programme aims to inform future service development.

Each chapter of the thesis addresses one or more of the spaces identified. The first chapter takes the reader through a description of the workshop programme that was developed and implemented. It is important to understand the content and design of the workshop programme in order to understand the design of the evaluation. The rationale for the use of specific facilitation techniques, environmental considerations and choice of creative occupations is presented. The design of the programme drew upon shared expertise and focused on occupational engagement throughout.

Chapter 3 presents the rationale for the project. Current research relating to recovery-oriented mental health services for women is critiqued. Irish mental health services are discussed as a key influence on service provision. Occupational therapy and its theoretical and practice relationship to the recovery model in mental health are evaluated. Self-esteem as a core element of positive mental health is presented. Potential for development of self-esteem through participation in creative occupations and shared experience is discussed.

The methodology for the research is described in chapter 4 where the conceptual framework underpinning the research project is presented. The overarching framework of critical disability theory situates the research in terms of the influence of social factors in mental health and how difference plays out in mental health services. In keeping with recovery as a central tenet of mental health policy, a
recovery framework is used to conceptualise the project. As a piece of occupational therapy practice a model of occupational engagement is used. The methods selected reflect fidelity to the recovery ethos. The use of a qualitative methodology that focuses on the experience of participants aims to be person-centred. The process of thematic analysis is described and the strategies used to maintain rigour and quality in the research are discussed.

The findings are presented in the programme evaluation discussed in chapter 5. The key themes of planning and design, the potential of occupational engagement, and shared experience and peer support that emerged in the analysis are presented and discussed. Each theme is presented and discussed using the relevant literature concurrently. Finally, the thesis concludes with a series of recommendations aiming to influence mental health policy, occupational therapy practice and recovery-oriented research.
Chapter 2 Description of the Programme

2.1 Introduction

Any successful occupational therapy intervention, with groups or individuals, requires careful thought, planning and clinical reasoning. A core tenet of the profession is client-centredness where goals and therapy are jointly agreed and based on meeting the needs of the individual/group in a meaningful way (Finlay 2004, Creek and Lougher 2008). The workshop series under review was designed following an audit of referrals to the community mental health service in 2013 that indicated particular needs relating to self-confidence and self-esteem for the women who used the service (Wallace and Shelton 2013). This aligned with findings from Silverstone and Salsali (2003) where self-esteem was identified as being lower in those who experience mental health difficulties, particularly women. In this chapter the aims and objectives of the programme are outlined first, followed by the rationale and the various factors that shaped programme design are noted.

The research was informed by a pilot project carried out by the researcher and occupational therapy students on clinical placement from a local university. Evaluation of this pilot project indicated benefits to the participants; thus the community based mental health service managers supported the decision to invest additional resources into programme development and evaluation.

A series of key processes and decisions informed the workshop series. These are explored in more depth in this chapter. Participation in the programme began before the first session with an initial interview by the researcher. This interview enabled the
participants to consider what they wanted to get out of the programme. It was also an opportunity to address any concerns the women had. For the facilitators the interviews were an initial key step in programme development. Summaries of these interviews were shared with the facilitators before the workshop programme. The definitions of self-esteem that arose in these interviews were important as the words used by participants formed the basis of the first group activity in workshop one.

The centrality of occupation to the workshop series was vital and each session was based on a carefully designed creative occupation. The occupations were selected based on the characteristics that facilitated three key processes – promoting discussion on self-esteem, enabling reflection and building self-esteem. The timing of the occupations in the programme was pivotal with initial group activities graded to lead to more personally reflective occupations in later sessions.

The programme was facilitated by two occupational therapists using a participatory approach. This involved the facilitators fully engaging in each element of the programme with participants. It was envisaged that this approach would provide potentially more meaningful experiences for the participants while also facilitating shared experience and equality in expertise. By participating in each activity the facilitators acknowledged and shared their own understandings in relation to self-esteem and learned from the participants also. This aimed to address the power differential inherent in most therapeutic encounters and to promote the expertise that the participants themselves brought to the programme. The environment for any therapeutic encounter is key and this was particularly evident in this piece of work.
The environmental adaptations to the clinical space carried out by the facilitators and the rationale for same are explained.

2.2 Background

This programme was developed following an audit carried out by the clinical nurse manager and senior occupational therapist (the researcher) working on a community mental health team. The audit was prompted by a team discussion regarding what group programmes would be offered to service-users over a specific time period. The audit aimed to identify the needs of people being referred to the service in order to promote responsive service initiatives.

An audit of referrals over the previous 12 months was completed in 2013 demonstrated that many women referred to the service identified needs in relation to self-esteem and self-confidence (Wallace and Shelton 2013). Traditionally these needs would have been considered the domain of the clinical psychologist on community mental health teams. The absence of a psychology service on the team at this time prompted the occupational therapist to consider the role of occupational therapy in response to this need.

An opportunity to respond to the specific needs came when two occupational therapy students were offered a clinical placement with the service later in 2013. This was their second clinical placement and neither had previous placement in mental health services. Initially the students completed a brief literature review considering self-esteem and mental health. This indicated that people with mental health difficulties
experience lower self-esteem than the general population and that women had lower self-esteem than men (Silverstone and Salsali 2003). Little research pertaining to the use of occupation and self-esteem was available.

A pilot programme was devised and facilitated with the students. Given the occupational therapist’s previous experience of running groups it was decided that the programme would take a workshop format. Four two-hour workshops were conducted over two weeks. This format was chosen to maximise participation and learning by having longer sessions that were closer together. This facilitated easier reflection on learning in previous sessions while also providing the momentum required to maintain focus and motivation. A series of creative occupations were used to facilitate discussion, self and group reflection and to develop self-esteem. The pilot workshop programme was informally evaluated using a questionnaire and a group discussion led by the occupational therapist and students. The original group of participants were positive about their experience and continued to meet after the programme independent of the facilitators. Given the positive feedback the programme was revised and a decision made to formally evaluate it leading to the current study.

2.3 Programme Description

The defined aim of the workshop programme was to offer participants opportunities to explore the concept of self-esteem and build positive self-esteem through the use of meaningful creative occupations in a supportive environment.
The programme objectives were:

1. To provide opportunities for social interactions with other group members through shared activities (facilitators)
2. To ensure everyone felt comfortable in the group setting (facilitators)
3. To provide a creative medium for self reflection and to allow participants to explore the meaning of self-esteem in their own lives
4. To produce a personal piece of artwork to bring home (participants)
5. To produce a piece of jewellery to bring home (participants)
6. To explore how engagement in occupation can facilitate positive self-esteem (participants)
7. To build positive self-esteem through the process of engagement in the workshops (participants)

The structure of the programme remained the same as the pilot with four sessions of two hours duration held over two weeks. The workshops took place at an urban mental health facility. The programme was advertised in all of the community mental health centres in the city and in the rehabilitation service. Self-referral was encouraged, however, participation was also facilitated by the occupational therapists and community mental health nurses on the teams through encouragement and direct provision of information. Six women participated in the programme of whom two self-referred.

Before the programme, each of the participants met with the researcher to complete an interview. Although these were the “initial interviews” for the research project, this
interaction was also part of the programme. The interview guide is found in Appendix 1 and is further discussed in the methodology chapter. During the interview participants were asked about their understanding of self-esteem and its connection to mental health and occupation. Participants were also encouraged to consider their personal goals for participation. Summaries of these pre-programme discussions were given to the facilitators as well as a list of the words used during the interviews to define self-esteem. This information allowed the therapists to structure meaningful opportunities for occupational engagement during the programme.

The programme was facilitated by two occupational therapists. The staff grade occupational therapist worked in the service and the other, a senior occupational therapist, at the local university. One session was co-facilitated with a tutor from the local adult education service (Clare & Limerick Education and Training Board). The facilitators met together before the programme to allocate roles and responsibilities and to review the programme guide (Appendix 2). They also met with the researcher to discuss the relevant information from the pre-programme interviews. The facilitators were also introduced to a reflective tool that would later facilitate discussion regarding their experience in their post programme interviews (Appendix 3).

At this point, the concept of participatory facilitation was discussed as the facilitators would engage in each activity in the programme alongside the participants. This method of facilitation was chosen to address the imbalance in power in the therapist/service-user relationship. This aimed to create an equality of experience/expertise that would enhance potential outcomes for participants. In using
this method the expertise of the participants was equally valued to that of the facilitators. It was also an acknowledgement of the shared experience of participants and facilitators as women.

Table 1 offers a broad outline of the workshop programme and the activities used to facilitate each session and then each workshop is described in more detail.

**Table 1 Outline of workshop programme**

<table>
<thead>
<tr>
<th>Workshop</th>
<th>Aims</th>
<th>Activities</th>
</tr>
</thead>
</table>
| **Workshop 1** | Introductions  
Ground rules  
Set personal goals  
Explore self-esteem  
Relationship between occupation and self-esteem  
Develop relationships and support | Word cloud/Card activity  
Feel good collage  
Time use chart |
| **Workshop 2** | Continue to stimulate group interactions  
Encourage creativity through jewellery making  
Create personal piece of jewellery to bring home  
Enhance self-esteem | Jewellery making |
| **Workshop 3** | Encourage peer exchange and support  
Reflect on self-esteem  
Develop personal affirmation  
Express affirmation through creativity  
Groupwork to create individual piece | Word game  
Flower affirmations |
| **Workshop 4** | Identify and accept positive things about ourselves  
Help others feel good  
Shared experience and group work | “I like you because…”  
My personal advertisement |
Table 2 indicates the key therapeutic approaches used in the workshop programme and aligns them with the associated theory indicating where this is discussed in the thesis.

Table 2 - Therapeutic approach used and associated theory

<table>
<thead>
<tr>
<th>Therapeutic approach</th>
<th>Associated theory</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation based</td>
<td>PEO Model</td>
<td>3 and 4</td>
</tr>
<tr>
<td>Choice and self determination</td>
<td>Recovery approach</td>
<td>3 and 4</td>
</tr>
<tr>
<td>Service specific to women/responsive services</td>
<td>Gender and mental health</td>
<td>3</td>
</tr>
<tr>
<td>Environmental considerations</td>
<td>PEO Model</td>
<td>4</td>
</tr>
<tr>
<td>Self-expression through creativity</td>
<td>Creative occupations and mental health</td>
<td>3 and 5</td>
</tr>
<tr>
<td>Group work and peer support</td>
<td>Recovery approach, peer support in mental health, group work mental health</td>
<td>3, 4 and 5</td>
</tr>
<tr>
<td>Participative facilitation</td>
<td>Critical disability theory and recovery approach</td>
<td>3 and 4</td>
</tr>
</tbody>
</table>

2.4 Workshop 1

The first workshop session focused on building a rapport among participants and therapists. The initial objectives were outlined as follows:

Facilitators

1. To build a rapport between all members of the group
2. To build an atmosphere of trust in the group
3. To produce a plan for the following sessions
4. To facilitate the development of peer support through group work
5. To offer an opportunity to develop social skills/relationships through group interactions
6. To provide an opportunity for participants to transfer occupational knowledge into their daily lives

Facilitators & Participants

1. To develop ground rules for the group
2. To explore the meaning of self-esteem for this particular group
3. To explore the relationship between occupation and self-esteem

Participants

1. To set personal goals for participation in the programme

Consideration was given to the environment from the outset. The facilitators softened the environment with the use of cushions, throws, candles and calming essential oils. This reduced the impact of a clinical space. Access to tea, coffee and refreshments was available throughout each session. Participants were welcomed individually as they entered the building and then as a group when everyone arrived. A paired activity to facilitate introductions was used as pairs introduced each other to the main group. The facilitators then facilitated a discussion relating to ground rules and the group agreed the parameters of participation. This was achieved through brainstorming and creating a chart of what was agreed. Rules included respect for all, one voice at a time and that everyone would do their best to be on time for each session.
The group aims and objectives as outlined above were introduced to participants. Occupational therapy was described in terms of meaningful participation and its influence on mental health and well-being. Participants were encouraged to consider their personal goals for the programme. They were invited to write these on post-its and then placed the notes on a poster. There was also an option to keep these goals private by using envelopes provided. The facilitators also shared in this activity setting their own personal goals for the programme. Some examples of goals are shown in Figure 1.

Figure 1 Goals

![Goals Image](image)

2.4.1 Activity 1 – Card Activity

A series of cards with words on them pertaining to self-esteem were developed after the pre-interviews. These words included positive and negative associations with self-esteem e.g. energetic, doer, ugly, lazy, love that participants had identified when asked to define self-esteem in their interviews. The words were written on coloured card. Between fifty and sixty cards were laid out on a table so that each were clearly
identifiable. Some words were repeated if they were mentioned by a number of women in the initial interviews.

For this activity two charts were placed on the wall, one with ‘positive’ and one with ‘negative’ written on them. Participants were invited to select words that described how they felt about themselves and to stick them on the positive and negative charts. They were aware that the words came from the initial interviews. A discussion of these words ensued.

To participate in this activity participants moved around the room. Ensuring that everyone participated in this initial session was a priority for the facilitators. The end products represented the thoughts of the whole group. Having the opportunity to repeat certain words/ideas allowed certain concepts to be emphasized. The visual representation of the concepts at the end of this activity was striking, contributing to meaningful discussion (Figures 2 and 3). For those who may have found discussion difficult it was important that their views formed part of the posters/word clouds.

**Figure 2 Words associated with positive self-esteem**

![Image of positive self-esteem words](image)
2.4.2 Activity 2 – Feel good collage & Time use

After a break participants were invited to create a collage exploring the relationship between occupation and feeling good. This pictorial medium enabled self-expression outside of the written word. Participants were divided into two groups and asked to create a collage using material from magazines to represent activities that help them to feel good. On completion each group presented their collage.

This activity was linked to a discussion about time use with participants completing a time use chart for an average day (Appendix 4). This tool is often used by occupational therapists in mental health settings when considering occupational balance (Bejerholm and Eklund 2006) Bejerholm et al. 2006). Programme participants used the chart to consider their activities in the day in terms of what makes them feel good about themselves. They were encouraged to consider simple changes that might make time use more positive. The time use charts were part of self-esteem journal that was given to each participant at the outset. The journal was a
simple booklet with some positive affirmations and space to record individual experiences and learning at each step of the programme (Appendix 5). An example of how one participant recorded positive associations with self-esteem is seen below (Figure 4). To close the first session time was given to questions and to agree an outline of the next session.

**Figure 4 Recording session in self-esteem journal**

![Image of self-esteem journal]
2.5 Workshop 2

2.5.1 Activity Jewellery Making

The main objective of the second session was to engage in an activity that promoted the development of self-esteem. The objectives were outlined as follows:

Facilitators

1. To continue to stimulate group interactions
2. To develop and encourage creativity through jewellery making
3. To engage in opportunity to enhance self-esteem through participating in a group, developing friendships, learning new skills, communicating with others and having fun

Facilitators & Participants

1. To engage in reflection on the group and topic through participation in creative occupations
2. To design and create a piece(s) of jewellery to take home

This workshop session was facilitated by a tutor from the local adult education service (Clare and Limerick Education and Training Board). She had previous experience of facilitating groups with the service and was well known to the researcher. Jewellery making was chosen as an activity for a number of reasons. Central to this was the potential for a meaningful end product to be created. As an activity it also promoted personal choice, creativity and sharing. The session started with a cup of tea/coffee and a relaxed recap of the previous workshop. The time use charts from the first
session were used to facilitate the discussion. Participants’ occupational engagement and impact on self-esteem and mental health was discussed. The jewellery making took place following this short discussion.

All the materials for the activity were provided and laid out for ease of accessibility and to offer choice. The facilitators engaged in this session as participants. The tutor instructed participants about how to design and make a necklace initially. This was followed by designing and creating a bracelet and earrings. Participants were encouraged to help each other and share ideas throughout. Participants modeled their jewellery for the group before taking the pieces home. Having a completed end product that was designed and made by the individual was an important consideration in the choice of jewellery making as an occupation. It was also important that the occupation used at this stage in the programme provided an opportunity to consider how engagement in occupation shapes emotions. Sharing and peer support occurred naturally as part of this activity with participants helping and encouraging each other throughout. Examples of the jewellery created by participants are shown in Figure 5.

Figure 5 Jewellery
2.6 Workshop 3

The third workshop continued the theme of how engagement in the occupations of daily life influences our self-esteem. This workshop offered opportunities to explore the benefits of positive self-talk. Participants were encouraged to consider what they learned so far and were given time to document this in their personal self-esteem journals. The objectives were outlined as follows:

Facilitators

1. To continue to stimulate group interactions
2. To provide a forum for peer exchange and support

Facilitators & Participants

1. To stimulate reflective thinking about self-esteem and doing through creative occupations
2. To engage in opportunities for enhancing self-esteem by participating in a group, developing friendships, communicating with others and having fun

Participants

1. To consider affirmations in relation to self-esteem and explore same using a creative medium

2.6.1 Activity 1 – Word Game

The first activity focused on what participants achieved in their lives that they felt good about. An envelope was passed around the group with a series of phrases to be
completed. Each participants chose a phrase from the envelope and finished it. Sample phrases were:

“I am most proud of …”
“I am better than most people at…”

There were eight opening phrases and all phrases were completed by each participant including the facilitators. On completion of the word game participants reflected on what they had learned over the past two sessions and were encouraged to document this in their self-esteem journals. They were prompted to consider how they felt about engagement in each creative occupation, if they had learned anything in particular about their own time use and how to use occupation to counteract challenges in life as they arise. A break was taken at this point.

2.6.2 Activity 2 – Flower Affirmations

This activity focused on the use of positive self-talk/affirmations. Participants were introduced to the concept of affirmations and were encouraged to identify a personal affirmation. The group was then split into two with one facilitator connected to each group. Wild flowers and greenery that had been picked by the facilitators and some bought flowers were made available to participants. Each group worked with the flowers to create a collage representing each participant’s affirmation on large sheets of white paper. Each affirmation was photographed and later printed and framed for each participant in the final session. The idea of working in small groups rather than individually encouraged peer support to complete each affirmation design. This
promoted communication, peer support and esteem building as each small group worked together. Once again at the end of this activity participants were encouraged to document their affirmation in their self-esteem journal.

2.7 Workshop 4

The final session focused on reflecting on what was learned over the programme. Further emphasis was placed on identifying positive things about oneself. Participants shared the positive things they learned about each other. Participants were also presented with their affirmation picture. The objectives of this session were:

Facilitators

1. To continue to stimulate group interaction
2. To continue to provide a forum for peer exchange and support
3. To stimulate reflective thinking about self-esteem and doing through participation in creative occupations

Facilitators & Participants

1. To identify and accept positive things about ourselves
2. To share what we have learned about each other in a positive way
3. To engage in opportunities for enhancing self-esteem by participating in a group, developing friendships, communicating with others and having fun
2.7.1 Activity 1 – “I like you because…”

The final workshop commenced with a brief reflection on the previous session with facilitators answering any questions and then presenting the final session outline. The reflection focused on changes participants were making in their lives that related to participating in the programme.

“I like you because…” is a simple activity that allowed group participants to compliment their fellow participants in an anonymous way. Each participant was assigned a blank greeting card. Then everyone was invited to finish the phrase “I like you because…” in each person’s card. The end result is that participants have a card with seven or eight compliments about qualities others admire in them. Each participant was then asked to share one compliment with the group. Each participant kept their own card. As with other activities the facilitators fully took part in this activity. Participants had an opportunity to help others feel better about themselves through offering compliments while simultaneously seeing themselves through the positive comments of others. Using the activity at the end of the programme was timely given that participants knew each other quite well at this stage.

2.7.2 Activity 2 – My personal advertisement

For the final activity participants designed an advertisement that represented themselves positively. This activity commenced with a discussion about advertising and how it related to women. Then participants presented their own advert using art and crafts materials such as paints, fabric and magazines. When the adverts were complete each participant presented their design to the group. Participants were
prompted to think about what they learned about themselves throughout the programme. Presenting their work to the group was an opportunity to share achievements and to receive positive feedback from their peers. Participants were invited to keep their adverts if they wished. Two examples of these adverts and personal collages are shown in Figures 6 and 7.

Figure 6 Personal advert

![Figure 6 Personal advert](image)

Figure 7 Personal advert

![Figure 7 Personal advert](image)
At the end of the final workshop participants were presented with a framed photograph of their flower affirmation.

At the end of the final session an informal discussion was facilitated regarding how the group might like to continue into the future. This allowed the women to continue the supportive peer relationships that evolved through participation in the programme if they chose to.
Chapter 3 Literature Review

3.1 Introduction

In this chapter the provision of mental health services for women in Ireland will be considered from several perspectives. The chapter begins by contextualizing current Irish mental health service provision and policy. This is a crucial element in the understanding of today’s services and the changing expectations of service-users. Although the concept of recovery is increasingly used to describe Irish service provision and the direction of policy, translation into practice has been slow. The reasons for this disconnect are explored.

Attention then turns to the role of occupational therapy in mental health services. Occupational therapy practice with women who use mental health services is examined. Self-esteem is identified in mental health policy as a key predictor of mental health. The literature on self-esteem as a significant factor in the experience of women who use mental health services is reviewed. The role of gender in mental health is explored with respect to the experiences of women. Given that the policy governing services remains persistently gender neutral, the specific needs of women are discussed to provide a rationale for including the perspective of women in service development. Therapeutic approaches to self-esteem are briefly critiqued. Potential therapeutic avenues for working on self-esteem in mental health are examined. Given that the main focus of these approaches is on individual processes and therapy, the literature review concludes with a discussion of the potential use of group work and creative occupations in building self-esteem in women who use mental health services.
Irish mental health services are delivered through community and hospital based multi-disciplinary teams. Occupational therapy, as a key discipline in mental health service provision, is introduced and the challenges of engaging in evidence-based practice are reviewed. Qualitative and quantitative methods used within international literature have informed recovery-oriented approaches in mental health. Particularly apparent, however, is the lack of evidence for occupational therapy practice to support women who access mental health services in Ireland. The literature evaluating occupational therapy services from a recovery perspective is limited, thus providing the rationale for this empirical study.

There is a range of approaches open to a researcher when completing a review of the literature. For the purposes of this project, a traditional approach to reviewing the literature was used. An alternative would have been to complete a systematic review, however, this approach was too narrow to capture the breadth of information required to contextualise the project. A comprehensive search strategy was devised and implemented in order to identify the most relevant literature to the subject. Literature was drawn primarily from occupational therapy, mental health and social sciences. The literature included reflects a critique of occupational therapy service provision for women using mental health services in Ireland, with particular reference to the contextual components of policy and practice.

Searches of the following databases were conducted; CINAHL, MEDLINE, AMED, Web of Science, PsycINFO, SAGE, and Social Sciences Full Text. The key search terms used were: occupational therap*, women, mental health services, Ireland/Irish, mental health policy, self esteem, self confidence, recovery, psychiatr* and gender. A
timeline from 2000 was used to include the most relevant literature. Secondary sourcing was used through screening reference lists and from hand searching key journals.

3.2 Mental Health Services in Ireland

This research project attends to the experiences of women who use mental health services in Ireland, focusing on their participation in an occupational therapy programme. The individual experience of each participant is central to the evaluation. The programme is considered in terms of its capacity to promote positive mental health through the occupations employed. To effectively understand the programme and to interpret the potential implications for participants and practitioners, it is crucial to situate this intervention within the Irish policy and service context.

Mental health services in Ireland are delivered as part of community-based health services. Mental health care is gradually becoming linked to primary and social care networks to provide clearer pathways for service-users under the Community Healthcare Organisation Framework (HSE 2014a). This restructuring aims to ensure that mental health services are integrated with other health and social care services to provide clearer care pathways (HSE 2014). To facilitate this process, nine Community Healthcare Organisations (CHOs) were developed throughout the Republic of Ireland. CHO 3, where this research is situated, comprises the Mid West region including the counties of Limerick, Clare and North Tipperary.
Alongside this structural change is a simultaneous ideological shift in mental health services. In the past decade there has been a significant challenge to the dominant biomedical discourse in psychiatry with the introduction of a recovery approach to mental health policy and practice (Higgins and McBennett 2007). A major shift in legislation, policy and service delivery is evident, particularly in the last thirty years with the transition from institutional care to community mental health services. The mental health strategy *A Vision for Change* (DOHC 2006) emphasised the need to develop community-based, client-centred services delivered by multidisciplinary teams. The *Bacon Report* (DOHC 2001) recommended the implementation of comprehensive community mental health services to better meet the needs of mental health service-users. In response to this report and to national policy occupational therapy, social work, clinical psychology and clinical nurse specialist posts were funded across the country in 2012 and 2013. These posts aim to support community mental health teams in delivering effective client-centred services.

The expectations of service-users in service delivery and development have simultaneously changed. Service-users and families now seek an equal role in decision-making, service planning and delivery (McDaid and Higgins 2014). There is a push to recognise the service-user as “expert by experience” not just in individual therapeutic encounters but also in how the services are developed, delivered and evaluated. *A Vision for Change* (DOHC 2006) marked a shift in expectation in relation to the model of service delivery, with the recovery approach becoming the mandated model of practice. This model places the service-user and their needs at the centre of service delivery and delineates the need for specialist services including those for the elderly, children and for people with intellectual disability. Despite this
clear guidance, there is no recognition of gender within current policy, a surprising absence given that gender is acknowledged as a determinant of mental health and illness (Bergin et al. 2013).

3.3 Mental Health Policy & Service Provision

An historical perspective on modern day mental health services assists in understanding what shaped service delivery. The 1966 Commission of Inquiry on Mental Illness indicated that Ireland had more people resident in mental hospitals per capita than any other country in the world, recommending the development of appropriate community mental health services. The response to mental ill health at this time remained embedded in the 19th century asylum system where individuals were admitted to psychiatric institutions, often remaining there for their lifetimes (Prior 2012). The most recent primary mental health legislation before the report was in 1945 (Mental Treatment Act 1945 1945). This Act aimed to improve standards and practices in Irish mental health services by providing voluntary access to hospital, appointing an inspector of mental hospitals and providing community care in the form of out-patient clinics (Kelly 2014). It did not, however, lead to fewer admissions to psychiatric institutions since, despite the commission’s recommendation to move to a community-based model of service provision, the emphasis on custodial and institutional care remained entrenched until the 1980s (Kelly 2004). The Irish government revisited the approach to mental illness with the introduction of the policy document Planning for the Future (DOH 2004). Until this time the ideals of the 1966 report were not realized. This policy aimed to shift mental health service provision to the community, resulting in the development of community-based day
hospitals, day centres and community residences. Although this transition aligned with human rights legislation (Amnesty International Irish Section 2006) two dominant criticisms emerged regarding the approach in *Planning for the Future* (DOH 1984). The first was that the medicalised understanding of mental health difficulties prevailed, with little or no attempt to consider alternative perspectives. The second was that the community residences managed by the health service functioned as “mini institutions”, failing to address the segregation and stigmatization of people with mental illness (Kelly 2015). De-institutionalisation continued from 1984, albeit in a fragmented fashion and it was not until the early 2000s that many of the country’s large institutions were closed. However, many community residences continued to function under the archaic institutional ethos with little evidence of rehabilitation (Mental Health Commission 2003).

The *Mental Health Act* (Government of Ireland 2001) introduced two main changes in mental health legislation. The main function of the Act was to address deficiencies in the legislation by addressing fundamental human rights abuses associated with the outdated law, which allowed for the detention of individuals in psychiatric care for indefinite duration. The rights of the individual admitted to psychiatric care were central to the new Act. Furthermore, the establishment of the Mental Health Commission, pursuant to the Act in 2002, aimed to enhance service provision. The objectives of the Mental Health Commission are to foster high standards in service provision and to protect the rights of those who are admitted involuntarily to acute psychiatric units. The Act introduced welcome change in mental health legislation including defining mental disorder and changing the procedures relating to involuntary admission and the right to review by a mental health tribunal. However,
the Act, the Mental Health Commission and Inspector were criticised by Amnesty International for the sole focus on in-patient services, which it argues diverts attention from the development of person-centred community services and alternatives to acute care (Amnesty International Irish Section 2006). The Act remains under review, with elements of the Act, such as the definition of “in the best interests of” in contrast to “based on a person’s will and preference” subject to change in 2016 in line with the Universal Declaration of Human Rights (UN General Assembly 1948).

A Vision for Change (DOHC 2006) was commissioned to activate change in mental health service provision. A wide range of service-users, carers, healthcare staff and the general public were consulted in its development. The consultation process affirmed that people wanted accessible, person-centred services where they could be partners in their own recovery. The policy highlighted the importance of a public health approach to mental health stressing the relationship between mental health and physical and social functioning. It emphasised the link between positive mental health and the prevention of mental health difficulties. A partnership approach between services and those that use them was recommended. Multidisciplinary community-based services with a range of therapeutic options were the cornerstone of service provision with specialist rehabilitation services recommended for those who experience severe and enduring mental health difficulties. Mental health recovery became the foundation of Irish mental health service policy. A Vision for Change (DOHC 2006) endorsed a recovery orientation in all aspects of service provision with service-users as partners in their own care. The policy referred to recovery in terms of the individual capacity to live a meaningful life in spite of the difficulties posed by
mental ill-health. It recommended that service-users and their families be included in service evaluation, development and delivery.

The translation of the policy of recovery into practice continues to challenge services. Although in-patient services have introduced person-centred care planning, this approach is not been implemented in community services. Consultation and collaboration with service-users and their families is often person-dependent and not uniformly engaged in across services (SHINE 2015). Similarly the expertise of service-users and family members is only recognised in an ad hoc manner.

3.4 Recovery & Mental Health

A recovery approach to mental health service provision developed internationally over the past 20 to 30 years. A recovery approach to service delivery is espoused across many countries including the UK, US, New Zealand, Canada and Australia. This apparent agreement on the importance of a recovery approach belies the lack of conceptual clarity regarding the meaning of recovery in mental health which explains some of the challenges to implementing recovery oriented services. Recovery as a concept is contested in a number of ways. Higgins and McBennett (2007) reflect that recovery is represented in two ways in the literature. In the first instance they describe the personal journey that is the core of recovery. The second relates this journey to how recovery can become an approach to care in mental health services, requiring creativity on the part of mental health practitioners to implement this approach. Recovery, however, is more nuanced than this.
Reflecting this complexity, Pilgrim (2008) identifies three conceptual models of recovery. The first is recovery *from* illness, where the traditional bio-medical model remains intact and successful recovery means absence of symptoms. The second refers to the social psychiatry movement and recovery in the context of successful rehabilitation. Recovery in this instance is equated with the development of skills that allow the individual to function in society. Finally, Pilgrim defines recovery as emancipation from coercive services and the ability to live a self-determined life. This perspective on recovery as a personal and social concept has its roots in the mental health survivor movement of the 1970s and 1980s (Mental Health Reform 2014). From the perspective of this movement recovery represents liberation from the traditional psychiatric model that emphasizes mental disorder to one where personal experience is respected (Anthony 1993). Deegan (1996) suggests that people who have mental health difficulties need to move beyond being passive recipients of care to being active participants in their own recovery journeys. Although this model emphasizes social inclusion it has been criticised for ignoring the impact of social structures on recovery (Pilgrim 2008).

Recovery in mental health is contested throughout the literature. On the one hand, psychiatric literature continues to reflect a biomedical model in conflating recovery with successful treatment of illness. On the other hand, recovery is defined as a personal journey of growth and development that occurs beyond attending mental health services and can happen whether experiencing poor mental health or not (Deegan 1996, Coleman and Taylor 2012) Anthony 2002). Pilgrim (2008) describes recovery in mental health as a “polyvalent” concept that has many meanings to those
who use services and those who provide services. He considers the challenges faced by local mental health services attempting to enact this philosophy in a meaningful way for practitioners and service-users alike. This challenge is reflected by Le Boutillier et al. (2015) in their exploration of how staff implement recovery policy. Likewise Piat and Lal (2012) noted the influence of this conceptual uncertainty on the success of recovery-oriented interventions in mental health services in Canada. Alongside this poor understanding of the concept of recovery, staff in these studies also indicated lack of organizational support as a barrier to implementing recovery in practice. It is clear that a gap exists in terms of how to define recovery-oriented practice for mental health professionals. It is recommended throughout the literature that concrete examples of what recovery means in practice will enable greater uptake of recovery-oriented practice. An increase in a partnership approach to mental health service development and provision between service-users and practitioners serves to facilitate positive experiences of services becoming more recovery-oriented (Farkas et al. 2008, Roberts 2014).

In the Irish context the concept of recovery was introduced by the Mental Health Commission in the discussion document Recovery in the Irish Mental Health Services (MHC 2005). Using the document the MHC aspired to facilitate discussion in the services regarding the potential of this approach. In 2008 the Commission published A Recovery Approach within the Irish Mental Health Services – a framework for development, a document that aimed to assist services and those who work in them to incorporate recovery into their philosophy and practice (Higgins and McBennett 2007). In the document the requirement for a significant cultural change to develop recovery-oriented services was recognised. Higgins & McGowan (2014) describe the
recovery model as a radical shift in the ethos and practice of mental health services where individuals’ rights to self-determination are respected and their experiences and voices are central to their recovery.

In their extensive review of the British recovery literature that included 170 papers, Bonney and Stickley (2008) identified six main recovery themes. These are identity; the service provision agenda; the social domain; power and control; hope and optimism; risk and responsibility. This review included service-based literature with personal narratives and carer perspectives. Additionally, it analysed intrinsic and extrinsic factors associated with recovery. The review demonstrated the importance of personal decisions and agency while also recognizing the key role of services in facilitating recovery. The power dynamic that exists in service-user/professional relationships is acknowledged as is the power of a person-centred facilitative relationship. The centrality of risk as a vehicle for learning and development in recovery is clear in this review. This is particularly salient given that risk-averse decisions are common in service provision.

The themes identified by Bonney and Stickley are mirrored by Leamy et al. (2011) who defined 13 key personal experiences associated with recovery and five processes that facilitate recovery through their review of 97 articles in the recovery literature. Hope, identity, meaning, empowerment and connection to others are identified as the key processes. These themes (Bonney and Stickley 2008) and processes (Leamy et al. 2011) are a useful starting point for mental health practitioners aiming to practice in a recovery-oriented manner. They are not, however, without challenges. Attempting to
provide opportunities and choice to facilitate personal agency is difficult in services
that are risk-averse. Services that are biomedically oriented with a dominant
psychiatric discourse challenge practitioners to develop therapeutic relationships
where the client is an equal partner in decision-making.

The value of hope in recovery is uncontested from all perspectives. Leamy et al.
(2011) refer to “hope inspiring relationships” and “belief in the possibility of
recovery”. These are avenues that can be explored by services and practitioners alike
to promote a recovery ethos in service provision. Deegan (2001) and Graham et al.
(2001) recognise the barriers to recovery that are built by professionals who over-
emphasise symptoms and deficits thereby decreasing hope. There is vast potential for
hope to be held for and explored with service-users, however, environments and
policies consistently impede hope.

The work of the Irish Mental Health Commission and the policy structure of A Vision
for Change (DOHC 2006) offer a clear vision of the type of service needed in Ireland.
The path toward the transformation required in services, however, is less clearly
defined. Walsh et al. (2008) recognise the gap between defining the shift on paper to
actualizing the change in services. The implementation of a recovery approach is
happening in a piecemeal manner across mental health services (Higgins & McGowan
2014). It is perhaps for this reason that studies relating to recovery in the Irish context
are limited. However, a number of projects aimed to define recovery from the Irish
perspective and also to explore the knowledge base of mental health practitioners. For
example, Kartalova-O'Doherty et al. (2012) in their grounded theory study on
recovery in Ireland, defined recovery from the perspective of Irish people who experience mental health difficulties. The study, which included interviews with 32 participants, defined recovery as “reconnecting with self, reconnecting with others, reconnecting with time and reconnecting with life” (Kartalova-O'Doherty et al. 2012). These processes link with the factors of “identity”, “the social domain” and “hope and optimism” as identified by Bonney and Stickley (2007). Although this work represented a start in defining recovery in the Irish context, the authors acknowledge the limitations of the study in its small sample size and the approach used. As a study with 32 participants, the authors recognised that the study could not fully capture the complexities of recovery and that further studies are required to produce a more robust understanding of the concept. Most participants were recruited through traditional services or peer support services so the perspectives of those not using services were excluded.

Kartalova-O'Doherty et al. (2012) present recovery from a service-user perspective. There is a gap, however, in terms of how well this type of understanding facilitates the implementation of a recovery model in mental health practice. Newman et al. (2015), in their integrative literature review of service-users’ experience of the mental health services conclude that the potential of the recovery approach is yet to be realized within services. Recovery needs to be fully understood and accepted by mental health staff to facilitate meaningful change in service delivery. Cleary and Dowling (2009) explored the knowledge and attitudes of mental health professionals in Ireland in relation to recovery through a questionnaire. They found that mental health professionals in Ireland struggled with defining recovery, and although positively displaced to the concept, placed an emphasis on symptomatology and
compliance with treatment. The authors concluded that adopting a recovery approach necessitated a shift in values and power. Although participants in the study valued recovery they felt further training was needed to change practice. A recent service based research project in the Irish Mid West relating to recovery education (McMahon 2014) demonstrated positive attitudes from staff towards the concept of recovery but the need for education was highlighted, with staff requesting training on how to be recovery-oriented in their practice.

It is questionable as to whether “training” in this instance will be enough to facilitate the change required. Recovery-oriented practice is about how service-users and their families are included in their own care and in service evaluation and development. Any form of training will need to include a practical component that facilitates learning through changed practice. A fundamental shift in the power differential that exists in the service-user/service provider relationship is required to promote the inclusion and full participation of service-users in their treatment and recovery (Newman et al. 2015).

In spite of the recovery orientation of national policy, from the perspective of service-users this has not translated into mental health practice. Mac Gabhann et al. (2010) in their work with 300 participants found that people with mental health difficulties described being treated unfairly in their close relationships, by healthcare staff, in dealing with public transport and welfare and found particular discrimination in relation to employment. Although an attempt has been made to define recovery in the Irish context the impact on service delivery is unclear with staff requesting further
information and education and service-users remaining critical of the services
received. Further research is required to demonstrate the potential of recovery-
oriented interventions in the Irish context, to critique these approaches and to
recognise the variety of understandings of recovery in mental health.

3.5 Women and Mental Health

As with many health issues the needs of men and women in relation to mental health
differ. Statistics indicate that women experience depression twice as much as men,
have more incidents of deliberate self-harm and have higher incidences of anxiety and
stress (Fryers et al. 2005). Women comprise the majority of people with eating
disorders and are more likely than men to be diagnosed with post-traumatic stress
demonstrated that in Ireland women report lower levels of positive mental health than
men. This may in part be related to poorer engagement with health issues on the part
of men, therefore under-reporting experiences of low mood or depression. The higher
incidence of depression among women could be argued to be associated with their
higher exposure to complex and challenging social circumstances and their response
to these (Picanelli & Wilkinson 2000).

Greater attention needs to be paid to how gender influences mental health (Bergin et
al. 2013). The causes of mental ill-health are complex and relate to broader inequities
in society which need to be taken into consideration when planning services (Elliott
and Masters 2009). Kohen (2001) argues that women specific mental health services
are needed to respond to their very specific experiences of mental health. Likewise,
Halliday (2005) recommends that “women only” or “women friendly” mental health services are prioritised. The current study is an example of an occupational therapy intervention devised specifically based on the needs of women that were identified in a service audit. The audit was not originally developed to capture the needs of women or men specifically, which may reflect the gender neutral nature of service development. However, some particular needs relating to female referrals were identified.

The literature that contributes to the above statistics typically reflects women’s experience purely from a medical perspective, focusing on symptomatology and medical treatment. In doing so the contribution of social structures and phenomena such as poverty, gendered roles, gender-based violence and ethnicity are ignored by psychiatry (Halliday 2005). From a feminist perspective, psychiatry can be considered to an agent of social control or a means of medicalising unhappiness (Wright and Owen 2001), with social and emotional problems increasing interpreted through a medical lens. Busfield (1996) described this as the “gendered landscape of mental disorder”. This gendered landscape was reflected in a study by Jebali (1995) describing the difficulties faced by women using the psychiatric services in the UK. Jebali argued that these services were entrenched in a patriarchal ideology that attempted to control people’s behavior, taking no account of individuality. She argued that this dominant discourse needed to be challenged to understand the experiences of women and accommodate their needs. This involves challenging what we believe to be knowledge, moving towards more qualitative methodologies that seek to understand service-users’ experience of service delivery and valuing their expertise as legitimate evidence-base for making changes.
Owen et al. (1998) explored what women with long-term mental health difficulties in the UK required from the services. The women involved in the study wanted choice in the service they receive, choice in the sex of their keyworker, to have help with practical activities and to be treated as normal. The study highlighted the importance of recognising the experience of women and the value of bringing women together to facilitate recovery through sharing experiences. This focus on the importance of examining and understanding the expertise of women in improving and developing services was clearly demonstrated by Barnes et al. (2006). An exploratory workshop entitled “Women’s Voices Women’s Choices” focused on engaging with women about their experiences who had expertise based on their life stories. Emerging themes included recognition of the importance of investing resources in developing women-only responses in times of crisis. The participants valued services that work creatively to provide opportunities for women to share with and learn from others with similar experience and include them in decisions made about recovery and treatment.

Kulkarni (2008) and Joffe and Greenfield (2009) argue that women’s specific needs must be recognised in order to provide appropriate services. Although defining mental illness as a discreet biological phenomenon, the authors of these studies nonetheless align with a feminist and the survivor movement’s recovery perspective in advocating for a model of service delivery that is socially inclusive by virtue of recognising women’s specific needs. Halliday (2005) suggests that the best way to empower women who use mental health services is to include them and their experiences in planning new services. Reflection on the gendered needs of clients when planning
and providing services is deemed obligatory from a nursing perspective (Horsfall 2001).

The consideration of mental health difficulties and its relationship to the experience of motherhood, personal relationships and physical health and well-being is beneficial to female services users. In the UK, the NHS has a policy relating to the provision of gender sensitive services for women (Kohen 2001). The general principles associated with gender-oriented services in the UK involve access to same sex member of staff, same sex doctor for physical health care, and women only therapy groups and social activities as highlighted above. Warne and McAndrew (2007) are, however, critical of the extent to which services are actually sensitive to the needs of women in the UK and query if this relates to the continued dominance of a paternalistic psychiatric discourse that underpins practice.

In Ireland the government adopted “gender mainstreaming” as a strategy to promote equal opportunities for women in society (Government of Ireland 2000). In their framework document (2012) the National Women’s Council of Ireland highlighted the absence of a gendered approach to both mental health policy and service provision for women. Although mental health policy includes social inclusion and participation as key issues gender is not addressed. SHINE (formerly Schizophrenia Ireland) in collaboration with the National Women’s Council of Ireland ran a national workshop in 2004 to explore issues relating the mental health and women. Through this process the importance of enabling women to contribute to discussions about policy and service provision was identified.
In spite of the specific experience of women in relation to their mental health Irish Mental Health policy remains gender neutral (National Women’s Council of Ireland 2012). Although *A Vision for Change* (DOHC 2006) draws upon the social determinants of health and makes specific recommendations for certain groups (e.g. children, older adults, people with intellectual disability) gender is not engaged with in any meaningful way despite it being a key dimension of individual identity (Bergin *et al.* 2013). The policy document does not reflect gender in either its content or recommendations. Gender is recognised by the WHO as a key determinant of mental health and illness (WHO 2013). Vlassof and Garcia Moreno (2002) describe the fundamental importance of gender analysis when developing health policy and indicate its importance in relation to health programmes and outcomes. They argue that a gendered analysis of service provision would improve services in a variety of ways including the detection and treatment of health problems through providing greater epidemiological clarity. This type of analysis would also detail the psychosocial factors associated with health in women and men and improve public interaction with health services.

Research exploring the gendered needs of mental health services users in Ireland is lacking. There is a need to re-evaluate our current knowledge base in mental health to create a more relevant understanding of the needs and experiences of the women who use our services. This programme evaluation needs to be considered in the context of recovery oriented service provision.
3.5 Occupational Therapy and Mental Health

Engagement in occupation has long been valued as beneficial to mental health. This recognition is evident in both Western and Eastern cultures (Creek 2010). The unique contribution of occupational therapy lies in the belief that engagement in meaningful occupation has the power to maintain, restore and transform health and well-being (Townsend 1987, Wilcock 1998). The roots of the profession lie in mental health practice and the moral treatment movement (Schwartz 1992, Peloquin 2005).

The experience of mental health difficulties can lead to disruption in occupation balance and engagement thus “doing” has historically been a central tenet of mental health occupational therapy practice. Individuals with mental health challenges can be at a greater risk of occupational deprivation given their experience of distressing symptoms and associated functional and social difficulties. This occupational deprivation and alienation can lead to social isolation and limited opportunities for meaningful engagement (Bryant 2008). It is for these reasons that occupational therapy is considered one of the key elements of multidisciplinary team working in mental health services (MHC 2005).

The profession of occupational therapy is experiencing increased pressure to demonstrate the effectiveness of its interventions across practice settings (Bannigan 2008). In the US where funding for services is based on quantifiable outcomes and evidence of effectiveness, a positivist approach to researching occupational therapy is evident. For example, in 2011, the American Journal of Occupational Therapy dedicated a special edition to the effectiveness of occupational therapy in mental
health practice (AOTA). Reflecting the dominance of the positivist paradigm in the evidence-based movement all of the research presented in this edition was quantitative. The edition included three systematic reviews relating to occupational therapy in mental health practice (Arbesman and Logsdon 2011, Bullock and Bannigan 2011, Gibson et al. 2011) that reviewed the areas of recovery, group work, and employment and education. Interestingly, given the profoundly personal nature of recovery in mental health the review of occupational therapy and recovery did not consider the qualitative literature. Although a positive relationship between occupational therapy and recovery was indicated, a qualitative analysis might have offered more meaningful insight into occupational therapy practice and how it relates to recovery. The narrow focus of the edition on research with quantifiable outcomes to the exclusion of qualitative research resulted in information that is removed from the reality of clinical practice and the experience of the people who use occupational therapy services.

The pressure to demonstrate the efficiency and cost effectiveness of services is also evident in the UK (Fuller 2011, Morley and Smyth 2013). Fuller reviewed literature relating to outcome measurement in occupational therapy concluded that there is a paucity of literature regarding the service-user experience of outcome measurement. Morley and Smith (2013) reflect on the challenges with using qualitative data to argue for investment in occupational therapy in the NHS. Here, there is also increasing pressure on therapists to work more generically through keyworking on community mental health teams. This change to work practice also reinforces the profession’s need to demonstrate the effectiveness of occupational therapy interventions (Pettican and Bryant 2007). The response to meeting requirements for funding is also evident in
other areas internationally. In an Australian study examining the effectiveness of an occupational therapy programme for people with mental health difficulties a pre and posttest design using a psychological distress scale was used (Kohn et al. 2012). Although this demonstrated positive outcomes in terms of the scale it was not an occupational therapy outcome measure and participants were not asked for their perspective in terms of what was effective for them.

While pre and post testing and the use of outcome measures are a valuable form of evidence for occupational therapy (Samsonraj et al. 2012), the importance of analysing the complex factors that inform occupational therapy interventions and its impact on those receiving the service needs to be explored (Robertson and Colborn 2000). This type of evidence can be accessed through the personal perspectives of service-users using qualitative methods. This is particularly relevant in services that aim to be more recovery and person-centred. Outcome measurement in mental health is multifactorial given the subjective experience of each individual, hence, the importance of qualitative approaches to evaluation.

Wimpenny et al. (2014) conducted a synthesis of the qualitative research relating to occupational therapy in mental health. This included 22 studies that explored the perspectives of service-users, carers and occupational therapists. The synthesis revealed four key qualities as central characteristics of effective occupational therapy interventions in mental health. The first is professional artistry or the ability of the practitioner to use professional reasoning, knowledge and reflections to work effectively in complex situations. The second is occupational engagement, which is
about ensuring that the opportunities to reflect, create, explore and challenge through meaningful occupation are available in therapy. Thirdly, creating new horizons refers to how the therapist facilitates the client to shift perceptions about themselves and their future. Finally, the quality of inclusion reflects therapy that promotes identity, participation and a sense of belonging. A key outcome from this synthesis is that occupational therapy has a valuable contribution to make to service-users’ recovery. It also highlights the importance of therapists capturing the effectiveness of their interventions. Wimpenny et al. (2014) go on to emphasise the necessity for occupational therapists to use occupation-focused interventions and client experience led outcomes as standard practice in mental health.

Similarly, Fuller (2011) recognised the need for occupational therapists to capture the outcomes of their interventions and also called for more meaningful research. In a critical review of the literature pertaining to outcome measurement in occupational therapy and mental health, Fuller noted the paucity of literature that pertains to the experience of service-users as a measure of effectiveness. This reflects the earlier work of Mee and Sumsion (2001) whose literature review demonstrated the overall lack of research pertaining to the effectiveness of occupation as a therapeutic medium in mental health practice.

Occupational therapy is identified as one of the key professionals on a modern mental health team in Ireland (MHC 2005, MHC 2008). In terms of occupational therapy in mental health in Ireland the evidence base is limited. Occupational therapy has a unique opportunity to establish a clear role and direction for the profession in the Irish
context (Lloyd and Williams 2009). This will be dependent on good quality research. O'Connell and McKay (2010) recognised this gap in the literature further to their exploration of the opinions of occupational therapists working on community mental health teams. Research needs to be completed and published to inform mental health practice in the profession (O'Connell and Williams 2009). This is increasingly important given the creation of new mental health posts over the past two years. Our ability to influence policy makers and service managers regarding the contribution that occupational therapy can make to recovery in mental health through the production of evidence is essential (Baum et al. 2005).

The theory and guiding principles of occupational therapy are aligned with those of recovery in mental health. There is congruence between the goal of occupational therapy to facilitate participation in daily life and of recovery to live a good life while experiencing mental health difficulties (Lloyd et al. 2004, Cone and Wilson 2012). As a result the profession is ideally positioned to lead on not just recovery oriented practice but also research related to recovery (Gruhl 2005). Although this theoretical congruence exists between occupational therapy and recovery in mental health it is questionable as to how this translates into occupational therapy practice. It is not enough to claim fidelity with a recovery ethos, occupational therapists need to demonstrate this in their practice through developing equal partnerships that maximise the potential in the expertise of both service-user and clinician. In a literature review pertaining to occupational therapy and mental health, Cone and Wilson (2012) determined that there was a lack of evidence relating to the use of a recovery approach in occupational therapy practice. Sutton (2010) explored the meaning of everyday occupations for people in recovery. A small qualitative study
with 13 interview participants demonstrated the potential of everyday occupations to promote recovery and change. Doroud et al. (2015) similarly aimed to explore how occupation and recovery are interrelated by considering the evidence in 17 studies over the past 30 years. The focus of this review on occupational engagement in everyday activities, however, does not capture the potential of the relationship between recovery and engagement in therapeutic occupations. This demonstrates the importance of defining and evaluating recovery-oriented interventions in occupational therapy practice.

Although there is a relatively small amount of qualitative literature exploring the benefits of occupational therapy in mental health, new studies are contributing to the growing body of evidence that explores the impact of occupational therapy on the lives and experiences of those who use services (McKay 2008). This type of research, based on the experience of participants, will align occupational therapy to a recovery ethos in practice. The effectiveness of occupational therapy and consideration of the benefits from service-users’ perspectives are the two key priorities for occupational therapy research in the UK (2008). As argued by Whalley-Hammell (2011) occupational therapists should be reflecting more on the contribution that occupation makes to meaning in peoples’ lives. Hence, there is a strong case to be made that in order for occupational theory to marry its ethos to practice there is a need for research that focuses on occupation and its impact on recovery in mental health from the perspective of service-users.
3.6 Occupational therapy and women with mental health difficulties

As has been demonstrated there is a need for further research into occupational therapy in mental health, with particular emphasis on the experiences of service-users. The evidence base relating to occupational therapy interventions for women with mental health difficulties is far narrower and there is no published literature pertaining to practice with this client group in Ireland. Given the complex nature of women’s experience it is imperative that occupational therapists consider the multifactorial nature of the challenges faced by women with mental health difficulties when designing and implementing their interventions.

Being aware of our clients’ social and cultural context is not new for occupational therapists working in mental health. It stands to reason then that we should take into account the particular needs of women who use our services. Nahmias and Froehlich (1993) recognised the particular requirement of occupational therapists who work in psychiatry to be acutely attentive given the pervasive gender role stereotyping that was found in psychiatric treatment at that time.

There are few studies that evaluate or reflect the work of occupational therapy with women who use mental health services. Spurrell (2008) argues that occupational therapy has a major role to play in the development of specific services for women with mental health difficulties, in particular for those who experience psychosis. She argues that professional expertise in terms of developing therapeutic space and determining activities specific to women is crucial in order to meet their needs effectively. Similarly, an Australian study found that the opportunity to participate in
women only activities was important to the recovery of women in an acute psychiatric unit (Kennedy and Fortune 2014). The study found that having women only exercise time was desired by all participants. Whitney et al. (2002), in their work from an occupational science perspective, use a case example to demonstrate the impact of depression on the occupational engagement of a young woman. The deprivation relating to her roles and daily occupations contributed further to her depression and impacted on her self-esteem, self-concept and self-efficacy. An understanding of the relationship between occupation and the symptoms of depression could provide a pathway for using occupation to facilitate recovery with this client group.

There is little evidence documenting the effectiveness of occupational therapy for women with mental health difficulties, despite the high proportion of women who use the service in the UK (McKay 2010). McKay details the body of literature pertaining to the specific needs of women who use services and the lack of apparent acknowledgement of this in the occupational therapy literature. She recommends the development and evaluation of occupation-focused women-centred mental health projects going forward.

As demonstrated, the evidence relating to occupational therapists’ work with women in mental health is limited. In order to increase understanding of the relationship between mental health difficulties, recovery and engagement in occupation for women further study is required. In Ireland statutory mental health services do not offer gender specific services. The development of such initiatives is at the discretion
of therapists. New responsive approaches to service delivery need to be evaluated and published to broaden the evidence base.

3.7 Self-esteem – a domain for intervention in mental health

Women with mental health difficulties face a number of challenges including the management of distressing experiences, stigma and consequent low confidence and low self-esteem (Silverstone and Salsali 2003). In Ireland the role of self-esteem in recovery and mental health promotion is recognised in mental health policy. In A Vision for Change (DOHC 2006) self-esteem is seen as a core element of mental health promotion and the development of service-users’ self-esteem is identified as a key goal. According to the Mental Health Commission (2005), key areas for mental health promotion are increasing self-esteem, coping skills and communication, strengthening communities and decreasing structural barriers to mental health.

Self-esteem is defined in many different ways, however, within the current study it is understood to be self-evaluation in relation to how people value and accept themselves and their general feelings of self-worth (Morton et al. 2012). Self-esteem grows across the lifespan through individual experiences of relationships, interactions with social and cultural environments and the developing attitude towards the self and personal achievements (Khanlan 1999). Healthy self-esteem is critical to social and mental well-being as it influences life choices, goals and interactions with others. Evans (1997) in a review of empirical studies portrays the importance of self-esteem in contributing to good health and quality of life.
Mann *et al.* (2001) argue that an understanding of self-esteem, its active protection and development are critical components of both mental and physical health. Self-esteem is a consistent feature of positive mental health and the ability to function and cope with life’s challenges. In contrast, poor self-esteem is associated with social problems, engaging in harmful risk behaviours and experiencing mental health difficulties (Mann *et al.* 2001). Low self-esteem is associated with depressive disorders (Patterson and Cabaldi 2001) and with anxiety and eating disorders (Michal Mann *et al.* 2004, Waite *et al.* 2012).

As well as being a predictive factor for mental health difficulties, low self-esteem is closely associated with the experience of poor mental health and associated stigma. Salsali and Silverstone (2003) demonstrated that people with severe and enduring mental illness had lower self-esteem and that women experience this more than men. Camp *et al.* (2002) also demonstrated the relationship between low self-esteem and stigma in women with chronic mental health difficulties. Hence a therapeutic focus on low self-esteem has the potential to improve treatment outcomes for people who experience mental difficulties (Waite *et al.* 2012).

Van Daalen (2004) reviewed the literature and determined that there were no qualitative studies that considered the experience of women with mental health difficulties regarding their self-esteem. She argued that in order for mental health professionals to understand the context in which self-esteem develops, they must shift the lens from the individuals in therapeutic encounters to focus on the political oppression which leads to low self-esteem. This broader consideration of how social
structures influence mental health and self-esteem has the potential to facilitate person-centred and recovery-oriented practice.

The important role of self-esteem in promoting positive mental health is evident. This, coupled with the links between low self-esteem and the experience of mental health difficulties for women, are important factors for mental health practitioners designing and delivering services.

3.8 Approaches to building self-esteem

In mental health there are a variety of approaches that can be taken when working on self-esteem. The approach and theoretical underpinning will depend on the discipline involved but can include, for example, cognitive behavioural therapy (CBT), psychodynamic therapy and mindfulness approaches. For an occupational therapist working on self-esteem with someone with mental health difficulties there are a number of avenues for treatment. The approach taken depends on individual goals, experience of mental health difficulties and occupational engagement. The occupational therapist collaboratively chooses meaningful therapeutic occupations tailored to individual needs. Examples of the use of occupational therapy to build self-esteem include skills development or engagement in previously valued leisure pursuits (Creek 2007).

In the mental health arena, CBT is perhaps the most common approach used with individuals experiencing low self-esteem. Self-esteem is commonly considered the
domain of clinical psychology in mental health services. CBT focuses on the links between the unhelpful thought patterns and behaviours associated with mental distress. A number of psychology studies demonstrate the effectiveness of this type of approach with self-esteem. Waite et al. (2012) used a CBT approach to address self-esteem with individuals who experience mental health difficulties. This randomized control trial demonstrated that individuals who participated in individual CBT had better functioning on a measure of self-esteem Robson Self Concept Questionnaire (Robson 1989) at the end of their treatment. This study, however, is based on quantitative measures thus does not explore the meaning of the intervention for individuals and does not consider other factors that may have impacted outcomes. The authors also acknowledge that further research is required to see if improvements made are maintained in the longer term.

CBT is also used as a group intervention to address self-esteem (Morton et al. 2012) CBT was used with women using an adult psychology service in Scotland. Thirty-seven women participated in CBT groups and outcomes were evaluated, also using the Robson Self Concept Questionnaire. Findings indicated that a CBT approach increased levels of self-esteem and decreased levels of depression and anxiety, however, the specific mechanism for change was not explored. Better outcomes may have been associated with participating in a group of women, meeting others with similar experiences or simply with having a social outlet. In this context, completing the post intervention measure in the final session might also have influenced the findings with participants associating the positive experience of ending the programme with their overall outcomes. A subjective evaluation of those who participated in the study could have enhanced the findings. The current research
project aims to understand the experience of participants in each element of the workshop programme.

Although the CBT approach has merit it is limited. When evaluated from the perspective of the PEO model (Law et al. 1996), which is used in the conceptual framework for this project, CBT focuses solely on cognitive processes, thus does not attend to the possible impact of the environment on the individual. Likewise it does not attend to the influence of engagement in occupation. From the recovery perspective provided in CHIME framework (Leamy et al. 2011), a tool to consider the recovery orientation of services, the central recovery tenet of hope and the importance of connectedness and relationships are not to the fore.

Mindfulness is a relatively new approach in the mental health arena. It is described as: “paying attention in a particular way, on purpose, in the present moment and non-judgmentally” (Kabat-Zinn, 1994:4). Mindfulness has been shown to be effective for individuals with low self-esteem. Fennell (2004) argues that the metacognition developed through mindful awareness allows individuals to recognise that beliefs about the self are learned through experience as opposed to being reflections of the truth. Developing mindfulness practice allows the individual to become more compassionate to the self therefore reducing negative self-perception (Kabat-Zinn 1994). A mindfulness-based approach to self-esteem does not take into account how powerful engagement in occupation in a supportive environment could be although mindful practice has the potential to enhance occupational engagement.
Occupational therapists working in mental health are acutely aware of the impact of occupation on their clients. Occupations are used to help an individual to develop a sense of self and to learn about themselves as an occupational being (Creek and Hughes 2008, Brown and Stoffel 2011). While working with groups and individuals this process is central to the therapeutic encounter. Mindfulness and cognitive behavioural therapy have the potential to influence self-esteem. Their focus is on altering thought processes and the development of awareness respectively, while the focus in occupational therapy is on healthy functioning and the ability to participate in all aspects of daily life. An awareness of the role of self-esteem in these areas is key to developing not just meaningful but also effective interventions. Although the impact of occupation on an individual’s sense of self is a key component of occupational therapy practice this is not reflected in the literature.

Occupational therapists often use groups to facilitate change and learning as part of their interventions. Although common practice, Bullock and Bannigan (2011) completed a systematic review of activity based group work in occupational therapy in mental health and found that robust evidence for the benefits of occupation based group work was lacking. As demonstrated in this chapter, there is some evidence that group work can benefit self-esteem. There is, however, no published literature available that considers the relationship between self-esteem and occupation in mental health recovery.
3.9 Conclusion

This is a time of change in mental health services in Ireland. The advent of recovery-orientation to policy and service delivery challenges the system in a variety of ways. The move from an institutional and biomedical model of care to a service that focuses on the needs of the individual, respecting their individual experiences and expertise is now expected. This change requires a fundamental shift in the power differential inherent in the service-user/service provider relationship and a change in how services are evaluated. The lack of conceptual clarity on recovery hinders the speed at which services adopt to this change. New approaches attempting to incorporate this approach need to be evaluated and published to develop and broaden the evidence base.

Occupational therapy is a key discipline in the mental health services in Ireland. There is theoretical congruence between the discipline and the concept of recovery, however the translation into practice is less evident in the literature. Given this congruence the profession is ideally positioned to lead on research that reflects a recovery ethos. There is an opportunity to evaluate occupational therapy using this ethos by focusing on the how individual service users encounter the service. There is a call for occupational therapy research to be based on the experience of the individuals using services. It has been demonstrated that women have particular needs relating to mental health. Research exploring the gendered needs of mental health service-users in Ireland is lacking. The experience of mental health difficulties for women are multifactorial and lend itself to qualitative exploration. This would create a more relevant understanding of the needs of women using mental health services. The need for occupational therapy to develop services and research the effectiveness
of occupation-focused interventions from the perspective of service-users has been demonstrated. This review highlights the gaps that exist in evidence relating to women mental health service-users experience of using occupation in a group context to build self-esteem.
Chapter 4 Conceptual Framework and Methodology

4.1 Introduction

This chapter introduces the process of the research project. Practical steps taken as the research progressed are described, from the choice of methodology and its implementation through to the ethical considerations. Firstly, the conceptual framework for the project describes the theories that support the research process. This orients the reader to the framework that was chosen to develop and evaluate the intervention. The conceptual framework for this research is based on critical disability theory (Goodley 2013), Person Environment Occupation Model (Law et al. 1996) and the CHIME framework (Leamy et al. 2011). It clarifies the lens through which the research is conceptualized, from the choice of method of inquiry to the types of questions that are asked to the method of data collection.

The aims of the project are discussed. The qualitative approach chosen to evaluate the project and rationale for its use are delineated. The range of methodological choices made in the process of the research are discussed, particularly in the context of occupational therapy in Irish mental health services. Each step of the research process is outlined, including the design of the study, recruitment of participants, data collection and data analysis. Potential avenues for data analysis are presented including ethnography and grounded theory. This section concludes with the relevance of the use of thematic analysis to this type of study. Issues of trustworthiness in qualitative research are addressed in relation to this specific study with particular emphasis on reflexivity. The strategies to promote reflexivity in the project are described.
4.2 Conceptual Framework

The conceptual framework is a set of broad ideas and principles taken from relevant fields of inquiry (Reichel and Ramey 1987). It helps the researcher to determine the research question and provides the foundation for decisions about how the research will be conducted (Marshall and Rossman 2011). It affords the researcher a conceptual map, a lens through which the research is carried out and analysed (Leshem and Trafford 2007). The careful consideration of the theories to be used in framing the research allows the researcher to design the study. In doing so it ensures that the right questions are asked and situates the project in terms of its contribution to the current literature. It enables a tentative theory on the phenomenon under investigation to be produced (Denzin and Lincoln 2013).

In developing the conceptual framework it is important to consider how the study contributes to the knowledge base in the area under review (Maxwell 2012). This involves examining current key related concepts and theories and reflecting on what the research project can potentially contribute. The conceptual framework is the foundation for a research project and thus it is imperative that the most salient theories are selected, with each making a specific contribution to the overall research process (Denzin and Lincoln 2005).

In order to develop the conceptual framework for this research project a number of strategies were used. An initial exercise involved careful reflection on personal beliefs, assumptions and experience through the documenting a reflexive self-statement. This highlighted the values and meanings that were important to me as an occupational therapist and a person. It also gave me greater clarity regarding my
motives for completing the research particularly in relation to incorporating the experience of the participants in the study. It prompted me to explore theories relating to occupational performance, recovery in mental health and those that foreground the experience of participants in research.

Existing theoretical perspectives that may relate to the study were also considered. This involved examining the types of theoretical approaches that were used in other studies in occupational therapy and mental health. Although this highlighted a variety of existing frameworks it became apparent that none of these provided a theoretical backdrop that would examine the complexity of the interactions under review. As a result I broadened the scope of the framework and introduced theories that would help to reflect on the paradigm of recovery in mental health and the experiences of the participants while also recognizing the centrality of human occupation.

This research project is broadly situated within the paradigm of critical disability theory and is simultaneously aligned with elements of social constructivism. Critical disability theory research essentially aims to address injustices in society and refers to the social construction of disability (Goodley 2010). Critical theorists aim to locate the creation of knowledge in the cultural, historical, economic and social contexts where individuals experience marginalization and oppression (Goodley 2013). As a research project set in Irish mental health services, I considered the social and cultural backdrop to the project as key to understanding the experience of those using services.
In this research my position as an occupational therapist and my role in the project is acknowledged as integral to what counts as knowledge. In researching occupational therapy practice in mental health, I anticipate making a contribution to changing service provision for women. I also expect that this research will contribute to more recovery-focused practice in the services while promoting the importance of evaluating therapeutic interventions from a recovery perspective.

Building knowledge through the use of qualitative methodology seeking to understand the experience of those who use services is considered an appropriate research approach in occupational therapy (Cole 2010). The conceptual framework for this research project, as an evaluation of occupational therapy practice in mental health, requires consideration at a number of different levels. This qualitative project is guided by critical disability theory (Goodley 2013; Goodley 2010) the Person Environment Occupation model of occupational therapy practice (Law et al. 1996) and the CHIME framework for recovery in mental health (Leamy et al. 2011). Each will be reviewed and connecting the important elements of each creates a strong and nuanced foundation for the project.

4.2.1 Critical Disability Theory

Critical disability theory is a framework for the study of disability issues aiming to deconstruct ideas about disability. It challenges the ableist assumptions present in society as a mechanism to examine the political, theoretical and practical issues that relate to disability in society (Goodley 2010). In particular, the theory contends that the differences between disabled and non-disabled people are socially produced. From the perspective of this research, critical disability theory offers insight into the social
construction of mental illness. Using this as a basis for the conceptual framework offers a lens to consider the dichotomies that exist in the structure of mental health services, the individual experience of mental health difficulties and the relationships between mental health service-users and providers. In current service provision mental health professionals are considered the experts with a power differential present in how services are set up, delivered and evaluated.

In critical disability theory the notion of “other” and difference is explored. It is suggested that a series of contrasts exist where there are normative and non-normative ways of being (Goodley 2013). In mental health this dichotomy is between being mentally well or mentally unwell. Critical disability theory offers the opportunity to explore this dualism and consider how it has reinforced difference in the relationships between service providers and service-users.

This notion of other is perpetuated by mental health services in a number of ways. The structure of the mental health service system adds to this creation of difference. As a system the service develops and responds predominantly to risk as opposed to need and certain forms of knowledge are respected and valued. As a service in Ireland, it does not fit in with other components of the healthcare system, standing apart from primary care or disability services, reinforcing the notion of difference/otherness and maintaining an authority on mental health. Within services the medical professions continue to maintain privilege and control. The power that exists in the mental healthcare system also plays out in the service-user/provider relationships that form the basis of service provision Critical disability theory explicitly tackles the power dynamics that exist in mental health services.
For occupational therapists working in mental health it is important to consider the ways in which difference is constructed within society and the services where our work is placed. Krupa (2008), in her reflection on difference and stigma in mental health, urges occupational therapists to base their relationships with service-users on acceptance and respect to counteract the influence of large scale system and service issues Whalley Hammell (2013) employs critical disability theory to critique client-centred practice and the notion of power in occupational therapy. She concludes that the profession needs to reflect carefully on the meaning of client-centredness and the role that therapist “power” continues to play in therapeutic relationships. These perspectives were used in the development of the workshop programme as well as in its evaluation through the research. The method of participatory facilitation of the programme was a deliberate design element that aimed to counteract the power differential in therapeutic relationships. It also aimed to understand how that would play out in terms of the experience of the occupational therapists.

Although critical disability theory offers one basis from which to develop and critique this research, the social model of disability in emphasising social structures has been criticised for underplaying the dimension of health and failing to capture the complexity of the human condition and life experiences (Shakespeare 2012). Shakespeare (ibid) suggests that a more nuanced understanding of disability is required as a bridge between disability studies and health studies, where the day-to-day experiences of people with disabilities is explored. In order to more effectively apply critical disability theory in occupational therapy research, two further models were used to create the conceptual framework for this study.
4.2.2 Occupational therapy and epistemology

From an epistemological perspective occupational therapy has historically been associated with humanism and pragmatism (Creek 2010). The mid 20th century brought with it the challenge of becoming more scientific in line with our medical colleagues (Creek and Lougher 2008). Occupation based research at this time became reductionist in nature to meet this challenge. Although the profession benefitted in terms of developing specialist practice at this time it resulted in the loss of the humanistic side and, perhaps, the core concept of occupation in practice. Since the 1980s the profession has become increasingly holistic, client-centred and systems oriented (Creek 2010) with a focus on partnership with community organisations in targeting public health.

Research into occupational therapy practice in mental health is limited, particularly in the Irish context. This project aims to learn about the impact of occupation-based therapy on outcomes for women who use the mental health services. An important element of the conceptual framework for the project is a model that examines occupation and its relationship to outcomes in mental health. Given the mental health context of the research and the focus of Irish mental health services and policy on recovery-oriented interventions a recovery framework was selected to reflect this component.

4.2.3 Person Environment Occupation (PEO) Model

A variety of occupation-focused models were reviewed that had the potential to provide an appropriate framework e.g. Model of Human Occupation (Kielhofner
2002), Canadian Model of Occupational Performance and Engagement (Polatajko et al. 2007). The Person-Environment-Occupation model (Law et al. 1996) was most relevant for this project given its ability to reflect the complexity and multi-faceted nature of occupation and occupational performance. The chosen model needed the ability to analyse both individual and group focused therapeutic occupations. The model also needed to allow exploration of the importance of the environment in relation to occupational performance. Many occupation-based models are linear or hierarchical in their construction, thus they do not reflect the dynamic relationships and interactions occurring during the therapeutic process in mental health occupational therapy. The PEO model offers this flexibility. The relevance of the model to mental health and previous use in this practice setting further contributed to the decision to draw upon this model.

The PEO model was devised by occupational therapists in Canada in the 1980s (Law et al. 1996). It is defined as:

a conceptual framework developed ........ to provide a systematic way to analyse complex occupational performance issues within the context of occupational therapy practice (Brown & Stoffell 2011)

The model was built on the work of earlier environmental behaviour theorists who considered the relationships between people, environments and human behavior. The causal relationship was considered too simplistic by occupational therapists; therefore a more transactive model was proposed where relationships are acknowledged as bi-directional. The components of the model are outlined in Table 2 (Law et al. 1996).
Table 3 Person Environment Occupation Model

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Person</td>
<td>An individual, group or organization considered in terms of their spiritual, social and cultural experiences</td>
</tr>
<tr>
<td>Environment</td>
<td>The context within which the occupation takes place. Includes social, cultural, institutional and physical environments</td>
</tr>
<tr>
<td>Occupation</td>
<td>Groups of self-directed functional tasks and activities</td>
</tr>
</tbody>
</table>

The central components of the model – person, occupation and environment – are interconnected (Figure 8). Each component effects change on the others over time thus ascribing meaning to the occupational performance. The point of connection among the three components is the location of occupational performance.

Increasingly effective links between the model components affords better occupational performance – the transactive relationships being interdependent with the result being greater than the sum of its parts (Brown and Stoffel 2011). The greater the congruence between each element the better the outcome in terms of occupational performance and the quality of the individual’s experience (Strong and Rebeiro Gruhl 2011) (Figure 9). The model focuses on enabling occupation through improving the PEO fit (Strong et al. 1999).
The PEO model also references the importance of the temporal aspects of occupational performance acknowledging the changes that occur in the interaction between elements over time. It allows the researcher to consider the occupational routines of the group and individual participants during therapeutic intervention. The ability to reflect on the temporal aspect is important given the focus of parts of the research intervention on the occupational routines of individuals before, during and after the programme.
The PEO model allows the researcher to consider the components of each of the occupations used in the intervention and their relative impact on the individuals and the group as a whole. The balance of these elements for each occupation can be examined in terms of the overall experience of the participants. It facilitates the analysis of the successful occupational elements of the programme and those that were less successful. The model also offers the opportunity to consider the experience of participants in terms of their own occupational profile, for example, whether they have had participated in these occupations previously and in what manner. The impact of the therapeutic environment can also be carefully explored using of this model as a guide.

The PEO model has been used to explore the concept of occupation and the potential of occupational therapy in mental health. A review of the literature by Strong and Rebeiro Gruhl revealed five of thirty six studies that referred particularly to its use in this arena (Strong and Rebeiro Gruhl 2011). Outcomes indicated the successful use of the model in an in-patient mental health setting, with women experiencing addiction problems, individuals with a diagnosis of schizophrenia, adults with mental health difficulties exploring the value and meaning of work in recovery and in a project focused on key components of the environment that relate to occupational engagement (Molineux 2004, McWha et al 2003, Bejerholm and Esklund 2006, Strong 1998 and Rebeiro 2001). All of these studies highlighted the importance of the dynamism of the model and the congruence between the component areas in determining the quality of the occupational experience.
In evaluating an occupational therapy intervention employing an occupation focused model is useful. The PEO model offers an opportunity to look at the work in this particular way. However, in the context of this research and its aims, it has its limitations and a broader theoretical framework is required in order to allow full exploration of the recovery orientation of the programme and the experience of the participants. Given the background context of the programme as being a component of mental health service delivery and that all participants are women with mental health difficulties, it is necessary to consider the project in terms of recovery in mental health.

4.2.2 Recovery and CHIME

The concept of recovery is an increasingly referenced and important component of mental health service research and policy (Pilgrim 2008). In Ireland, as in other jurisdictions including the UK and New Zealand, mental health legislation and government policy is based on recovery concepts and models (DOHC 2006). However, in spite of its widespread presence in policy, there is little empirical evidence on recovery as a theoretical framework for mental health practice. Given the situation of the project in the mental health services in Ireland, recovery is central to informing the study design.

The construct of recovery is based in the compelling narratives of people with experiences of mental illness from the 1970s when individuals aimed to express recovery in terms of their own personal journeys, as a self defined, individual and non-linear process. It extends beyond the absence of psychiatric symptoms but rather
the living of a satisfying, purposeful, connected and hopeful life (Anthony 1993). It is far more than the clinical outcomes associated with recovery in the health sphere. Recent research in the Irish context aimed to define recovery from self experience defines recovery as “reconnecting with self, reconnecting with others and reconnecting with life” (Kartalova-O’Doherty and Doherty 2010). Common themes throughout the recovery literature include personal agency/responsibility, hope, connectedness to others, supportive relationships and healing environments.

In spite of the centrality of recovery theories in mental health service policy and the depth of literature relating to personal experience of recovery journeys, little work had been completed in order to conceptualise recovery or demonstrate its potential in terms of a framework or theory. Ryan and Deci (2000) and Mancini (2008) used Self Determination Theory, to determine the functions of autonomy, relatedness and competency and their relationship with recovery in mental health. Although the theory relates well, in part, to the motivating and enabling factors required for recovery it misses the central theme of hope.

The need for a conceptual clarity on recovery has been emphasised (Silverstein and Bellack 2008, Warner 2009). To this end a systematic review of the recovery literature was carried out by Leamy and colleagues in 2011. In total 97 papers were reviewed. The resulting report highlighted 13 characteristics of the recovery journey and five processes which facilitate recovery. These are listed in the following tables (Tables 3 and 4).
Table 4 Recovery Journey Characteristics

<table>
<thead>
<tr>
<th>Characteristics of the recovery journey</th>
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</thead>
<tbody>
<tr>
<td>Recovery is an active process</td>
</tr>
<tr>
<td>Individual and unique process</td>
</tr>
<tr>
<td>Non-linear process</td>
</tr>
<tr>
<td>Recovery as a journey</td>
</tr>
<tr>
<td>Recovery as stages or phases</td>
</tr>
<tr>
<td>Recovery as a struggle</td>
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<tr>
<td>Multidimensional process</td>
</tr>
<tr>
<td>Recovery is a gradual process</td>
</tr>
<tr>
<td>Recovery as a life-changing experience</td>
</tr>
<tr>
<td>Recovery without cure</td>
</tr>
<tr>
<td>Recovery is aided by supportive and healing environment</td>
</tr>
<tr>
<td>Recovery can occur without professional intervention</td>
</tr>
<tr>
<td>Trial and error process</td>
</tr>
</tbody>
</table>

Table 5 CHIME Processes

<table>
<thead>
<tr>
<th>Recovery Processes</th>
<th>CHIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connectedness</td>
<td>Peer support and support groups</td>
</tr>
<tr>
<td></td>
<td>Relationships</td>
</tr>
<tr>
<td></td>
<td>Support from others</td>
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<tr>
<td></td>
<td>Being part of the community</td>
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<tr>
<td>Hope and Optimism about the future</td>
<td>Belief in the possibility of recovery</td>
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<tr>
<td></td>
<td>Motivation to change</td>
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<td></td>
<td>Hope-inspiring relationships</td>
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<tr>
<td></td>
<td>Positive thinking and valuing success</td>
</tr>
<tr>
<td></td>
<td>Having dreams and aspirations</td>
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<tr>
<td>Identity</td>
<td>Dimensions of identity</td>
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<tr>
<td></td>
<td>Rebuilding/redefining positive sense of identity</td>
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<tr>
<td></td>
<td>Overcoming stigma</td>
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<tr>
<td>Meaning in life</td>
<td>Meaning of mental illness experiences</td>
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<td></td>
<td>Spirituality</td>
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<td></td>
<td>Quality of Life</td>
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<td></td>
<td>Meaningful life and social roles</td>
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<tr>
<td></td>
<td>Meaningful life and social goals</td>
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<tr>
<td></td>
<td>Rebuilding life</td>
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<tr>
<td>Empowerment</td>
<td>Personal responsibility</td>
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<td></td>
<td>Control over life</td>
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<tr>
<td></td>
<td>Focusing upon strengths</td>
</tr>
</tbody>
</table>

It is postulated by the authors (Leamy et al 2011) that the CHIME framework could be a useful tool for mental health professionals in the evaluation of clinical practice.
The framework captures recovery at two levels in the research i) the position of the participants in their own recovery journey and ii) the extent to which the intervention meets the CHIME processes. Similar to Jones et al (2011), I wanted to fully represent the dimensions of personal recovery for the women in the project and not base findings on traditional clinical outcomes such as scales that measure symptomatology.

Occupational therapists consider the recovery approach in mental health to be akin to the central tenets of the philosophy of the profession (Rebeiro-Gruhl 2005). The intervention being evaluated was developed and delivered with recovery principles to the fore. The participants in the programme were at different points in their own recovery journeys. The CHIME framework allows examination of the intervention in terms of the processes required to promote recovery and also to consider the recovery outcomes for individual participants.

Although the CHIME framework grounds the study in recovery, it does have limitations. The authors themselves acknowledge that it considers recovery purely from a first person account and does not acknowledge the wider environmental and socio-economic contexts (Leamy et al. 2011). It does not afford the opportunity to consider aspects such as stigma and discrimination. Although it provides a framework of processes from which to examine clinical work it does not allow us to examine the power relationships between clinicians and those who use mental health services.

In order to allow for this more in-depth understanding of the individual experiences of participants the study draws upon critical disability theory. It was important to capture the potential influences of the social circumstances of the participants as well as the
impact of the relationship between mental health practitioner and service-user and the relationship between peer service-users. The conceptual framework for this research project includes critical disability theory (Goodley 2013), the Person Environment Occupation model of occupational therapy (Law et al. 1996) and the CHIME framework on recovery in mental health (Leamy et al. 2011).

4.3 Study Methodology

In this section the aims of the research project are outlined. As a qualitative research project a rationale for this approach is provided. The methods used to evaluate the programme are outlined with a justification for their choice and use. Ethical and quality considerations are discussed.

4.3.1 Project aims

The key aims of the research are:

- To evaluate the occupation-based programme in terms of its structure, content, process and facilitation of change
- To understand the concept of self-esteem from the perspectives of women with mental health difficulties
- To capture the participants’ experiences of engaging in the group
- To understand how engagement in group and individual occupations shapes self esteem
4.3.2 Study Design

This programme evaluation was completed by employing a qualitative methodology. The research comprised two strands of programme evaluation which involved:

1. Pre and post intervention semi-structured interviews with participants in the programme. Pre interviews took place two weeks before the programme and post interviews took place four to six weeks after the programme finished.

2. Post intervention semi-structured interviews with facilitators of the programme (two occupational therapists) one at four weeks and the other at eight weeks after the programme finished.

4.3.3 Rationale for qualitative approach

Qualitative research explores the meanings of personal experience (Denzin and Lincoln 2005). It is research that draws tacit knowledge into awareness, facilitating an understanding of the subjective experience of individuals and groups. In the process of analysis, the complexities inherent in the participants and their context are acknowledged and examined (Marshall and Rossman 2011).

There is a strong ethos and tradition of scientific inquiry in medical research. The randomized control trial is considered by some to be the gold standard in levels of evidence (Peters 2010). Medical journals typically prioritise scientific studies that can be quantified. Quantification and experimental approaches to research remain the source of “good” evidence (Busfield 2006). The evaluation of mental health services
in Ireland mirrors this focus on numbers and statistics. Statutory services tend to measure their effectiveness and quality through the use of key performance indicators such as acute bed numbers and attendance at out-patient clinics (HSE 2016). Although quality committees exist, their work is dominated by risk assessment and cost containment. The Mental Health Commission, set up in response to the Mental Health Act 2001, has responsibility for monitoring quality and ensuring safety in services in Ireland. Quality in services is determined through adherence to a set of standard articles pertaining to the Act (DOH 2001). Although this is essential in ensuring safety and decreasing risk it is unclear if they affect any change in service-user experience. Adherence to risk assessments and safe practice, while necessary, do not appear to allow for the views of those who use the service to be taken into account in measuring service effectiveness.

Bracken and Thomas (2006) query this over-reliance on scientific evidence in mental health, questioning if progress in the delivery of services can be measured in this way. The needs that are so frequently identified by service-users, access to services, meeting the same clinician, housing, social supports, employment (Bracken and Thomas 2006) are not typically measured by the key performance indicators and standards outlined above. The fact that services base their development and delivery on outcomes that have no relationship to expressed needs is a cause for concern. Creating services to meet expressed needs and measuring quality through ascertaining service-user experience provides a more meaningful rationale for service development and delivery. Bracken and Thomas (2006) suggest that any progress that has been made in this arena has come from changes in social attitudes and social policy. The Mid West region is no different in this regard. Some positive changes in mental health
service provision in the past five to ten years have come from housing authorities, education providers and charitable mental health organisations for example, Focus Ireland, National Learning Network and Mental Health Ireland.

The advent of service-user led research is slowly turning the tide regarding what constitutes evidence in mental health services. Beresford (2007) indicates the concern in the mental health service-user community as to what constitutes evidence in service development. The narrow focus of the evidence based practice discourse, which privileges systematic reviews and randomized controlled trials is being challenged (Beresford 2007). Since research evidence is a key influence on mental health service design and delivery, it is imperative that a meaningful understanding of people’s experience of using the service is included (Repper 2003).

Peters (2010) indicates how mental health research has lagged behind in using qualitative methodology. Research into mental health experience does not lend itself to positivist inquiry given that the complex and multifactorial nature of mental health difficulties cannot be quantified in scales or standardized assessments (Bassett 2004). In order to meet needs of those who use mental health services more effectively service-users and their supporters are demanding to have more influence on service design and delivery. Irish mental health policy states that service-users and their families and carers should be involved in service development and evaluation (DOHC 2006). The Advancing Recovery in Ireland project had the inclusion of a service use perspective in service delivery as a clear goal for 2015 (ARI 2014). The National Mental Health Division appointed a service-user to its board in 2014 and aims to
ensure service-user and carer representation on service management teams across the country through the Community Healthcare Organisation system.

In occupational therapy there is a turn to qualitative methodologies to help understand the experiences of those who use services in order to improve services. The good fit between occupational therapy outcomes and qualitative methods has been identified (Curtin and Fossey 2007, Frank and Polkinghorne 2010). Wimpenny et al. (2014) synthesised the qualitative mental health literature examining studies that incorporated the perspectives of service-users and carers/family members. This synthesis demonstrated the value of using qualitative methodologies to understand the perspectives of those using occupational therapy services. Asmundsdottir (2009) indicated the value of including service-user experience in the evaluation and subsequent development of mental health occupational therapy services in Iceland.

This research project aims to understand the perspectives of service-users and service providers regarding a short-term occupational therapy intervention. The experience of those involved is key to the project and, as such, could not be ascertained through the use of quantitative approaches. Self-esteem checklists and self assessments were examined as to their usefulness in the evaluation of this project. However, a number of the scales were considered to have a distinctly negative outlook in terms of measuring self-esteem against normative negative gender stereotypes. This negative focus does not link with this research, which seeks to understand experience in the context of occupation and recovery in mental health and its relationship to self-esteem.
This current study does not aim to define or measure changes in self-esteem. Rather the aim is to understand the experience of those that participated and how participation in occupation facilitated development of self-esteem. The negative standpoint and limited focus of the quantitative tools does not facilitate exploration of the depth of experience which is sought in this project. Qualitative research can create a rich depiction of people’s experiences. Through prioritizing and learning about the participants in this manner it is anticipated that meaningful changes can be made to how services are developed and delivered for women with mental health difficulties.

The key concerns guiding the methodological choices needed to reflect the tenets outlined in the conceptual framework. An approach that had the capacity to consider occupational engagement at individual and group levels while accounting for the impact of time and environment was essential. Given the personal nature of recovery in mental health a flexible methodology with potential to capture the experiences of the women involved while facilitating exploration of the environmental and occupation based components was required. A qualitative approach was the most appropriate methodology to respond to the aims of the research.

### 4.3.4 Semi structured Interviews

For the purposes of this research in-depth semi-structured interviews were the method of inquiry. In qualitative interviewing the researcher specifically aims to access the knowledge, experience and perspectives of the research participants (Kelly 2010). Interviews of varying types are the most commonly used tool for collecting data in qualitative research (Grbich 2007, Green and Thorogood 2014, Flick 2007).
Interviews potentially offer a deeper understanding of the complex social world in which engagement with services happens (Kelly 2010, Brenner 2006) in comparison to other methods of inquiry such as survey or questionnaires.

In this study, comprehending the participants understandings of self-esteem in the context of their lives, experiences of mental health difficulties and interactions with mental health services was central. Semi-structured interviews are the most appropriate method of eliciting this in-depth understanding. The interview questions are designed to have sufficient openness and flexibility to capture the experience of the individual (Wengraf 2001). This approach allowed the agenda to be set in terms of topics that needed to be covered while simultaneously allowing the flexibility required for the participants to expand on their own personal experiences (Green and Thorogood 2014). The semi-structured interview allows the participant the space to control the interview in a way that facilitates the construction of meaning.

Kvale (2007) clearly outlines the skills required for successful interviewing in qualitative research. As a less experienced researcher using this approach, I was able to employ the skills I have in interviewing as a therapist while relying on the general structure of the interview to ensure all relevant topics were discussed. These include the ability to establish a strong rapport with the research participant, the careful construction of the questions to be asked and planning with regard to location and other practicalities. My skills in setting the participants at ease and establishing a positive rapport facilitated the research process while the interview guide maintained my focus to elicit the relevant experiences. In order to promote clarity and ensure that participants felt understood the use of elaboration, reflection and clarification were
used throughout all interviews as recommended by Rossman and Pallin (2003) and Rubin and Rubin (1995).

It is imperative in qualitative interviewing that the questions are carefully constructed. In qualitative interviews the use of open questions that allow participants to describe their experiences in depth are required. Green and Thorogood (2014) highlight the importance of having good topic guides and the careful consideration of what types of questions generate the most useful information. In this study the pre-interview questions were designed initially with reference to the research question and previous experience of running a pilot of the group programme. The questions were developed with the conceptual framework in mind. Although some qualitative researchers state that no interview guide should be used as it impedes the researcher-participant relationship, Rapley (2004) advocates for having the interview scripted and at hand to ensure that all points are covered. The interview guide was refined in consultation with my research supervisors and piloted with a colleague.

The pre-programme interviews aimed to elicit the participants’ experience of self-esteem as women who use the mental health services. This information was key to the development of the programme. In terms of the research it gave an initial understanding of the participants and their experience of self-esteem in the context of their lives. The variety of factors that contribute to self-esteem were explored with particular emphasis on participants’ daily occupations and their influence on how women feel about themselves. The exploration of participants’ previous engagement in group work in mental health and other contexts was another core aspect of the pre-programme interviews. Although an interview guide was used, ample opportunity and
scope was given to participants to expand and introduce new topics as the interview progressed. Topics covered in the pre-interviews included defining self-esteem, the relationship between self-esteem and doing and previous experience of groupwork. The pre-interview guide can be found in Appendix 1. The pre-interviews took between 40 minutes and 75 minutes. All interviews were digitally recorded. The process of information provision and consent are described later in this chapter.

The location for data collection in qualitative research can shape the information gathered (Green 2007, Green and Hart 1999). Different aspects of the participant’s identity can be emphasised in specific locations, for example, a different account of experiences might be portrayed in a mental health service environment compared to home. Kelly (2010) argues that the use of health related settings in this type of research can reinforce the power and influence of the medical setting. This was a challenge in the organization of interviews for this project. Given my dual role as researcher and therapist, it was not appropriate to organize the interviews to take place in participants’ homes. The participants were not known to me and it was important to consider their privacy in this regard. In order to promote confidentiality, respect and a relaxed atmosphere the interviews were conducted in the community mental health facilities that were previously known to participants. I was able to book consultation rooms in four mental health facilities across the city to facilitate the interviews.

Occupational therapists frequently use time charts to consider occupational balance and the influence of different occupations on mental health with clients in practice (Bejerholm and Eklund 2006). In the pre-programme interviews a visual prompt in
the form of a blank timetable was used to facilitate the discussion regarding balance of occupation and weekly routine. Some participants chose to fill out the timetable in the course of the interview and others used it as a guide when answering questions regarding their occupational participation.

There were five post-programme interviews with participants. They varied in length from 65 minutes and 130 minutes. They were carried out from two to four weeks post participation in the programme. Interview guides for these interviews were initially devised by the researcher and refined further following the pre-programme interviews and through discussion with my research supervisors. Rubin and Rubin (2005) advocate a flexible approach to the use of interviews in qualitative research where the questions posed are continuously reassessed in an iterative design. This process of continuous adaptation ensures that the researcher can include what is found as the research progresses.

The post-programme interviews were longer than the pre interviews and contained questions relating to the overall experience of the programme as well as each element. Each aspect of the programme was explored in turn. For example, the participants were asked about their experience of the word cloud and collage activities in the first workshop. Engagement, participation and changes made further to participating in the programme were also explored. The themes of defining self-esteem, self-esteem and occupation and the experience of group work were discussed again. As with the pre-programme interviews, scope and space was given to participants to expand and explore their experiences beyond the parameters of the interview guides. The post interview guide can be found in Appendix 6. The post interviews all took place in the
same location as the programme itself. This was considered to be appropriate as being present in the environment where the programme took place facilitated memory of participation. This room was in a mental health facility located centrally in the city that was easy to access with provision for parking.

Green and Thorogood (2014) discuss the use of material prompts in qualitative interviews. Using these items in interviews is considered a good way of helping to generate the stories about experiences that lead to rich data. Guillamin and Drew (2010), in their work exploring the experience of women with post natal depression, used pictures and drawing to facilitate their interviews. In the post interviews for this study a variety of material prompts were used. Some of the collages and word clouds created during the workshop programme were used to prompt discussion. The researcher requested that participants bring the pieces of jewellery that they made on the programme, their self-esteem diary and the framed picture of their affirmation to their post interview. All participants but one did so and it was found that this greatly facilitated the discussion. Participants used their own pieces of work to reflect on their involvement and this also reminded them of the group interactions and experiences at different points in the programme. Bringing their pieces of jewellery gave them the opportunity to connect with how they felt during and at the end of the activity. Reflecting on their collages helped them describe their thoughts and feelings in more depth.

The post interviews commenced with the advantage of the rapport previously established in the pre interviews. It has been recognized that continued engagement of researchers and participants over a number of meetings facilitates greater rapport and
better and more meaningful engagement (Cornwell 1984). The focus of the discussion on the experience of the workshop programme and the use of material prompts greatly facilitated the discussion and engagement at the post interview stage.

Post-programme interviews were also conducted with the occupational therapists who facilitated the workshop programme. The facilitators’ experience of each element of the programme was explored using a semi-structured interview guide (Appendix 7). Their insights into how each creative occupation and element of the programme enabled the programme aims were discussed. The interview guide for the facilitators followed a similar outline to that of the programme participants.

Similar strategies were used to establish rapport and expedite the interview process with the facilitators. Their post interviews were also held in the same environment as the programme. This was again to promote accurate recollection and to aid reflection. Material prompts were also used, for example a number of examples of collage made during the programme. To further aid the interview process I requested that the facilitators bring their reflective logs to the interview. This served as a useful aid in these interviews. The reflective log template can be found in Appendix 10.

A typist was used to transcribe the interviews verbatim. A confidentiality clause was signed to protect the confidentiality of participants (Appendix 11). The audio-recordings were stored as password protected digital files. These recordings were given by hand to the transcriber again to ensure anonymity and avoid any issues with electronically transferring data. On completion the transcribed e-documents were physically returned to the researcher.
4.3.5 Participants

Participation in the research was initially open to all female service-users of the local adult mental health services who self-referred to the occupational therapy programme. The two occupational therapist facilitators were also asked to participate in the research. In order to protect the participants all demographic data is displayed here in aggregate form.

Inclusion criteria for participants in the workshop programme were that the women were adult (over 18) female service-users of the local adult mental health services; had independently identified an interest in participating in the programme and that they could give informed consent. Potential participants were excluded from participation if they were currently experiencing acute symptoms which would impact on their ability to fully participate and give informed consent.

Information in the form of posters and information leaflets regarding the workshop programme and associated research study was circulated to the three city day hospitals of the local adult mental health service (Appendices 8 & 9). The occupational therapists at each of the day hospitals acted as gatekeepers, offering the detailed information sheet on the research to anyone who expressed an interest in participating in the workshop programme and/or the research.

Potential participants were asked to contact the researcher directly by telephone if they wanted to participate. When an expression of interest was received the researcher ensured that the potential participant had the information leaflet and clarified any further queries. A “first come first served basis” was operated. The maximum number
of participants for the occupational therapy programme was eight. Once eight was reached any further expressions of interest were maintained on a waiting list for the next workshop series.

Eight women signed up to participate in the workshop programme. One participant dropped out immediately before the workshops starting due to a physical complaint and another participant only attended one workshop, ceasing her involvement due to mental ill health. Of the remaining 6 participants, five of the women chose to participate in the research project. Both facilitators of the programme also agreed to participate in the research. The five research participants attended all four workshops. Five women completed pre and post interviews and both facilitators completed post interviews. One woman participated in all workshop sessions but chose not to participate in the study.

All of the workshop research participants were Irish and came from the city where the workshop programme took place. All of the women grew up in the city centre apart from one woman who lived in several locations as a child due to the transient nature of her parent’s work. Four participants ranged in age from fifty two to fifty-nine years. The youngest participant was twenty-five. The four older participants were all in married relationships (20 years plus), living with their partners, owned their own homes and had grown up children. The youngest participant was not in a relationship and lived with a parent.

All of the women had experience of full-time employment. One of the women continued to work on a part-time basis. One participant had a university qualification
and worked using this skill for over twenty years. Difficulties with her mental health necessitated a break from work over twelve years ago and she had not worked since. In contrast, another participant worked since the age of eleven for over forty-five years. She never had formal schooling as, being the eldest, was always required to look after her younger siblings at home. In the past year she had returned to education. One of the other participants worked until she started a family. Another participant completed two years of a university degree, ceasing same due to mental health difficulties. She planned to return to college in the future.

The facilitator participants came from other parts of Ireland. They were both female and aged 30 and 35. Both facilitators were qualified occupational therapists with Bachelor of Science degrees. The senior therapist also has a post professional Masters degree. One facilitator had eight years occupational therapy experience. Seven of these years were in physical and paediatric settings. She had one year experience working in adult mental health. The second facilitator had worked for ten years as an occupational therapist predominantly in child and adolescent mental health. Table 5 presents the participants and facilitators by pseudonym for ease of reference in the rest of the thesis.

**Table 6 Pseudonyms**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Facilitators</th>
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<tbody>
<tr>
<td>Kim</td>
<td>Jane</td>
</tr>
<tr>
<td>Cathy</td>
<td>Aoibhinn</td>
</tr>
<tr>
<td>Marion</td>
<td></td>
</tr>
<tr>
<td>Sarah</td>
<td></td>
</tr>
<tr>
<td>Julie</td>
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4.3.6 Analytical Approach

A variety of analytical approaches are available to the researcher when undertaking qualitative research. The approach used is determined by a range of factors. The researcher needs to consider the underlying theoretical assumptions inherent in the research and also the questions that the research project is trying to answer. The desired end product should determine the type of qualitative analysis used (Cutler 2004). A number of analytical approaches are evident in the qualitative literature pertaining to mental health including grounded theory, ethnography, discourse analysis, phenomenology and thematic analysis. Different approaches to analysis were considered in this project.

Grounded theory as an analytical approach has its origins in the work of Glaser and Strauss (1967) with its aim being to generate theory through a systematic analytical approach starting with in vivo coding and ending with identification of a core variable (Green and Thorogood 2014, Pawluch and Neiterman 2010). It is perhaps the most cited qualitative approach globally (Clarke 2007). Used in its truest form it is an intensive process involving a continuous cycle of data collection and analysis until saturation is reached. It is considered by some to have close affinity with post-positivism in the rigidity of its approach (Grbich 2007).

Kartalova-O’Doherty and colleagues (2012) used a grounded theory approach to explore recovery in mental health in terms of re-connecting with life for individuals in recovery in Ireland. It was acknowledged that the development of a theory in this regard was difficult given the documented individual nature of recovery for individuals with mental health difficulties (Higgins 2008). Grounded theory was not
considered an appropriate analytical approach for this project as it does not align well with the research question and does not fit well with the conceptual framework. The current study was not aiming to generate theory.

Discourse analysis is another potential analytical approach used in qualitative research. It is predicated on the belief that human actions and practices are constituted in discourse and language (Sarangi 2010) and through examination of text and language we can better understand the patterns of power and experience. In the healthcare arena discourse analysis appears to have a strength in fostering change in communication practices, raising awareness of power dynamics and in education of staff and service providers. Hui and Stickley (2007) demonstrate this effectively in their exploration of mental health policy and service-user perspectives on involvement in service development. The aim of this research project is not to examine the discursive practices and their impact on power in the mental health setting. It was not the intention to identify particular discourses and explore them from the outset; thus, this option was excluded.

Ethnography is an approach that is concerned with culture and cultural knowledge (Cutler 2004). This approach involves prolonged observations undertaken with the identified research population where the researcher takes part in everyday activities with participants while observing and recording impressions (Prentice 2010). Although the current study is concerned about women’s perspectives, it is fundamentally a programme evaluation, thus an ethnographic approach is not appropriate.
This research project aimed to identify the processes, relationships and occupational characteristics of the group programme that contributed to the experience of the individual women who participated. As stated in the conceptual framework each step of the methodology is informed by its aim to capture experiences of occupation, experiences of recovery. It is important these are solely based on the unique perspective of each participant. Thematic analysis was chosen as the most appropriate approach to capture these important facets.

4.3.7 Thematic Analysis

Thematic analysis is an accessible and flexible approach to the analysis of qualitative data that can be applied across a range of epistemological approaches. Thematic analysis (Braun & Clarke 2013) allows the researcher to identify and analyse repeated themes occurring in the research data. Thematic analysis is an accessible and flexible approach to the analysis of qualitative data that can be applied across a range of epistemological approaches. It is also considered a more appropriate analytical approach to utilize in the context of a programme evaluation.

Thematic analysis has been used in mental health research. For example, it was employed in a recent exploration of factors relating to resilience in mental health occupational therapists (Ashby et al 2013). In this study the authors used thematic analysis to identify challenges faced by occupational therapists in mental health practice. In another occupational therapy study examining the occupational experience of female carers of young men with schizophrenia, Chaffey & Fossey (2004) used thematic analysis to interpret the qualitative data collected through
interviews. In this study an understanding of the meaning, diversity and complexity of
the carer experience was the key focus.

Thematic analysis offers a useful approach in this research, following the six-step
approach as detailed by Braun and Clarke (2006). While the flexibility in this
approach makes it an attractive option, Braun and Clarke are consistent regarding the
importance of clarity in the process and application of the analytical method. Braun
and Clarke (2006) outline six key steps in this type of analysis. The first of these is
familiarising yourself with the data. Detailed field notes were completed following
each interview. A field note guide was used to facilitate reflection on each aspect of
the interview process, and to consider what was being heard and learned from the
very outset (Appendix 10). The field note guide starts with a description of the
location of the interview including particular details such as sounds, level of privacy
and environment. Further to this the participant is described in as much detail as
possible including body language, tone of voice and appearance. The flow of the
interview in terms of rapport established and level of participant responses is then
reflected on and noted. Any interruptions or unexpected events that needed to be
explained to the transcriber were detailed at this point.

In each field note any key words or phrases used by the research participant were
noted and the key points of each interview detailed. Space was given to reflect on
how the particular research interaction helped to respond to the key research question
and how the interview connected with the aims of the research. The final part of the
field note encouraged me to focus on the personal experience of each aspect of the
research process. Compiling and maintaining field notes was considered an initial
analytical aid in this research project. It helped me become immersed in the project. Each field note was completed within two days of the interview taking place. Further to completion of detailed field notes following each interview, I listened again to each recording and made rough notes as to the content. At this point all of the data had been transcribed verbatim. I read and re-read the associated scripts to familiarise myself with the data.

The second step in thematic analysis involves generating initial codes. Braun and Clarke (2006) describe codes as initial feature of interest in the data, the most basic pieces of the raw data that can be ascribed meaning. They advise to code for as many potential patterns or themes as possible. To this end transcripts were loaded into Atlas.ti and an initial list of ideas of what was in the data and points of interest were noted. Atlas.ti is a data analysis software package that supported the researcher in managing and analyzing qualitative data. The initial code list was devised drawing on key words from the field notes, research notes and listening back to the recorded interviews. This initial code list was discussed with research supervisors and a research student colleague. Changes were made and coding of the data commenced. As coding progressed new codes were added as appropriate. All of the data was coded using this code list.

The next stage of analysis involved searching for themes. During this phase the codes were used to start to analyse the data in terms of the ideas that were emerging both pre and post the intervention. An initial piece of work involved creating a table that presented each aspect of the workshop programme, the goals of each session and the outcomes in terms of the perspectives of the participants. A reflective note was
maintained at the end of each session that outlined the key ideas/themes that were emerging. Each element of this table was then linked with the codes and their appearance in the data set. The key ideas emerging at this point were used to create a series of charts that reflected the key ideas and their importance in the research. The charts provided a visual aid to the consideration of emerging themes.

At this point a framework of emerging themes started to become clear. A pre and post evaluation of the programme was drafted with a focus on each activity used in the programme and the associated outcomes as per the experience of participants and facilitators. This provided clarity in terms of a step-by-step evaluation and also in terms of the ideas that were emerging frequently in the evaluation. This review of themes allowed further definition of the preliminary themes.

In order to ascertain the importance of these ideas in the research a further series of queries were run using Atlas.ti. For example, the codes self-esteem and creativity, self-esteem and shared experience were combined using the query tool in Atlas. All instances where these codes intersected were further analysed to identify any addition connections or contrasts across the data set. This allowed me to see what key ideas were important in terms of the evaluation and what were the important relationships that were emerging. A programme evaluation was drafted that focused on these key ideas pre and post the programme.

Three key themes were identified as programme design and facilitation, the power of occupational engagement and shared experience and peer support. In the final step of thematic analysis the report was produced taking each theme in turn and discussing it
in terms of the experiences of participants. Each theme was explored using the conceptual framework and is discussed in the context of the current literature.

### 4.4 Ethics

Ethical approval for the study was obtained from the ethics committee of the Health Services Executive Mid West (Appendix 12). To deliberate on the ethical issues pertaining to this study I drew upon the guidelines and codes of practice published by the Tricouncil Policy Statement for the Ethical Conduct of Research from Canada (TCPS2 2010) and the HSE National Consent Policy (HSE 2014b). These documents clearly outline the requirements for high quality research while attending to the ethical principles of voluntariness, beneficence, nonmalificence and justice (Beauchamp and Childress 2001). Central to all is that any research should be designed, reviewed and carried out in a manner that ensures integrity, transparency and quality. Essential to this is that participants are fully informed as to all aspects of the research, that participation is voluntary and free from coercion and that the confidentiality and anonymity of participants is maintained. Any conflicts of interest or potential tensions must be explicit and there needs to be clarity regarding potential risks and benefits.

#### 4.4.1 Ethical tension/conflict

In any research project it is important to identify and clarify any potential ethical tensions. Yin (2011) refers to the importance of disclosing the conditions that may affect the conduct of a study in terms of maintaining integrity in qualitative research. One of the most salient ethical dilemmas in this work is my dual role as a mental
health practitioner (occupational therapist) and researcher. The impact of this dual role on the research is evident at a variety of points in the work. Perhaps the most obvious point is that of being healthcare provider conducting research with people who use the service. There is an obvious power relationship, a situation often found in health research (Kelly 2010). In order to capture the impact of my dual role I have kept a journal during the research process and noted any issues that arose during the research process that demonstrate this tension and the likely impact on my interpretation or presentation of the work.

Some of the potential conflicts were identified before commencing the project. The impact of my position as a senior member of staff to one of the facilitator participants was clear from the outset. Although I had a very good working relationship with this therapist the power differential remained. This is something that we discussed prior to obtaining her consent to participate. I was also keenly aware of the pressure on the two therapists to “do well”. This was a programme that I had devised and was now evaluating and I was aware of their desire to ensure good outcomes. Again we met together prior to the research and discussed this issue. I was assured that positive outcomes for the participants were the main focus of their work. I noted in my research diary that they had met separate to me so that they could make the workshop their own and assign each other roles and tasks. I also noted during the workshops that they contacted me with small adjustments to the programme so that they could meet the needs of the particular group. I felt confident that the participants in the workshops were their key focus at all times and not my needs as a researcher.
An ethical tension that became apparent as the research progressed was my difficulty in shifting between my roles as therapist and researcher. The tension that I was aware of is noted in my in-depth fieldwork notes as I reflected on taking particular care to not engage as a therapist in my interviews with participants and on remaining impartial in my analysis of the data. Using a careful fieldwork log and research diary was particularly useful in this regard. As an occupational therapist with many years experience working in the service where the research took place, there was the likelihood that I would know one or more of the participants through previous work. This was not the case, although there remains the possibility that I will meet them in the future.

4.4.2 Consent

Informed consent involves giving sufficient appropriate information about the research prior to the study taking place. This is the ensure that potential participants have received sufficient information to understand the possible risks and benefits of participation in research (HSE 2014b).

The workshop programme and associated research was advertised using a poster in three community mental health centres across the city (Appendix 8). Once a potential participant expressed an interest in participating in the workshops and the research they were given an information leaflet describing the research (Appendix 9). The leaflet used clear and accessible language. This information sharing was facilitated by the occupational therapists located in each community mental health centre. Contact was made with the researcher by phone whereby the participant had opportunity to seek clarification on any aspects of the programme or the research project.
Informed consent was obtained from each research participant before participating in the project (Appendix 13). When participants attended for their pre-interviews the information sheet relating to the research was reviewed and the process of consent explained. The consent form was reviewed in detail with all participants to ensure full comprehension and to clarify any questions. It was made explicit from the outset that participants were free to avail of the occupational therapy programme intervention without taking part in the study. It was also made clear that participants were free to withdraw from the study and withdraw their consent without any consequence. People could be involved in the workshops without taking part in the study and this was the choice of one woman. Consent was obtained from the facilitators at their post interviews. The facilitators were offered the option not to participate in the research if they wished.

There were minimal risks associated with participating in the study. It was anticipated and outlined to the participants that they could encounter some discomfort or embarrassment when discussing personal elements relating to self-esteem. For example, one participant became tearful as she recalled difficult experiences from her childhood. I felt able to reassure and comfort her appropriately, offered the opportunity to take a break from the interview and continued as led by her. Any issues such as this were dealt with If this arose these were dealt with in a similarly compassionate manner.

Participants were reminded at all stages of the research process that discussions were confidential and involvement was completely voluntary. The researcher had contact
details for the relevant mental health supports in the event that a participant became distressed during an interview. All interviews took place in HSE buildings where there was access to a number of support staff had that been required.

4.4.3 Confidentiality and Data Management

Confidentiality and anonymity were maintained throughout the study. All digital data was encrypted and is held on password protected HSE computer. All data is retained for seven years in a locked cabinet in HSE buildings as per HSE policy. Further to this the data will be destroyed by the researcher. Anonymity is protected by ensuring that any publication of the research will use pseudonyms. Pseudonyms were chosen by participants at the outset and will be maintained through any further publication or presentation. Transcriptions were anonymised. The digital recordings were downloaded on a password protected and encrypted computer.

4.4.4 Potential conflicts of interest

Perhaps the main conflict of interest in the research is that I designed the programme and subsequently carried out its evaluation. This is a tension that is well recognized where “practitioner-researchers” need to consider how to balance professional responsibilities with research ethics guidelines (Birch et al 2002). Given that I work in the services where the research has been conducted, any negative outcomes may have also presented a conflict of interest. This is particularly salient given that during the research I was promoted to occupational therapy service manager. It is the aim to present any criticisms of the services in a critically reflective manner which can ultimately lead to change and better service provision. As a manager in the service I
was also positioned uniquely to understand the context of the research and also how the outcomes can be disseminated appropriately into the future.

4.5 Evaluating the Project

Quality in a qualitative research project refers to how well a rigorous and systematic approach has been demonstrated at each part of the research process, from design to data collection to analysis and interpretation and how transparent the whole process is (Fossey et al 2002; Seale et al 2004). In this section the trustworthiness and rigour of the study will be examined with reference to the sections on ethics and reflexivity. Trustworthiness refers to the extent to which findings are a reasonable reflection of the experience of those under investigation (Curtin & Fossey 2007). The aim throughout was to provide an accurate reflection of the experiences of the participants in this study.

There are a variety of methods and criteria used to evaluate qualitative research and a number of guides and questionnaires have been published in this regard. For the purposes of this project the CASP, Critical Appraisal Skills Programme approach to evaluating qualitative research is used. This approach to evaluating qualitative research involves answering a series of questions relating to the clarity of research aims, appropriateness and quality of research design, ethics and overall value of the research.

Quality in qualitative research refers to the transparency of the whole research process and the credibility and transferability of the outcomes. Lincoln and Guba (1985)
identified four elements to demonstrate evidence of trustworthiness in qualitative work. These are: credibility, transferability, dependability and confirmability.

4.5.1 Credibility

Credibility refers to the extent to which the research findings represent an accurate picture of the phenomenon (Marshall and Rossman 2006). In order to achieve credibility it is expected that the researcher engages with the research environment and participants over a long period of time, while using a variety of approaches to decrease any potential bias. In this project I engaged with the research participants over a period of four and a half months, meeting participants at least twice for one to two and a half hours duration in interview settings. Meeting participants on these occasions for extended periods of time allowed for in depth exploration of experiences, thoughts and feelings.

To decrease any potential bias in the research I initially used a reflexive self-statement. This was a piece of self reflection which detailed my own beliefs, assumptions, passions and concerns that I compiled during the design of the conceptual framework phase of the project. This was a very useful tool in highlighting clearly my own beliefs and any impact that they could have on the project. I also used a research diary throughout the project which details any decisions I made in the process. I maintained in-depth field notes following all of the interviews. Another way of ensuring credibility is to discuss emergent findings with peers and experts (Marshall and Rossman 2011). I was able to consistently discuss findings and process with student researcher peers and my supervisors at regular supervision throughout the project.
4.5.2 Transferability

Transferability refers to the extent to which the findings of the research can be transferred to other situations/settings (Marshall and Rossman 2006). This is ensured through the clear description of all the processes involved in the research including sampling, description of setting and methodological clarity. In this research project the process of the research has been clearly described with a careful rationale for the choices made at each stage. The setting and participant profiles have been detailed clearly. To date the programme has been successfully run twice more with two different groups of women who use mental health services.

4.5.3 Dependability

Dependability is described as the extent to which the data and the findings are consistent. This is evidenced through a clear description of the choices made at each point of the research, particularly in relation to data analysis and interpretation. I maintained a careful audit trail of the work so that any point of the research process can be examined in terms of the decisions made. The thematic analysis process is presented in detail earlier in this chapter.

4.5.4 Confirmability

This covers the strategies used to limit any potential bias in the research. The use of a research diary, in depth fieldwork notes, reflexive self-statement, peer discussion and reflection and regular supervision were used in this project. These are detailed further in the reflexive section. The use of Atlas.ti as an analytic tool enabled efficient
retrieval of quotes from participants and also used analytical memos in the software to
document key decisions thus creating a clear audit trail. Where quantitative research
refers to validity and reliability as the constructs that ensure the quality of the work,
qualitative research references trustworthiness. For example, analytical memos were
maintained throughout the analysis to clearly document key analytical decisions.

4.6 Reflexivity

Reflexivity is a critically important component of qualitative work (Gough 2003). It is
a key activity in demonstrating attention to quality in the qualitative research process
and is one of the pillars of critical qualitative research (Fontana 2004). Finlay &
Gough (2003) define reflexivity in its simplest form as the process whereby
researchers critically look at themselves and their role in the research. It is described

In qualitative research the researcher is considered to be a central figure who
continually influences the research process. Through reflexive action the researcher
examines his/her own impact on the research at each step of the process. Reflection
on the process and how one’s views and beliefs may influence findings adds
credibility to the research and should form part of any qualitative inquiry (Jootun et
al. 2009). Reflexivity is an important tool in critically examining the power balances
between researchers and participants, a factor that is important in this research project
(Finlay 2003). Dowling (2006) further develops the importance of reflexivity in
research. She considers it a vital component of research as the researcher identifies
with the women she is researching and so must be constantly aware of how her beliefs
and values have the potential to influence the research process. Engaging in reflexivity aids the construction of an accurate account of the research process. It demonstrates the belief that the findings of qualitative research are influenced by the researcher and fundamentally situated in the social context and environment (Finlay & Gough 2003).

Reflexivity happens at a number of levels. Reflection that simply focuses on the personal experiences of the researcher does not take into account the relevant and powerful influences of the social and cultural environment and the interpersonal relationships that are formed during the research process. The researcher must situate his/herself in each of these different contexts. In this research project I was challenged to situate myself in the different contexts that defined my research. As a practice evaluation this research happened in my place of work. As an evaluation of occupational therapy practice I found myself in the position of evaluating my colleagues and their work on an intervention that I had developed. Working with a group of women with mental health difficulties as a researcher as opposed to a therapist brought the challenge of this change of role. These contexts highlighted the following areas of concern:

- Power differential in relationships – this potential was evident at a number of levels in this research project; between the research and participants, between the researcher and facilitators, and my dual as a therapist and researcher. The importance of acknowledging power relations is an important consideration in feminist research (Edwards & Mauthner 2002).
• Role of researcher vs. role of therapist – I documented the challenges associated with my new role as researcher during the data collection stage. Dowling (2006) highlights the difficulties faced by nurses in similar contexts.

• Context of workplace – I was aware of the complexities associated with completing an evaluation of a piece of practice in the area where I work. My awareness of this is demonstrated in my research diary entries.

• Researcher as a woman with her own self esteem challenges – I identified in my diary the impact of the interviews and what I learned of the experiences of the participants on my own self perception and esteem. I was consistently aware of the potential to over identify with participants and had to regularly ensure that my values, beliefs and experiences were not influencing the research process. I ensured this through engaging in supervision and reflection and discussion with student colleagues.

4.6.1 Reflexive strategies

I used a variety of strategies to ensure reflexivity in the research process. At the outset careful examination of the choice of research question occurred through in-depth discussion with my supervisors. Also from the outset I maintained a careful audit trail. I utilized a research diary that carried an account of all decisions made in the research process. It detailed how and why decisions were made, and my thoughts and ideas as the research progressed. At the beginning of the research process I completed a reflexive self-statement which clarified my beliefs, thoughts and feelings in relation to
the research. This helped to define the conceptual framework for the project and also was an effective reflexive tool in identifying areas of importance for me as I proceeded through the research process. Yin (2011) also indicates the importance of reporting throughout the research in a self-reflexive manner. I have attempted to continuously work in this way, being consistently honest in reporting my own thoughts, feelings and influences on the research with my supervisors and research student colleagues.

Strategies to promote reflexivity were embedded in each step of the analysis. I maintained detailed field notes following the pre and post interviews. These field notes represent an accurate account of my thoughts and feelings at each step of the data collection process. Yin (2011) highlights the importance of field notes that demonstrate that the researcher is fully present in the data collection to ensure quality in the research. Gough (2003) advises that the researcher articulates a theoretical position which promotes critical thinking. In this project this is achieved through the use of the conceptual framework designed for the study.

This research project was carried out under the framework of critical disability theory using qualitative methods. This type of research advocates strongly for reflexivity to examine how the researcher might identify with the participants in the study thus influencing the research process. The framework of CHIME is also used to extrapolate the recovery paradigm in mental health, in terms of participant’s own recovery experience and also the recovery promoting components of the environment, relationships and therapeutic intervention.
Chapter 5 Programme Evaluation

5.1 Introduction

In this chapter the findings of the programme evaluation are presented and discussed. The analytical approach used to evaluate the workshop programme is presented first followed by a discussion of the key themes identified in the analysis: (1) programme design; (2) potential of occupational engagement; and the (3) power of shared experience.

This programme was designed as a recovery focused initiative in keeping with the re-orientation of mental health services. As demonstrated in the literature review, there is a lack of empirical evidence relating to the application of a recovery ethos in occupational therapy. A key component of evaluating a programme situated in mental health services was to consider how it contributes to personal recovery outcomes for participants. In order to reflect how the programme demonstrated a recovery ethos, the findings and discussion are presented using the CHIME framework (Leamy et al. 2011) as an evaluation tool. This framework was chosen as it reflects the key processes involved in promoting recovery. This definition of the components of recovery focused practice is important in looking at what recovery means for those engaged in occupational therapy as practitioners and clients (Gibson et al. 2011). CHIME is used throughout the evaluation and ensured that person-centredness guided the evaluation. The PEO model (Law et al 1996) frames the analysis of environment, chosen occupations and person-centredness. The evaluation uses the participants’ accounts of their experiences and perspectives to present and discuss the findings. As
an intervention designed for women, elements pertaining to gender are presented throughout the discussion.

The recovery literature references the “expert by personal experience” and the “expert by profession”, considering the important skills that each brings to a therapeutic encounter or relationship. The views of the participants and the facilitators are represented together in this evaluation. This does not, however, deny the significant power imbalance that exists in the therapist/service-user relationship in mental health services. Instead it is an attempt to use the perspectives of both sets of participants to provide a more nuanced account of the effectiveness of the programme. There are also key points where it is important to separate the experiences which will be made explicit in the discussion.

5.2 Analysis

A programme evaluation formed the initial stage of data analysis. The first step in this process involved coding all interview transcripts using Atlas.ti as outlined in chapter 4. Further to this the workshops were broken down into their component parts to ascertain how each creative activity facilitated the aims and objectives of each session. A table was created that included each of the workshop sessions, the activities used and the objectives of each session. The perspectives of the participants and facilitators were separated in the table. Quotes from the transcriptions that related to each workshop session highlighted outcomes for the programme. At the end of each session in the table a brief reflective piece was documented. In order to ascertain commonalities in experience, points of connection between participants were noted.
The frequency of reference to these points was also documented. Likewise, points of dissonance and/or differences in experience, particularly between participants and facilitators, were recorded.

The next stage of the analysis involved using the table described to document a linear evaluation of the programme. Each session was taken in turn and analysed in terms of the experience of the research participants. This facilitated the recognition of key ideas that were found across all sessions. The programme was then evaluated in terms of the key ideas that emerged. An overarching facet that contributed to the success of the programme on a number of levels was the design of the programme, which included the environment and its layout. The key ideas that were found through the initial analysis were personal growth and learning, the power of daily and creative occupation, a relaxed atmosphere, shared experience and group interaction and development. A draft evaluation was written up using these key ideas as headings. Further to this a series of queries were run on the data to consider if the ideas could be further refined into themes. These queries included cross referencing self-esteem with each idea. This helped to clarify the final themes which were:

- Programme Design
- Potential of Occupational Engagement
- Power of Shared Experience and Peer Support

The final themes and associated subthemes are presented in Table 5.
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<thead>
<tr>
<th>Key themes</th>
<th>Sub themes</th>
<th>Key elements</th>
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<tbody>
<tr>
<td>Programme design</td>
<td><strong>Timing</strong></td>
<td>Schedule</td>
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<td>Pace</td>
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<td></td>
<td></td>
<td>Participants change over time</td>
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<td></td>
<td></td>
<td>Facilitators generosity with their time</td>
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<td>Structure</td>
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<td>Planning, response to need</td>
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<td>Preparation pre programme</td>
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<td>Group size</td>
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<td>Choice of activities</td>
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<td>Grading</td>
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<td>Environment</td>
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<td>Preparation of space</td>
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<td></td>
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<td>Social environment and sense of safety</td>
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<td>Facilitation Style</td>
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<td>Complexity – co-participation</td>
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<td></td>
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<td>Shared vulnerability</td>
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<td>Gender</td>
<td></td>
<td>Design, environment, facilitation, activities</td>
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<td>Potential of occupational engagement</td>
<td>Benefits of occupational engagement</td>
<td>Choice</td>
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<td>Enjoyment/fun</td>
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<td>Self-reflection</td>
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<td>Levels of engagement</td>
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<td>Benefits of creative occupational engagement</td>
<td>Self expression</td>
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<td>Flow</td>
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<td>Increased confidence/achievement</td>
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<td>Doing more</td>
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<td>Enhanced motivation</td>
<td>Increased self-esteem</td>
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<td>Power of shared experience and peer support</td>
<td>Shared life experience</td>
<td>Mental health difficulties</td>
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<td>Engagement with mental health services</td>
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<td>Compromised self esteem</td>
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<td>Peer support</td>
<td>Shared experience of the programme</td>
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<td></td>
<td></td>
<td>Feeling connected</td>
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<td></td>
<td>Enhanced self-esteem</td>
<td>Feeling supported</td>
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</tbody>
</table>
5.3 Programme Design

it was brilliant because ‘tis pointless coming to things like that where say the tutor will do things for us. We’re better off going in, having it laid out and figure it out ourselves … and the girls joined, the two girls they joined in with us … oh you wouldn’t even know they were say tutors (Marion)

The design of any programme implemented in mental health services is central to its success. The design of this programme emerged strongly as a theme in the evaluation. In terms of this programme there are certain elements of planning and design that contributed to the overall successes and challenges of the programme from the perspectives of both facilitators and participants. Key elements in the design included timing, structure, environmental considerations and the mode of facilitation.

5.3.1 Timing, structure and planning

Overall, the practical aspects of timing, structure and location were considered effective in the evaluation. The pace of the programme and the time allowed for individual and group activities worked well. The choice of activities and the graded use of same facilitated participation. The efforts to create a relaxed and women-friendly space contributed to positive experiences of the environment that enhanced learning and development. The preparation of participants through the pre-interviews and of the facilitators through the programme guide and reflective logs demonstrated the importance of this level of planning. The specific method of participatory facilitation reflected the challenges associated with being a recovery-oriented practitioner.
A key element of design that emerged in this evaluation was the influence of planning and preparation for both participants and the facilitators. In the development of the programme, a decision was made to include a pre-programme interview which would offer participants the opportunity to consider their own personal goals for participation. These interviews also informed some of the programme content and served as the pre-interviews for the research. Both facilitators made several references to the fact that the participants appeared “ready” and “prepared” for participation in the programme. Jane attributes this in part to “a good assessment by the services” and that the programme was “clearly bang on in terms of what clients were looking for”. Both facilitators also considered that the individual work done by each participant prior to participating in the programme greatly facilitated engagement and participation and ultimately outcomes. Aoibhinn noticed this readiness from the outset where participants very easily set meaningful goals. They had obviously thought about goals before coming to the programme. Jane recognised the participants willingness to engage and their openness “right from the start” and felt that was “down to the work done prior to the group”.

This “preparation” links to the concepts of identity, meaning and empowerment found in the CHIME framework (Leamy et al. 2011). Recovery-oriented services provide opportunities for individuals to engage in activities that are personally meaningful while affording choice and self-determination which empower the individual to lead a meaningful and productive life (Le Boutillier et al. 2015). The pre-interviews allowed the participants to consider personal goals in relation to their self-esteem and occupational performance. This preparation allowed their participation to commence
at a more personally meaningful level than if this work was not completed prior to the programme.

Preparation for the facilitators came in the form of a guide to the programme that carefully outlined the aims, objectives and activities of each session (Appendix 1). This level of planning is imperative to positive group participation and outcomes (Vroman 2013), and Cole (2005) considers this type of planning an “obligation” to the group. The programme was recovery-oriented and provided clear instruction and guidance throughout, which was valued by both facilitators. Aoibhinn found it “great to have this plan to work from” and that it “flowed well”. Jane commented that the content of the plan and programme facilitated a broad range of abilities to engage: “I think just the way the group was planned out it really facilitated people being at different levels and that being ok”.

Group theory suggests that careful planning, design and the establishment of therapeutic norms relate to levels of participation, satisfaction and outcomes (Gersick 2003). For occupational therapists, environmental considerations as well as choices that reflect person-centred planning are key to programme development (Cole 2005). Primarily the initial design choice made for this programme was to create an intervention specific to the needs of women who use the mental health service. The structure and timing of the workshops was effective from the perspective of the participants. Few of the participants had past experience of group work. Kim, had previously attended in-patient groups and she found the timing (two workshops per week) useful. The space between workshops facilitated her learning: “it was good… the space in between, you know you were able to think… to think about what you’d
learned”. Sarah, who was new to group work, found the small numbers of participants meant she felt more comfortable and better able to participate. Cathy remarked on how the full attendance at each session indicated it was working and that participants were enjoying the programme. However, she stated that “people would still have come for another three or four weeks” indicating that the programme was too short from her perspective. Julie would also have liked for the programme to continue longer stating that “we had only just got going” when the programme ended.

The suggestion that a longer programme might have worked better was echoed by the facilitators. Aoibhinn queried whether two more sessions would work in the future. She suggested the one session could possibly focus on healthy lifestyle in terms of exercise and diet given the positive response of participants to the healthy snacks available during the programme. The timing and structural element also worked for the facilitators with Jane feeling that two sessions per week and the break in between “worked really well” facilitating rapport. She also felt that participants were “held” by this timing. Consideration of the potential for the group to continue to meet together into the future without the input of occupational therapy was something that should have been introduced sooner from Jane’s perspective.

The PEO model considers the balance and fit of the occupation, environment and person to be central to the quality of the occupational performance experience for the individual (Law et al. 1996). The model references the importance of time in terms of occupational engagement. It attends to the changes that take place in each of the elements, person, environment and occupation, over time and how this impacts the congruence among the three elements. Timing of activities was an important
component in the planning of the workshop programme. The programme started with exploratory activities working through to finishing with more in-depth, personally meaningful work. Maintaining a balance between more emotionally demanding activities and lighter fun activities was important. The timing of these through the programme was carefully considered and the facilitators and participants both remarked how the pace and increasing complexity of activities worked well. Occupational therapists regularly use this type of grading of activities in their work to facilitate skills development and goal attainment (Hersch et al. 2005). The recognition that participants were learning and changing over the course of the programme and that this contributed to levels of engagement was also key. As participants became increasingly confident and received feedback and support from their peers, their levels of participation increased and this was noticed by the facilitators.

The activities chosen for the workshops also contributed to a facilitative atmosphere. At the beginning the ‘word cloud’ activity encouraged participants to move around the room. Participants commented that this helped them to ease into the group and ensured a comfortable atmosphere from the outset. This was also recognised by the facilitators. In the first session the ‘feel good collage’ promoted a feeling of fun and joy while also enabling a good deal of interaction. Similarly, the jewellery making session was a fun session for the participants. Marion described the pleasure that was had in completing their final pieces with everyone admiring each other’s work and staying on later to chat. This was mirrored in the flowery affirmation session when everyone moved around the room to help each other with their pieces.
Where participants engaged in a more emotionally challenging activity, for example the ‘word game’, the atmosphere was also considered positive, although in different ways. A sense of “warmth” was detected by Jane in that session as support and encouragement came from participants towards each other. The sessions were planned so that none of them finished on a difficult note and instead ended with something lighter or an acknowledgement of achievement. The use of the creative occupations in this manner aimed to ensure that motivation and participation were maintained throughout the programme (Finlay 2004).

5.3.2 Environment

The environment used for the programme emerged as an important subtheme in the design of the programme. The environment, a room in a city-centre outpatient clinic, was a good space, accessible to all participants. The participants indicated that it was accessible in terms of transport and that there was lots of room for the different activities during the programme. In planning the workshops the facilitators made a particular effort to “soften” the clinical environment as much as possible, using candles and soft furnishings. Several participants remarked upon the access to healthy snacks and drinks throughout all sessions, which they felt contributed to a relaxed atmosphere. This effort to facilitate an environment that was relaxed as well as promoting choice appeared to work well. Participants recognised the role of the facilitators in creating a safe and relaxed atmosphere and their flexibility and accessibility contributed to the positive atmosphere:

the minute even when you walk in the gate you can feel the warm atmosphere, coming up and the same the minute you come in everyone then is so friendly (Marion)
A number of the participants made reference to how well the room was laid out and how having access to snacks and tea throughout the sessions made the workshops more relaxed. Kim spoke about the nice atmosphere and described the workshops as “our space”. She said “the girls had set it up lovely with all snacks and everything”. This deliberate attempt to create a warm and relaxed atmosphere on the part of the facilitators appears to have worked well and links to the centrality of environment in the PEO model. In any form of group work an occupational therapist will endeavour to ensure that the atmosphere is relaxed and non-threatening (Finlay 1997). Consideration of how to promote a facilitative group climate through preparation of the physical environment is discussed by Vroman (2013). It is also highlighted by Cole (2005) who included the manner of facilitation and the media used as important contributors to group mood and atmosphere. Characteristics of the physical space can influence group development and functioning (Cole 2005) and it appears to have positively facilitated participation in this case.

The facilitation of the programme and how it responded to the needs of participants at varying places in their recovery journey indicates that it was planned well in terms of the person component of the PEO model. The chosen occupations were flexible enough in terms of their demands to enable all participants to engage. This is explored further in the next theme.

5.3.3 Facilitation

The planning that went into programme design reflects the activities of many occupational therapists aiming to be client-centred in their practice. Basing the programme on a service audit was the initial step in being responsive to identified
needs. As a service that typically provided a gender-neutral service it was the first attempt to meet the gendered needs of service-users. Consideration of what it means to be a recovery-oriented practitioner informed the design of the programme and in particular how the facilitators participated in and facilitated each workshop session.

The programme was facilitated in an informal, relaxed manner that promoted participation at every level. A key difference in this programme was that the facilitators participated in every element of the programme alongside the participants. A flexible and comfortable approach to facilitation is evidenced through the comments of the participants. Cathy found the facilitators readily available, never rushing people away. They stayed after each session which allowed participants to speak with them if desired. Julie considered it a “safe” space because of this approach. The relaxed atmosphere allowed participants to opt out of certain aspects of the workshops. Marion found this particularly valuable, taking a break at a point that she found personally challenging. Recognition of this relaxed approach ensured Sarah was “not put on the spot” and as a result “less under pressure”. A flexible approach to facilitating the workshops engendered feelings of safety in the group allowing participants to engage with the workshops at their own pace.

Further to this flexible and relaxed approach Jane identified another element of facilitation which she related to the gender specificity of the programme. She felt that it was important that the environment that was established was “feminine and nurturing” and stated that facilitators consciously engaged in being; “very open and honest … there has to be a real, compassionate, open, accepting, almost loving facilitation of what is going on”. The efforts made to create a therapeutic environment
and atmosphere appear to have been matched by the style of interaction used by the facilitators.

The level of sharing and support that occurred during the programme may also be attributed to the method of facilitation. As group leaders the facilitators used a variety of skills in running the programme. Egan (2001) described the counselling skills that can be effectively used by group leaders including empathy, genuineness and self-disclosure. Cole (2005) argues that imparting genuineness as a facilitator can have a profound effect on groups, encouraging group members to make meaningful and helpful responses to their peers. As co-participants in the programme the facilitators also self-disclosed personal experiences, which Egan (2001) highlights as important to positive group experience. It is possible that these elements of facilitation also contributed to the level and experience of support that happened in the workshop group.

Traditionally in mental health services the practitioner or mental health professional is considered the expert and the leader of the programme. As described, a particular feature of this workshop programme is that the facilitators also participated in each of the activities. This promoted the expertise of the participants themselves and worked to level the power differential inherent in therapeutic relationships in the mental health setting. Most women experience self-esteem difficulties from time to time (Camp et al. 2002) and thus taking the focus away from just mental health was also a rationale. The resulting approach facilitated participation and contributed to a relaxed environment. It unveiled a vulnerability in the facilitators that was respected by participants but difficult at times for the facilitators to manage.
This approach was valued by the participants as it created a sense of equality and promoted joint learning. Marion liked that the facilitators were also participants and recognised the challenge that it may have been for them; “the girls joined in … you wouldn’t even know they were tutors like … they were more nervous than we were”. Cathy considered that this role was carried out effectively by the two facilitators; “they got the balance right … they participated but not overly so”. This level of participation created a greater connection between the facilitators and participants and promoted respect and equality. Sarah noted that “the fact that they took part it was easier to speak with them and easier to get on with them”. Marion added; “it wasn’t just we’re up here and you’re down there you know … you didn’t feel like you had an audience”.

Although this approach held challenges for facilitators it was considered beneficial by participants. They too recognised the value of participating while facilitating but also described the challenge of this role. Being a facilitator and active participant in the workshop sessions was considered by Aoibhinn, similar to some participants, to be important in terms of group formation; “it worked well … it makes a rapport faster … and we should experience what we are asking people to do”. While learning the techniques required in the jewellery making session she described how her participation naturally “worked”; “I was getting really into it as well … we were just doing together … which worked”. Jane also recognised the potential that participating can offer in terms of the group gelling, noting that “we were just part of the group sitting around the table”. The ability of the facilitators to be active participants as well as group leaders appeared to facilitate group development.
Although positive, this dual role was not without its challenges. Jane found some sessions “incredibly anxiety provoking” as she tried to juggle her own participation and emotions with “being present” for participants. Aoibhinn also found participation “tough and intense at times” particularly during the ‘word game’ session. Receiving their card was something that both found emotionally moving to engage in with Jane remarking “reading my own card is overwhelming”. Similar to participants Aoibhinn keeps her card somewhere where she can regularly access it to help her feel better. Both facilitators referred to their use of reflections at the end of each session and being open with each other as vital in meeting this challenge:

We would have been very open and honest with each other around our anxieties … reflections really helped and we needed to do that (it was) essential (Jane)

The support and time given to each other as facilitators was an important component of this dual role working effectively.

The experience of the participants and facilitators of this manner of facilitation brings into question what it means to be a recovery-oriented and person-centred practitioner. Bordin (1979) defined the therapeutic relationship as an alliance that constitutes an emotional bond between therapists and their clients with collaborative agreement on goals and tasks. In order for this “alliance” or “relationship” to be successful mental health staff must demonstrate and communicate the basic human qualities of kindness, warmth, empathy and honesty (Sweeney et al. 2014). Occupational therapy literature abounds with references to “therapeutic use of self”, “therapeutic relationships” and “person/client-centred” interventions (Rebeiro 2000, Finlay 2004, Creek and Lougher 2008). In fact, client-centredness is claimed as a core tenet of the profession and is defined as practicing in a manner that is informed by clients’ lives,
values and priorities (CAOT 1983, COT 2000, AOTA 2002). Cole and McLean (2003) define the therapeutic relationship in occupational therapy as “a trusting connection established between therapist and client through collaboration, communication, therapist empathy and mutual understanding”. In spite of this it appears that occupational therapists remain unsure of their capacity to use themselves therapeutically or what this actually means in practice (Taylor et al. 2009). In the occupational therapy literature that explores service-user perspectives on client-centredness the key capacities of collaboration, respect, closeness over distance, warmth, support and kindness - are defined as important (Bibyk et al. 1999, Rebeiro 2000, Blank 2004, Whalley Hammell 2013). The recovery literature similarly emphasises the importance of the service-user/mental health professional relationship as a key factor in recovery (Cades et al. 2005). In this programme, the active involvement of the facilitators as co-participants unveiled a vulnerability in them that facilitated a positive experience for participants.

Shared vulnerability does not appear explicitly in the literature as part of therapeutic relationships. It is recognised that facilitators are challenged in containing strong emotions in group settings (Morton et al. 2012) but the vulnerability exposed through participation is not acknowledged. Perhaps it most closely relates to the “mutuality and friendship” discussed by Green et al. (2008) that is important for service-users in their therapeutic relationships. In this study people with enduring mental health difficulties most valued relationships with clinicians who were competent, caring and trustworthy who treated clinical encounters more like friendships. The value of hearing each other is demonstrated in a study by Schwartz et al. (2013). In this participatory action research project consumers valued hearing the stories of providers
as it took down the shields of psychiatry. Although relevant, it is important to note that this research was based on service delivery issues and how “listening” could contribute rather than sharing experiences in a therapeutic setting. The appreciation by service-users of having a common ground with clinicians is also demonstrated by Ware et al. (2004) in their work with people with enduring mental health difficulties.

In this programme evaluation, the commonality of experience as the facilitators participated in each programme element alongside participants may have facilitated better relationships and, as a result, positive outcomes for participants. The positive response of the participants towards the facilitators and their level of participation indicate that this approach enabled positive interactions and outcomes.

5.3.4 Gender

As an intervention that was designed based on the needs of women as a specific group the emergence of a subtheme relating to gender is not surprising. The strength of the subtheme at many levels highlights that the attempt to design a service specific to this group was successful. As a programme based on the outcome of a service audit, the intervention aimed to be responsive to need. Gender is present in many aspects of programme design that have been outlined in this programme evaluation. From the specific efforts by the facilitators to create a “women friendly” space to the choice of creative activities that were used as therapeutic media, these deliberate choices in design facilitated positive outcomes for participants and facilitators. For the occupational therapists who designed and facilitated the programme the skills of creating appropriate therapeutic spaces, central to occupational therapy practice, were foregrounded in the programme evaluation. This was highlighted by Spurrell (2008) who considered these occupational therapy skills as essential to the development of
mental health services for women. The development of “women only” and “women friendly” mental health services is strongly advocated for in research (Kohen 2001, Halliday 2005). The level at which this programme afforded opportunities for sharing of experience and making positive choices responds to the characteristics of services that were called for by the women participating in the study by Barnes et al. (2006). Providing those opportunities in a creative manner was also important in that study. The use of creative occupations as discussion, reflective and esteem building tools in this research worked effectively.

Elements of programme design emerged as a strong theme in the participants’ assessments of the outcomes of the programme. Key components of design included timing, structure, environmental factors and the style of facilitation. It was agreed that the frequency/sequencing of the sessions was appropriate, however, all agreed that additional sessions would have been beneficial. The choice and grading of the programme activities facilitated participation and positive experiences. Importantly, the level of preparation of both facilitators and participants ensured a “readiness” that made the programme more responsive to the women’s needs. Environmental considerations were important and how these met the needs of the participants was recognised and valued. The participative facilitation of the programme uncovered a vulnerability in the facilitators that raised questions regarding what it means to be a recovery-oriented practitioner.
5.4 The Potential of Occupational Engagement

But I think of all the groups I’ve ever ran it’s been the one that’s most apparent how important occupation is and how the creative activities or occupations were the cornerstones of what happened (Jane)

The power of engagement in occupation emerges as a key theme in this programme evaluation. Three subthemes underline this including: 1) the potential of engagement in creative occupations; 2) the benefits of occupational participation and 3) enhanced motivation and self-esteem. A strong relationship between levels of engagement in everyday occupation and self-esteem is discussed.

In the programme, creative occupations were used to facilitate discussion about self-esteem, to promote self and group reflection on self-esteem and to develop self-esteem for the participants involved. Group and individual occupations were used at different times in the programme. The link between self-esteem and participation in occupation was explored pre and post the programme. The effectiveness of the creative occupations used in the programme was examined in the post interviews in terms of the PEO model (Law et al. 1996) and the potential to promote recovery using the CHIME framework (Leamy et al. 2011).

5.4.1 Benefits of occupational engagement

The pre interviews provided a baseline exploration of how the participants felt that participating in occupations affected their self-esteem. A strong link between self-esteem and doing was evident from the outset. Participants explored their own patterns of engagement in occupation and how this impacted on their feelings about themselves. Discussions that ensued were based on broad perspectives of engaging in
everyday tasks such as maintaining the home to engagement in tasks that participants considered “good” for them such as varied leisure pursuits.

From the outset a strong link between being engaged in “doing” and positive self-esteem emerged. Invariably participants defined self-esteem in terms of ability and “doing”. Julie described people with high self-esteem as “they are always the doers … the go-getters … the organisers”. In particular, the negative impact of not “doing” was apparent and how this can become a negative pattern, a “vicious cycle”. Cathy described the impact of doing nothing on how she felt about herself:

I’m beating myself over the head about it. I mean if I laze all day then I say, ‘well today’s one day, tomorrow’s another day, tomorrow I’ll get up and tomorrow I will do something … when is this day going to come when you’re going to kind of start to produce or to start to, what would you say, start to make a difference?

This sentiment and its impact on how she felt about herself was similarly expressed by Julie when she stated “you’re going to think you’re not good enough, you’re not capable enough, you’re existing rather than living”. Participants in the programme clearly linked poor occupational engagement with lower self-esteem and the negative impacts of not “doing” on self-esteem were reflected in all pre-interviews.

When discussing engagement in activities that were enjoyable, participants’ responses varied from feeling proud and having a sense of achievement to feeling relaxed and uplifted. Marion described her feeling of recently being engaged in decoupage at a local community centre “I mean it now I am proud of myself”. She was learning that she had creative skills and was feeling fulfilled and proud of her achievements. While Julie described her love of dancing and how it made her feel stating “oh, elated … full of life, ah … joyful, ah … ecstatic … I just loved it. It was like enjoying life”. Sarah
described the sense of achievement she felt having attended the gym or when spending time with her cats.

Self-esteem is central to mental health and well-being and as such is an important construct in recovery (Silverstone and Salsali 2003, Michal Mann et al. 2004). Participants in this programme indicated that engagement in the activities of daily life was central to their self-esteem and how they perceived the self-esteem of others. Doroud et al. (2015), in their scoping review of the literature, consider how occupational engagement in daily life and recovery are interrelated in mental health. The review concludes that recovery is a process that requires ongoing engagement and re-engagement with everyday occupations and life. This centrality of engagement in everyday tasks resonates with the life experience of the participants in the programme under review.

5.4.2 Benefits of creative occupational engagement

The link between the power of occupational engagement and its influence on self-esteem was maintained throughout the programme. Creative activities and occupational therapy have been allied since the foundation of the profession (Wilcock 1998). Craft activities have the potential for skills development, to enable management of daily routines and promote peer support (Horghagen et al. 2014). Creative occupations were used in the workshop sessions to facilitate a relaxed atmosphere, promote group discussion, encourage reflection and develop self-esteem. In the first session collage was used to draw out perspectives on ‘feel good’ activities. For the participants there was a clear sense of enjoyment around this activity. It was
described positively by all participants in their post interviews with Julie stating she “didn’t want it to finish” and Marion giving it “100%”. In conjunction with this sense of fun the participants were surprised at how a creative activity like collage helped them to represent their lives. The use of an alternative medium to represent the occupations in their lives was novel and effective for these women. As a group activity the collage promoted discussion. Cathy noted that the women were quiet at the beginning but once they got going there was “lots of chat”, with participants sharing ideas and expressing interest in each other’s work.

The facilitators had similar positive reflections regarding this and other activities. Jane felt that the use of a creative activity such as collage that “doesn’t have to be perfect” facilitated the objectives of the session. The facilitators remarked that it helped the participants to start to think of themselves as occupational beings and how what they do impacts self-esteem. The positive level of engagement with this and other creative activities suggest a good person-environment-occupation fit according to the PEO model (Law et al. 1996). It infers that the chosen activity is meaningful for participants and that it has been facilitated and planned in a well-thought out manner that meets the needs of the group.

The lighthearted atmosphere generated by the use of creative materials and activities also links with elements of programme design described earlier. The relaxed atmosphere and fun facilitated positive experiences for participants with Sarah reflecting “it was probably because we were having great fun and getting into it so much”. In their study on engagement in art and recovery in mental health, Sapouna (2012) discovered the importance of “fun” as a transformative element of the success
of artistic activities as part of mental health services. Experiencing fun through artistic activities facilitated wellness for participants in that study. This experience of fun happened through all of the workshop sessions. The jewellery making session was the favourite of most participants for a variety of reasons including the experience of enjoyment. Marion described her experience of this as “feeling like a two year old” and “dancing around like Michael Flatley” when it was finished. In the third workshop the participants engaged in making affirmations from flowers, leaves and berries. These were photographed and framed. Again, this was a fun, enjoyable activity for the participants.

The element of fun was balanced by the creative activities that encouraged self and group reflection, promoted self-esteem and offered opportunity for learning. The flower affirmations session is an excellent example of this. Participants were surprised by their own creativity and were pleased to have an end product with their own personal affirmation. Marion kept her framed affirmation on her bedside locker, Julie on the mantelpiece and Cathy in the kitchen. Julie loved seeing the creativity of others in this session commenting that it was “lovely to see what others did too”. She made the suggestion that it would be nice to have a framed collage of all the affirmations when they were complete. This activity was meaningful to participants because it helped them to reflect on themselves through thinking about their personal affirmation.

Similar to the flower affirmations participants were pleased with having an end product in the jewellery making session. Engaging in this creative activity was a new experience for many participants and learning a new creative skill combined with an
end product was well received. The main aim of the workshop was to offer an opportunity to develop self-esteem and it appeared to achieve this for most participants. Marion described her bracelet and necklace as her “proud possessions” and “couldn’t believe” that she had made them. Showing them to her husband she received praise for her achievements from someone “who hadn’t paid her a compliment in 40 years”. Marion’s experience is reflected in that of other participants who spoke about “loving” the activity and saying they would have happily stayed at it all day. Cathy, in particular, found engagement in the creative process relaxing and calming. Marion used the example that she and her fellow smokers (two others) in the group “forgot” to go for a cigarette as evidence as to how much she and the others were engaged in the session.

The element of personal choice within the creative process facilitated a positive experience. Having a “choice to do whatever we wanted” was important to Julie and resulted in participants creating pieces of jewellery, collages and affirmations that reflected themselves and their personalities. A number of the participants remarked on this. Having end products was spoken about by all participants and was a source of pride, esteem and joy. Creating something “just for me” was important. The level of choice available for participants in all programme activities, including whether to participate or not, is congruent with the provision of recovery-oriented services. Choice is inextricably linked with empowerment, a key element of recovery in CHIME (Leamy et al. 2011). Similarly, the choice of an occupation that meaningfully relates to the needs and interests of the individual/group are essential for optimum occupational engagement in the PEO model (Law et al. 1996). Facilitating personal
choice enabled participants to engage with and express their own sense of self which is an important pillar of recovery under the CHIME framework.

5.4.3 Enhanced self-esteem and motivation

The focus on exploring and developing personal self-esteem was perhaps most evident in the final session where participants made an advert about themselves. They were free to use collage and other arts materials. They presented their piece to the group on completion. The predominant outcome for participants in this activity was the extent to which it promoted self-reflection through creative occupation. All of the participants described how this activity encouraged them to think about their lives. Some considered their past and how far they had come with others focusing on hopes and dreams for the future. The key recovery themes of hope, a sense of identity and meaning were facilitated through this activity. For Cathy, the activity allowed her to think about herself in the context of her family, how she can be a “star” in her own right and how the basic things in life are important and can make her happy:

You know I think that genuine stars are people that don’t try to shine their light too much themselves. They’re not the ones trying to go around looking for publicity really … they’re just ordinary people … and I am an ordinary person so why not me a star as well?

The activity and the materials that Cathy used to represent herself enabled her to portray her identity and her hopes for the future. Julie’s collage also represented her in the context of family, reinforced the importance of friendship and demonstrated her interests. She was surprised at the extent to which her collage represented her so clearly:

But looking at it now isn’t it strange? That’s actually me and yet when I came in first I said to you I’d done it wrong you know, I’d done it different. But looking at it now that is actually me, so it’s a good representation of me.
The medium of collage enabled Julie to see herself by representing the important parts of her life. The potential for the activity to afford self-expression in this way was also evident to other participants. Sarah thought it was better and more effective than writing:

It was a positive activity and it was better than just writing ‘I am great because blah, blah, blah … it was a better way of doing it … definitely for people with low confidence it would be a better way of doing it … because if someone asked you to write ten negative things about yourself you’d have no problem doing it but if someone asked you to write five positive things you’d be a while thinking about it.

Kim was surprised at how effective the medium was and enjoyed looking at what her peers had produced:

It was very good, I was looking at them all I was saying, how did they think of them? … I thought some of them were very artistic, some of them were very jolly too, the impacts they put into them.

The advert design also facilitated a sense of recovery and hope, particularly for Marion and Sarah. Marion’s experience of this activity was especially positive for her in that it facilitated consideration of her past which she had not previously been able to do. Only one session earlier, during the word game activity she found this difficult, taking a break from the session, “I tell you it’s the first time in my whole life that I let my past come in”. Marion went on to describe how she considered the possibilities for her future through collage when describing her advert:

That’s the old you and look there you are coming back. You’re going to get your hair done, start pushing yourself to greater heights, open Pandora’s box because there’s a lot in there for you.

Marion referred to Pandora’s box in considering the potential for her future in a positive way. Making reference to looking after herself was a positive change for her, as she had looked after others since she was a child. On reflecting on her creative
representation of her past Marion was then able to envisage a more positive future for herself through the creative medium:

You have the power to take the next step, you’re going to feel younger in yourself and be the superwoman that you are now and … a new dawn. And everyday when you wake up it’s a new dawn for you

She used the collage to represent a younger and more powerful version of herself where she could visualise new opportunities with each day. Sarah’s advert used pieces which described her qualities at that moment in time including how she would like to see herself in the future, fit, healthy and at work.

5.4.4 Discussion

In her discussion of meaning and occupational therapy, Hammell (2004) argues that the focus of therapy needs to be on the dimensions of occupations that contribute to a meaningful life. The element of “becoming” in her writing refers to the potential for individuals being able to envision their future selves and consider new possibilities for their lives. The personal advert activity was experienced as meaningful for the participants in terms of facilitating this element of ‘becoming’ the person they created through this creative occupation.

For the facilitators, however, the potential of this creative activity was not initially clear. They found themselves questioning the choice of activity and their own ability to participate in it. In making the personal advert, both Jane and Aoibhinn found themselves challenged by the prospect of facilitating the session. Aoibhinn found herself to be worried about making her own advert commenting that she “didn’t realise how hard it was”. Jane was concerned about the medium of collage, being unsure as the appropriateness of its use with adults. Both were surprised at how it was
“completely appropriate medium to use … they absolutely loved it”. They considered the end products to be personally meaningful and symbolic with very powerful imagery. Jane also recognised the level of personal reflection at work; “you could see everything that went on every single page, a lot of thought went into it, there was nothing just slapped on”.

The element of meaning is also important when considering the activities with a gendered lens. Some of the activities were viewed as “inherently feminine” by participants and facilitators alike, in particular the jewellery making and affirmation sessions. Jane attributed this element to the popularity of these sessions commenting “doing together … doing an activity that is very appropriate to women and very enjoyable” contributed to the positive atmosphere and experience. The “doing” piece was very important with Jane acknowledging that the group could have had a discussion about engaging in activities you enjoy but she felt it was the “doing together” that worked.

Occupational therapy is a key discipline in multidisciplinary team working in Irish mental health services. Therapists use occupations in their work with service-users at a number of different levels from assessment to skills development to providing opportunities for personal growth and development. In today’s services occupational therapists are increasingly expected to work in a more generic fashion, with competing demands on their time to case manage and use general mental health skills (Lloyd et al. 2004, Rosen and Callaly 2005, Pettican and Bryant 2007, Ashby et al. 2013). This pressure is well recognised in the literature and the importance of demonstrating the effectiveness of occupation-focused interventions is recommended
as one of the key priorities for the profession (Hitch and Lhuede 2015). This workshop programme was designed against this backdrop and aimed to be occupation-focused at all levels.

Occupational therapy has been associated with the use of creative arts in intervention since the start of the profession, asserting the links between engagement in creative occupations and well-being. Wilcock (1998) describes the creative nature of human beings, reflecting that to withhold our creativity is a denial of our true being. Creative occupations are an example of what humans can use to find meaning in life (Trombly 1995). In a review of the literature in the late 1990s, Thompson and Blair (1998) examine the value of the use of creative arts in occupational therapy. Similar to the today’s service context, they express concern that the value of the occupational therapy perspective is at risk of being lost with a move towards verbal therapies. Their review demonstrate that the use of creative therapies promote self-expression, play and fun, flow and learning. Similarly, the creative activities chosen for use in this programme appear to have been successful because of their characteristics. These include the elements of choice, fun, meaning, identity, expression and recovery. These clearly link to the six main outcomes of the use of creative arts in therapeutic practice identified by Perruzza and Kinsella (2010) in their recent review of the literature. These outcomes include how creative arts can promote self-expression and assist in building a sense of self while enhancing control and gaining a sense of purpose. These characteristics link well with those identified by the research participants in this study.
The creative occupations used in the programme also offered the participants the experience of ‘flow’. ‘Flow’, a construct from social psychology, has been defined as the state of being fully engaged in an intrinsically motivating and meaningful task so that nothing else seems to matter at that time (Csikszentmihalyi 1975, 1997, 2008). It occurs when an individual is engaged in what is known as the “just right” challenge, where the challenge of a task and the skills required to complete it are perfectly matched. A consequence of a flow experience is that the usual worries of everyday life can be put aside for a period. For occupational therapists, understanding flow enables them to design therapeutic occupations that facilitate this positive experience (Rebeiro and Polgar 1999, Larson 2004). Marion referred to how smoking participants “forgot” to have a cigarette break during the jewellery making activity in particular. Csikszentmihalyi suggests that creative tasks are more likely to contribute to the experience of flow (2008). McHugh (2016), in examining the relationship between flow and creativity, argues that agency and autonomy are often missing from the lives of women who experience mental health difficulties. Offering opportunities to engage in creative and meaningful arts that facilitate choice may increase agency and flow experiences and may have benefitted participants in this study in this way.

The series of creative occupations chosen were also successful for another reason which relates to the recovery ethos. Participants in the programme were at different points in their personal recovery journeys and yet were able to participate in all aspects of the programme. This was valued by Kim who acknowledged that at times during the programme she wasn’t feeling well but she was still able to take part. She noted that during the jewellery making “I was still able to make something”. Jane, as a facilitator, also recognised how the activities were flexible enough to afford
participation to differing abilities, making the programme accessible to all participants. The link between art making and recovery in mental health is explored by Van Lith (2015). In this study the participants found that art making was directly linked with recovery, enabling them to take control of their lives with increased self-confidence giving them greater control over their recovery journeys. Although the programme under review did not focus on therapeutic art, outcomes for participants relating to recovery do appear to be similar.

The benefits of occupational engagement in daily life emerged as a subtheme in the evaluation. In the post interviews all participants were asked about their thoughts on the links between what you do and how you feel about yourself and if they had changed following participation in the programme. All participants made reference to the clear links between themselves as occupational beings, their mood, confidence and esteem. Some made changes to their daily routines while others felt more motivated and confident to participate in new activities or attend family functions that previously would have been difficult. Similarly the facilitators recognised changes in the participants as the programme progressed.

For the participants strong links were made between doing everyday tasks and feeling better about themselves. Cathy, who had struggled with her motivation to complete tasks before the programme, found that her routine had changed since participation. She felt that it was not as boring and that she was doing more of the normal things. Even though in her pre-interview Cathy aspired to do something “amazing and “make a difference” she now recognised the achievements in doing everyday things, “I’ve
achieved something”. Similarly Marion linked everyday doing with how she felt about herself:

It doesn’t matter whether it’s housework, even painting you know the house, It’s just the simple fact that you can get up … the enjoyment of the fact that even when you’re washing up a couple of dishes or making the beds you’re not feeling down or anything, with me I’d be humming away.

Likewise Kim clearly linked doing things each day to how she feels about herself; “if your day doesn’t have any importance in it … it can take away your self esteem. You have to be a doer to give you self esteem”. Kim spoke about an achievement for her following the programme which was going down town, looking around the shops and meeting a friend for coffee, something which she had not done for years. She stated that the programme helped her to realise her ability in relation to rearing her daughter and maintaining her home, “I can do things … I have learned to love myself”. Similarly, Sarah felt more motivated to do the day to day things that previously she would have put off:

We discussed this in the workshops that a lot of us felt more motivated to do things the day after each workshop session … be it housework or getting some chore out of the way that you were putting off for ages or in my case going to the gym.

One of the immediate influences of participation in the programme reported by the women was a shift in motivation to do everyday tasks. Julie described washing her windows between sessions which she had been putting off, while Sarah increased her participation at the gym as described above.

This importance of engagement in everyday tasks is central to occupational therapy in mental health (Law 2002). One of the aims of the programme under review was to give participants the opportunity to explore the relationship between participation and
mental health, in particular self-esteem, using creative activities. Although participation has many influencing factors, for all participants in the programme, doing the normal things of daily life was significant. Through her work with community arts projects in the UK, Ede (2008) concludes that engagement in arts activities offers opportunity for increasing independence and developing occupational balance among participants. The potential of ‘doing’ in everyday life to influence recovery in mental health is explored by Sutton (2010). In this study engagement in everyday activities is defined as an important medium for change among people with mental health difficulties. The level of engagement is considered a recovery outcome in itself. In the current programme participation in the activities offered participants insights into their own abilities and increased their confidence to participate in daily life.

As well as reconnecting with everyday participation a number of participants also went on to engage in new activities following the programme. Marion started yoga and art classes and associated this with her increase in confidence having completed the programme. Kim also had started a number of new endeavors including guitar lessons and singing at mass in her local church. Both held great meaning for her and helped her to recognise her increase in confidence:

So I’d go from there to guitar … so I love that. I started singing in the church at three o ‘clock, with three guitarists, three men. Choir singing … so they heard me singing and they asked me to sing with them … it’s a healing mass for healing so I do that at three o ‘clock every Saturday … I love it. I love singing yeah I was thinking of that this morning. I never shake! Usually I get nervous and start shaking but when I go in there I just sing away. It doesn’t bother me at all

Julie found a new confidence relating to her engagement with family and friends. Before the programme she described how her front door was like a barrier to
engaging with the outside world. She regularly did her shopping and other tasks late at night or early in the morning in order to avoid others and had limited contact with family or friends. Following the programme Julie attended a fashion show with her sisters:

You know that to me, the fact that I went to the fashion show and for the fact that I got all dressed up I thought it was lovely because I haven’t done that for so so long and I liked that I did. And you know … it would have been one of the best nights in I couldn’t tell you when

She associated this with an increase in confidence and esteem and a realization that she is capable, “I’m just laughing now that I said I’m the doer”.

This link between moving from anxiety and low levels of participation in everyday life to exploring new interests with engagement in creative activities is reflected in the experience of the participants in the Art + Minds project in Cork (Sapouna 2012). Similarly, participants in that study found participation in the arts programmes to be a key step in the move towards independence and developing the confidence to try new things in life. This is mirrored in the study in the UK by Lawson et al. (2014) where participants in community arts describe increases in self-confidence and self-worth leading to engagement in other activities that enhance daily life. This relates to the contribution that meaningful engagement in occupations can make to not just competence, skills development and value but to quality of life (Hammell 2004).

Engagement in occupation was important at two levels in this programme. The recognition and exploration of the importance of engagement in daily occupations was central to understanding self-esteem and how participation impacts our self-perception and mental health. The carefully chosen creative activities used in the
programme demonstrated their potential to enhance self-esteem as part of the recovery journey and promote discussion and sharing. When asked to describe what she considered the most powerful part of the programme, Jane responded:

I have just written down ‘the power of occupation’ which I shouldn’t be surprised by because I’m an occupational therapist. But I think of all the groups I’ve ever ran it’s been the one that’s most apparent how important occupation is and how the activities or occupations were the cornerstones of what happened really. The discussion was one part of it but the essential group ingredient for why that group worked was the idea of doing together and creating together and even what being creative can bring up in allowing for discussion, the camaraderie, the interaction. I think that just really came through very strongly across all of the activities. If they had been less occupation-based that lightness and fun would be lost

The facilitator, an experienced occupational therapist, was surprised by the power of occupation demonstrated in the programme. She acknowledged the centrality of occupational engagement to the experience as a whole, noting how the occupations facilitated discussion, positive relationships and enjoyment.
5.5 Shared Experience & Peer Support

When you kind of listen to the other ladies’ stories as well and about their past and their lives you’d kind of say, Jesus I’m not the only one  (Kim)

The final major theme that emerged in the programme evaluation relates to shared experience and peer support. Although shared experience was occurring at a variety of levels, including between facilitators and participants, this theme relates to the women who participated in the programme. Participants in the programme shared experience at two distinct levels that are important in the programme evaluation. The first is that of shared life experience as women who have mental health difficulties and who are using mental health services. The second is the connection as co-participants in the programme under evaluation.

5.5.1 Shared life experience

For the participants in this study the idea of not being alone in one’s experience was apparent from the beginning. The pre-interviews explored the women’s understanding of self-esteem in the context of their life stories and their recovery stories in particular. From the outset it was clear that this was a group of women with many experiences in common. A number of the women had left school early to work to provide for or to care for younger siblings. In Marion’s case, she had never really attended school instead having responsibility for the care of her younger siblings through her school years. Three participants came from working class areas of the city. Parental alcoholism and mental health difficulties were other commonalities. Four participants were mothers and all had also cared for another relative. Challenging early life experiences and the traditional gendered roles of caring and mothering were linked by all participants to their sense of self-worth and self-esteem.
In terms of mothering, the challenge of being the sole parent even when in a relationship was highlighted by Julie and Kim. These shared experiences, although not explicit amongst the group at the outset, may have contributed to the speed at which the group gelled and worked together. Different aspects of these shared experiences emerged in the storied aspects of the workshop activities.

A common factor that emerged in the pre-interviews for all participants was how their mental health difficulties have impacted on their self-esteem. Participants described experiencing stigma relating to their mental health difficulties particularly from family and close friends. For example, Julie commented:

So, when we all get together it’s a lovely occasion, but I don’t want to be harping on about me or this thing again, but if it’s anything to do with the in-laws I get the palpitations, I get the anxieties, I get all that ammm…and, but now I know that they always say ‘oh, is she sick again?'

Sarah noted “I mean I wouldn’t tell even my family that I’m coming here … ‘cause I mean I know they think less of me and I wouldn’t want them to think I was mad or whatever”. Similarly, Kim stated “it’s an awful stigma attached to it. Some people I know they talk about me. I know people talk about me”. The experience of mental health difficulties and use of services resulted in similar experiences relating to perceptions of others and how participants felt about themselves.

A sense of loss in relation to mental health was also evident. Kim describes how she lost her old self:

Well I feel that I’ve, I’m ... lost myself, somewhere along the line, and that I don’t connect like I used to. I used to always be more outgoing and I was having a chat and whatever. When I go out socially I kinda go away into the corner and just talk when I have to talk.
Cathy also experienced loss in relation to her mental health, feeling that she had missed out on important milestones as a young person due to mania or depression.

### 5.5.2 Peer support

In the pre interviews most participants indicated they had limited previous opportunities to meet or share with others with similar experiences of mental distress or with others using mental health services. Although a number of the women had been in hospital due to mental health difficulties, none other than Kim had experience of peer support outside this arena. Given her previous participation at GROW, a national peer support organisation, Kim was able to conceptualise the possible benefits of being in a group of others with similar experiences:

> I like being in a group yeah. ‘Cause I like to know there’s others out there, trying to achieve their own goals, whatever goal it’d be ... they might even if they haven’t been in hospital, they’ve been there in some way, they’ve been there and they understand, we understand one another

Even though others had little experience of peer support or group work they looked forward to meeting others and not feeling alone, and particularly to relating with other women. Marion said “because I have never met anyone before you see that would have … had similar, or a similar life as myself”. Julie similarly expressed:

> Well I’m hoping it … just hearing maybe some other women …with the same … problems is sort of a wrong word, I don’t like to say problems, but with the same ah … illness is another wrong word to me …experiences, thank you. Because I did think for a long time like, it was only me that had these problems

Feeling connected to others and part of a group or community is an important element of recovery. This is reflected in ‘connectedness’ being a key process in the CHIME framework (Leamy et al. 2011) The potential of connecting with others with similar
experiences was an important reason for participants deciding to engage in the workshop programme.

The programme itself, not only brought a group of women with similar experiences together, it also afforded and facilitated many opportunities to share and support one another. A progression is evident where participants initially described not feeling alone through learning that others had similar experiences. They then moved on to starting to support one another during the programme through honest and caring interactions and finished with participants making plans to meet again once the programme ended.

The sharing of experience was promoted further in the second half of the first session where the ‘feel-good collage’ helped participants communicate in a more light-hearted fashion. Julie remarked on the ease with which this happened especially when it was just the first day the group was together. Cathy noticed that the group was a little quiet during the initial stages of the first session but described how once they got going there was loads of chat. The facilitators also recognised that the collage generated interaction and facilitated “great discussion” and both facilitators noticed the level of sharing of ideas and life experiences that was occurring.

The strength of shared experience became particularly evident again in session three during the ‘word game’. This session was referred to as the most challenging by participants and facilitators as they had difficulty reflecting on and presenting their achievements in life. Although they found it difficult they were also able to highlight positives, reiterating that the activity reinforced a sense of belonging and not being
alone in one’s life experiences. Julie said “but our common ground of ‘someone else like me’ was reinforced” and Sarah commented “It made me feel better to hear other people were in hospital or depressed”.

Not being alone was referenced by all participants as a positive to this activity. There was a sense that the group was closer at the end of the activity with Marion saying that “by the end we all had these experiences in common”. This closeness was also observed by the facilitators. They spoke about how the participants facilitated and supported each other during the activity. The support was very evident from Aoibhin and Jane’s perspectives. Jane described this as occurring naturally, where the participants were present and listening to each other. Aoibhin felt that at times they as facilitators didn’t need to say anything with the support and encouragement naturally arising from the group itself:

Very supportive you know? Sometimes Jane and myself didn’t need to say anything and other ladies were like god that’s hard but look where you are at now, you know … she was getting support from the other ladies around

This is an excellent example of the development of informal peer support occurring organically in this group. As the participants shared personally meaningful information in this session they were able to facilitate and support each other at difficult points. This may have been facilitated by the gender differences that are present in the experience of peer support. Women experience peer support as signifying connectedness to others while for men it is about demonstrating ability and skills (Bracke et al. 2008). By the third session the participants appeared to have made a connection and were naturally supporting each other. Creating an environment that allows women the opportunity to support each other in this manner is
recommended by Barnes et al. (2006) where these authors advise that services should work to creatively open spaces for women to share with and learn from each other.

Marion described how important the support she received was:

> Oh you don't know how supportive it is you know? … sometimes it’s hard to explain what it does to help a person like myself … because when you’re like myself now you’re kind of fighting the bad thoughts all the time

She described how she had been able to support others simply by being present:

> I could sit there now and I was able to listen to one of the girl’s stories. I mightn’t have been able to say anything but at least I was there … and listen. I didn’t criticise anyone or no one was criticised or no one criticised me or the fact that I was trying to take my own life

Sarah found the supportive, non-judgemental atmosphere important in her experience:

> And I found it supportive in the sense that people didn’t judge you … and you didn’t think people were thinking you’re mad or mental or any of those negative things … that was the main thing. I found it supportive, we weren't judged

Peer support in mental health is described as a process of giving and receiving support and help, founded on mutual respect, responsibility and agreement on what is useful (Mead et al. 2001). The idea that someone with experience of a particular difficulty can be helpful to someone else in the same position can be found in support groups throughout society. For example, Living Links for those bereaved by suicide, Arthritis Ireland support group, Caring for Carers among others. Peer support is founded on the belief that someone with experience of a problem can better relate to the experience, consequently offering real empathy and more practical resolutions to problems (Repper and Carter 2011)

Peer support groups in mental health are defined as a space for sharing life’s challenges and exchanging information to help each other (Montgomery et al. 2012). Although peer support is often understood to be provided by a trained peer support
worker, peer support can also occur spontaneously (Bouchard et al. 2010). The experience of peer support can be found naturally in group environments. Occupational therapists are one of many mental health professionals who use group work to facilitate therapy. The benefits of group work are well established and focus on shared experience and the potential for learning and development through working with others. In mental health, group settings afford opportunities to hear new ideas, learn from others and try new things in safe environments. Having said this it is important to recognise that peer support does not necessarily establish peer support and the activities of this programme appear to have facilitated this.

The recognition that ‘I am not alone’ commenced with the first activity, the ‘word cloud’. Participants recognised and related to the experience of others through their choice of words. Participants reported feeling “not alone” and how it was “lovely to see others having the same feelings” during this activity. This activity also created space for peer support where some participants offered help to others who seemed uncertain. Bracke et al. (2008) identify the benefits of providing rather than receiving peer support, something Marion describes as she helped one participant to overcome anxiety to come into the group room on the first day:

Like that now that when I came in first and there was another girl standing at the door; the two of us, and the two clicked together and I just turned around and I said to her, I said; we’ve come this far, let’s go in … she was very unsure of herself and I said, so am I, I said I’m in the same boat sweetheart I don’t know whether to run, cry or whatever, I don’t know what we’re doing up here … so I just said to her I said, let’s just hold hands and walk in together, and that’s exactly what we did

Julie recalled how helping another participant in that first session helped her as well:

And she did actually she came over then and she put one or two things up on the positive and I liked that because I thought she was sort of you know focusing so much on the negativity. I was feeling sorry for her that she kept thinking of negative
These initial activities of the programme started the process of group bonding. It was noted by both facilitators and participants that this happened very quickly. This is linked to a variety of factors. Foremost among these for the facilitators was the “readiness” of the participants to engage in the activities and associated discussion. They were “amazed” at how well the group settled and worked together. This group dynamic from the outset was also linked by the facilitators to the creative activities and how this facilitated participation. For example, jewellery making promoted positive interactions and sharing skills and was the favourite activity of most participants. The facilitators noticed the level of interaction that occurred during this session with participants continuously helping each other. One group member who was particularly anxious had skills in this area and was able to help and teach others. The facilitators also described watching the group develop and grow as members got to know each other. This was evidenced through the recognition of each other’s personalities in the pieces that were created. Participants commented on how the pieces of jewellery reflected the personality and style of their creator. Group dynamics and connectedness were enhanced during the ‘flower affirmations’ activity that followed as participants worked together to create an end product for every individual. Jane noticed the importance of working together and helping each other and how this collaboration fostered positive group dynamics. Aoibhinn observed that there was lots of interaction throughout the session and remarked on how group members were growing in confidence with some being “nicely assertive” with others.
5.5.3 Shared experience, peer support and enhanced self esteem

This positivity, interaction and naturally occurring support was evident in the final sessions as participants filled in their compliments on each other’s cards. This activity contributed to group connection. In fact, a positive group dynamic was essential to this activity working well and this was evident in the good reaction that it elicited from the participants and facilitators. Everyone valued the honesty and meaningful ways that people participated. Jane acknowledged that the setting had become a “safe space” for this group of women and this fostered a “nourishing environment” where participants could be open. Both facilitators felt that participants put great effort into supporting each other in a way that was “heartfelt and genuine” offering “specific” comments and feedback. The facilitators recognised how well the group had gelled and how this allowed participants to be open and vulnerable with each other.

Learning and a sense of personal journey is evident in this card activity. The continued journey of self-discovery is clear for Marion; “I didn’t know that I was like that, that I had achieved all that until someone else wrote it down about me”. Marion valued the viewpoints of others in terms of her personal journey, describing how much she had worked to change her life. It was meaningful for her that her peers could see this too:

Because I know as I said to you a few months ago and that it was for me getting into things, to do new things and to try to prove to myself that I can do it, prove myself to myself and to do the things that I truly love doing

Participants appreciated honesty from others in this activity which reinforced the positive experience of giving the compliments and receiving the cards. Although Cathy initially queried how meaningful it could be given the short space of time the
group was together; “twas grand but it could be a surface, like in fairness I only knew
the girls for four days”. She later acknowledged the meaning it held for her:

Oh it was lovely, it was nice. I mean the ‘talented’ bit was nice to have heard … and
‘down to earth’ was nice too, and ‘interesting’. I’d like to be interesting, I wouldn’t
like to be a bore you know, I wouldn’t like to be somebody who goes on and on. And
the fact that I was helpful to the group as well

Julie also valued the honesty that she found in her card. It reinforced her sense of
identity as she felt she had really been herself with the group:

But I hadn’t my clown face on here and that was the difference … it was me being
normal as I call it, me being myself, me being me that’s what it was … that there is
nice and positive, people think something positive of you. It is lovely and I thought it
was a great, great idea at the end of it because even if you didn’t have some sort of
esteem that you could, you know that by looking at what people wrote about you that
they’re genuine because they don’t know you from Adam … so therefore it’s
genuine, so that’s what I liked about it

The beneficial effects of the feeling of being appreciated by others is also identified
by Castelein et al. (2015). Verhaeghe et al. (2008) and Bracke et al. (2008) also
demonstrate how peer support can contribute to increased self-esteem as in the case of
Marion’s experience with her card. In these studies balanced peer support augmented
feelings of self-worth and increased feelings of competence. The feedback from her
peers allowed Marion to acknowledge her qualities and achievements.

The personal advert activity in the final session also introduced a layer of reflection
on the gendered nature of self-esteem and the pressures on women today. Before
creating the advert the group discussed how women are portrayed in the media and in
society. Jane reflected on this “really nice conversation” around these pressures and
how group members shared their own experiences, concluding that “you come to a
stage in your life when you realise it is just a pile of … you know, its not relevant”.  

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Although most feedback in relation to mutual understanding and support was positive, Cathy felt that this part of the experience could have been enhanced. She thought that the programme would have benefitted from exploration of each other’s background from a mental health perspective. She felt that hearing about others’ recovery journeys would have enhanced her experience:

I mean down to doing those and all the different things, your self-worth and your self-esteem … but there was no talk or discussion about how we got there what were we like? Was there a time that we remembered that we were well, was there a time that we remembered that things were starting to fall apart on us? And then how did you cope with that? And how did you, has your quality of life now been restored or are you still suffering side effects of the illness that you have I mean I don’t want us moping in here, labelling ourselves as mental cases, but it might have been helpful

Cathy’s point reflects an appetite for more in-depth peer support, as she sought a deeper understanding of her peers’ life experiences and would have liked to share her own.

In the context of the support and sharing that occurred in the group, some participants went on to form friendships that continued after the workshop programme. Three of the participants in particular met to go swimming together and also met in one woman’s house for coffee. These friendships were meaningful and important to participants:

The girl I connected with the most we still talk it’s like we knew each other our whole lives. We talk, I’ll ring her up on the phone and we chatting away like we never not knew one another

(Kim)

The giving and receiving of informal peer support benefitted participants through learning, self-discovery and development of confidence and self-esteem. Sharing activities and experiences facilitated connectedness throughout. The environment and
space dedicated to women facilitated these processes. A more in-depth exploration of mental health and participants’ background in this regard may have facilitated a more positive experience for some participants. The realisation that “I’m not the only one”, which commenced with the opportunity to participate in the programme was evident throughout and continued through to the formation of friendships.

The value of shared experience and peer support in mental health is well documented. Patricia Deegan (1996) in her description of her personal recovery journey describes how powerful it could have been for her had she met someone who had similar experience to hers. In Ireland peer support centres and groups are becoming increasingly common, similar to developments in the UK and US. In 2016 there are plans to develop peer support worker roles through the Advancing Recovery in Ireland initiative. Formal peer support services have been evaluated in a series of reviews (Repper and Carter 2011, Walker and Bryant 2013) and have demonstrated positive outcomes for service-users and peer support workers.
5.6 Conclusion

The programme demonstrates congruence with the key areas for effective interventions in occupational therapy as identified by Wimpenny et al. (2014). These are professional artistry, occupational engagement, new horizons, and inclusion. Wimpenny et al (2014) recommend that further research is needed to examine the use of occupations that provide space for healing, creation of identity and self-discovery. The creativity inherent in the design and facilitation of the programme is evident throughout. The programme design from the outset demonstrates a commitment to meeting the needs of service-users in a more meaningful manner through a carefully considered and planned programme. Time, in particular recognition that a longer programme would have been welcome, was highlighted as a factor by all participants. The evaluation has reflected the key role of facilitation and questions what effective facilitation looks like in terms of a recovery ethos for occupational therapists in mental health. The attempt to de-construct the power imbalance in the service-user/service provider relationship through an alternative method of facilitation has demonstrated benefits. This participatory facilitation has revealed a shared vulnerability on the part of the facilitators which warrants further investigation. The potential for occupational engagement and reflection on its meaning at micro (creative occupations) and macro (doing in daily life) levels has been demonstrated. The power of occupational engagement in its capacity to enhance self-esteem, motivation and mental health recovery has been highlighted. The recovery ethos and how it mapped onto the experience of participants in the programme was examined, with reflection on how hopes for the future were facilitated. The space in the programme for self-reflection and development is evident. Developing a programme to address the gendered needs of participants was also successful in creating a women friendly
space. However, a more in-depth consideration of women’s experiences of mental health was considered to be something that would improve the programme.

All participants were asked what they considered to be unique about the programme on its completion. Being with a group with similar experiences was repeatedly referred to by participants as a highlight of the programme experience as a whole. The characteristic of the group in terms of their openness and ability to relate to each other easily and readily was also identified by all participants. The facilitators, in particular, related this to preparedness to engage with participants having time to consider the programme through the interview prior to participation. The element of peer support was universally acknowledged as a very positive component of the programme experience.
Chapter 6 Conclusion and Recommendations

The thesis opened with a consideration of the spaces that are emerging in mental health services in Ireland as policy and practice change to becomes more recovery-oriented. Spaces exist in terms of the meaning of expertise, how services are evaluated, how services are designed and the value of occupational therapy in service delivery. Through its execution this research has demonstrated the value of using a particular methodology to evaluate services, the potential of occupational engagement, the importance of shared experience in mental health and raises questions about what it means to be a recovery-oriented practitioner. All of the women who participated in this study were open and honest about their experiences. They spoke about the link between mental health, self-esteem and occupation in their lives and offered personal reflections of their experiences of participation in the workshop programme. The value of the design of the programme, the power of participation in creative and everyday occupations and the support generated through shared experience has become evident through the analysis of this data. At the outset of this study there was no published literature relating to women using mental health occupational therapy services in Ireland. This research offers a preliminary understanding of the experiences of women service users relating to occupation and its relationship to self-esteem.

A variety of outcomes in relation to occupational therapy practice in mental health in Ireland are demonstrated. These outcomes occur at a time of change and challenge in Irish mental health service provision. The expectation of change to more recovery-oriented service provision introduces challenges to how services are delivered and
evaluated. This research encourages us to question what it means to be a recovery-oriented practitioner, how service-users perspectives can be meaningfully incorporated into service evaluation, what are the needs of women in relation to mental health and to consider the value of shared experience and the expertise of those who use services.

This project has demonstrated how carefully designed occupational therapy service delivery that has a robust assessment can meet the needs of service users. It also shows how alternative methods of facilitation that challenge traditional power relations can lead to more meaningful participation for service users which is important in promoting a recovery ethos. The level of support that participants experienced through sharing experiences reflects the evidence base supporting the value of peer support in mental health recovery.

The use of qualitative methodology deliberately foregrounds the experience of participants in this research. This choice reflects the move towards recovery oriented service provision in Ireland where the specific expertise of service users is valued. The use of a recovery framework together with an occupational therapy model in the conceptual framework offers the opportunity to examine the relationship between recovery and occupational therapy in mental health. This concluding chapter presents the contribution to knowledge of this research. A reflection on the quality of the research is provided. A series of recommendations to individual service providers, mental health services and mental health policy are made. Areas for future research are outlined with a plan for knowledge translation of the research findings.
6.1 Key Points from Findings

The key objective of this occupational therapy programme was to offer participants the opportunity to explore the concept of self-esteem in the context of their lives. It aimed to build positive self-esteem through the use of meaningful creative occupations. From the outset, the design aimed to promote social interaction and sharing of experience. The findings of the research indicate that the activities and facilitation of the programme offered participants many opportunities to explore self-esteem and mental health. The positive impact of engaging in creative occupations for self-esteem is evident.

There are a number of salient processes that contributed to the positive outcomes for participants. A key process was the design of the intervention from the outset as a responsive intervention that was based on presenting need. As is demonstrated, the development of an aspect of service solely for women in this case has worked very well for participants. Another central process was the preparation of participants through the use of the initial interview. This lead to the development of personally meaningful goals and promoted a sense of ‘readiness’ that facilitated greater participation. The careful planning and design of each creative occupation and the associated environment was also instrumental in shaping experience. The use of a graded approach from simple group activities such as the word cloud and feel good collage to more personally demanding and reflective tasks such as the personal advert ensured personal and group development through the process. The level of choice inherent in each part of the programme facilitated empowerment, a key element of the recovery ethos, at all times.
An area of difference present in this research is the method of facilitation. Participatory facilitation offered an alternative approach that contributed to the successes of the programme from the perspective of participants. It challenges the notion of “other” so present in service delivery today. The ability of the facilitators to engage in and share their own personal recovery journey alongside participants went some way to dissolving the power differential inherent in mental health user provider relationships. This alternative approach to facilitation was characterized simply by participation on the part of the facilitators and allowing themselves to acknowledge and demonstrate their own vulnerability. It questions what it means to be a recovery-oriented practitioner and what constitutes the therapeutic use of self in occupational therapy interventions.

The use of a qualitative methodology answers important questions relating to what constitutes meaningful evaluation in mental health research. This is particularly relevant in attempts to measure our understanding the personal experience of mental health recovery. As a contested concept it challenges service providers and policy makers to strive to better understand how to define and subsequently capture and facilitate recovery outcomes for those using services. Greater clarity needs to be provided for practitioners as to what A Vision for Change (DOHC 2006) means when it calls for “more meaningful research”. Using a qualitative method that centralises the experience of the individual strives to aim towards a recovery ethos in the research design.
This project has demonstrated the learning that is available to occupational therapy in mental health through using qualitative methodology. The myriad of factors that influence mental health and well-being are well documented and can be explored and better understood using this type of approach. Using the experiences of participants to understand the outcomes of the workshop programme has offered a depth of understanding that cannot be obtained through more traditional quantitative approaches.

A central finding in the research is the reinforcement of the value of meaningful engagement in occupation to good mental health. Also reinforced is the potential therapeutic value of creative occupations as therapeutic tools. The use of creative occupations in this research provided scope for a variety of processes that facilitated outcomes for participants. The occupations facilitated exploration of individual and group experiences, promoted discussion, provided opportunities for learning while also enhancing self-esteem. The use of the CHIME framework (Leamy et al. 2011) demonstrated how the use of creative occupations had the potential to facilitate each of the key processes defined as essential to recovery-oriented service provision. In using this framework congruence between occupational therapy practice and recovery was explored. This research demonstrated the potential links between occupation-focused practice and recovery.

6.2 Quality

Quality is important in all research to ensure the integrity of the outcomes. It is particularly important in qualitative research which is often considered softer
research. In this project quality reflects my ability to adhere to the principles of ethics, credibility and trustworthiness and to make a valuable contribution to the evidence. It is also demonstrated through the acknowledgement of the limitations of the project.

By its nature qualitative research is time and resource intensive. This project has demonstrated the commitment required to carry out a research project to this level. This is an important consideration in recommendations for research in practice into the future. An obvious element that would have had the potential to augment the research would have been increased service-user participation from the outset. An action participatory model involving service-users was not excluded, but in the context of limited resources, the project was curtailed to incorporating this perspective as an element of the evaluation. This type of input could have assisted me in making the interview guides more meaningful and relevant to participants. Again it is important to consider how this type of input can be valued and included in future service research. Similarly, the validity of the research would have been strengthened by some form of member checking or verification of findings with participants. A deliberate choice was made in this instance given that the intervention was part of service provision and trying to maintain a balance of not over-burdening participants.

In terms of the contribution to evidence in the field this research is both timely and relevant. More Irish research is required where the principles of recovery are reflected in practice and evaluation. Research in occupational therapy and mental health in Ireland is similarly limited.
6.3 Future Research

Further to this study there are a series of openings for research that relate to occupational therapy practice, mental health services for women and recovery-oriented service provision. At a practice level it is not always practical or realistic to expect clinicians to engage in in-depth research. There is, however, an expectation that all service providers engage in audit activities to improve and maintain quality services. This research shows how the use of audit resulted in a well-designed, responsive and as a result effective therapeutic intervention. It is recommended that occupational therapists regularly engage in audit that examines the needs of service-users so that services can be developed in a manner that is responsive to emerging need.

Mental health services would benefit from using a recovery framework such as CHIME to develop and evaluate services that are intended to be recovery orientated. Similarly, occupational therapists need to demonstrate the value of their practice in the mental health setting from a recovery perspective. The strong theoretical congruence between occupational therapy and recovery needs to be challenged and explored to see if this exists in practice. This research and further research that explores the use of occupation in the Irish context is necessary.

There is scope for further exploration of what it means to be a recovery-oriented practitioner and the influence of participatory facilitation in particular in group settings. In occupational therapy further exploration of the concepts of “client-centred practice” and “therapeutic use of self” would benefit from this type of inquiry.
The best way to develop more appropriate methods of service evaluation is to include the expertise of service-users and their family members in the design of appropriate tools and interpretation of results. Their knowledge of what constitutes “good” services ensures asking the right questions in the right way. Participatory action projects that collaborate with service-users and family members should be promoted in mental health services to facilitate service development.

6.4 Recommendations

A series of recommendations that emerge from this research are made at a number of levels. These are made directly to occupational therapists, mental health service managers and mental health policy.

6.4.1 Occupational therapists

Occupation focused practice

Occupational therapists need to re-engage with the core skills of the profession and to demonstrate the value of their practice in the mental health setting in a meaningful way. As an occupational therapy manager in mental health services I regularly receive requests from staff to complete CBT training, mindfulness training, among others. I am aware of similar patterns among my colleagues across the country. The lack of confidence of the profession of occupational therapy in its core activity in Ireland is evident. Occupational therapists, need to re-engage with the core tools of the profession and know that carefully planned occupation focused interventions have powerful transformative potential in mental health.
Recovery and occupational therapy

The strong theoretical congruence between occupational therapy and recovery in mental health requires exploration to understand how it exists and plays out in practice. There needs to be an engagement with concepts of recovery as practice is evaluated. Consideration of what it means to be a recovery-oriented practitioner should form part of occupational therapists’ continuing professional development and reflective practice. This research has shown how a novel approach to the delivery of a programme raises questions as to what it means to be a recovery-oriented therapist. It challenges the boundaries commonly associated with mental health practice and the notion of “therapeutic use of self” extending the possible understanding of this concept.

Planning and Design

It has been demonstrated how key elements of planning and design on the part of the facilitators contributed to outcomes in this programme. The pre-programme interview in particular allowed participants to commence at a different level facilitating better outcomes. For occupational therapists planning group interventions in particular it is important to consider the importance of this element of the programme.

Expertise

A key element in recovery-oriented service provision and in client-centred practice is the recognition of the expertise inherent in the experience of the service-user. Throughout the programme participants used their own experiences to help each other which facilitated positive outcomes. Occupational therapists need to acknowledge the limitations of their expertise and be open to working with the expertise of those who
use our services. A natural progression for this intervention would be for the next programme to be co-facilitated by an occupational therapist and service-user who had previously completed the programme.

6.4.3 Mental health service managers

Responsive services
This research has demonstrated how an accurate assessment of service-users’ needs through the use of an audit facilitated the development of a meaningful programme. Too often services are delivered in response to new ideas or because it is “what we have always done” as opposed to being based on an accurate assessment of need. In basing the intervention on the outcomes of an audit facilitators were able to carefully design the programme. Similarly this work responded to the identified needs of women. Mental health service managers need to consider the gendered needs of the service-user population to develop and provide more meaningful and accessible services.

Service evaluation
The potential of using a qualitative approach to service evaluation in mental health is reflected in this research. The depth of understanding realised through the process greatly enhances the comprehension of the experience of service-users and what facilitates their recovery. The information obtained through qualitative research needs to be valued and acted upon by services. Clinicians and managers should be encouraged to explore their practice and services using these methods.

Service-user participation
Mental health service managers are in the position to advocate for increased service-user and family member participation in services. Recognition of the expertise associated with self-experience has the potential to lead to a point where service-users are integral members of community mental health teams and service management teams. This would promote an equality in expertise not previously recognised in services in Ireland.

6.4.4 Mental Health Policy

Definition of recovery
It has been demonstrated in this project that the subject of recovery is contested in mental health. Policy documents require clarity in the definitions and associated expectations regarding recovery and what constitutes recovery-oriented practice.

Participation and expertise
The process of acknowledging and valuing expertise by experience has commenced in Ireland with the appointment of a national director of service user and family engagement at the National Mental Health Division. The next step is to create the structures to mirror this locally. Through these types of developments effective participation and collaboration on service development can occur.

Meaningful evaluation
National service management and policy makers need to re-define what constitutes evaluation of services. Service development should be built on meaningful outcomes for service-users as opposed to based on numbers of beds, clinic attendances and
matrices on risk management. Qualitative approaches that can explore these outcomes need to be promoted and valued at national level.

6.5 Knowledge Translation Activities and Future Dissemination Plan

One of the key knowledge translation activities for this research will be to disseminate the findings and understandings to occupational therapists in Ireland. This can be facilitated through oral presentation at Association of Occupational Therapist of Ireland (AOTI) Mental Health Advisory Group Study Days that happen twice yearly. There is also the option to present at national AOTI conference, an annual event. It is also anticipated that the findings of the research will be published in peer reviewed journal articles.

In terms of feedback to the services there is the opportunity to present at a service development initiative that occurs at the end of 2016. This new initiative focuses on quality and recovery-oriented practice in the Mid West. As an integral member of the local Advancing Recovery in Ireland project group I am in a position to lead on recovery-oriented practice initiatives and already use my learning from engagement in research to facilitate this.

The programme has already been facilitated twice since the original research group. Once was with adult women service users through the mental health services in Limerick. It was facilitated by a local occupational therapist and a student on final clinical placement. The programme was changed according to interim findings in the research, including lengthening it by two workshops to include focus on mental health.
and well-being and future considerations as advised by the participants in this research. The second time the programme was facilitated was with teenage girls. The creative occupations were changed to respond to the demographic. Photography and the creation of a magazine cover to advertise oneself was very successfully used. I recently met with two peer support workers at our local peer support centre and intend co-facilitate the programme with one of them at their centre over a series of evenings in September 2016.
References


Bordin, E. S. (1979) 'The generalizability of the psychoanalytic concept of the working alliance', *Psychotherapy: Theory, Research & Practice*, 16(3), 252-260.


HSE (2014b) National Consent Policy, HSE Dublin.

HSE (2016) Mental Health Division Operational Plan 2016, Dublin: HSE.


Lawson, J., Reynolds, F., Bryant, W. and Wilson, L. (2014) 'It's like having a day of freedom, a day off from being ill': Exploring the experiences of people living with mental health problems who attend a community-based arts project, using interpretative phenomenological analysis', Journal of Health Psychology, 19(6), 765-777 13p.


Mental Treatment Act 1945, 1945, Ireland.


Appendices

Appendix 1 Participant Interview Guide Pre Intervention

As you know my name is Niamh Wallace and I am an occupational therapist.

The purpose of the workshops is to understand the experience of self esteem for women who use mental health services and to help the participants to explore how what you do impacts on your experience of self esteem. The research is evaluating your experiences of participating in the workshop programme.

Before we begin:

- To ensure that we aren’t disturbed during the interview I am going to turn off my mobile phone. Can you do the same? We should not be disturbed during the interview but if we are I will turn off the voice recorder to deal with the interruption.

- Feel free to interrupt or ask for more information and let me know if you need to take a break during the interview.

- If I take notes during the interview it is form me to use as a prompt as part of a question – to assist my memory

- I am interested in your opinions and personal experiences, there are no right and wrong answers to the questions.

Is that ok?

Again, can I please have your permission to record this interview?

Warm Up Questions

- How did you hear about the workshops?
- Tell me about your interest in participating in the programme
  - what attracted you to take part?
  - had you taken part in anything like this before?
- What are your expectations of the workshops?
  - do you think they will help you?
  - in what way?

Self Esteem and “Doing”

- As an occupational therapist I am particularly interested in the influence of what you do on your mental health and how you feel about yourself. Tell me about how you spend a typical day – week/weekend (use time sheet prompt)
- Tell me about things that you enjoy doing.
How do you feel when you are doing these things?

- Does what you do or how you spend your time impact on how you feel about yourself? In what way?
- Tell me about things you do that boost how you feel about yourself.
- Tell me about things you do that might make you think negatively about yourself.

**Defining Self Esteem**

- Tell me in your own words how you would define self esteem.
  (Use pen/paper as appropriate)
- What words/ideas do you associate with positive self esteem?
- What words/ideas do you associate with negative self esteem?
- Do you think that your mental health difficulties have shaped how you feel about yourself? In what way?
- From talking to others I understand that other things can influence how we feel about ourselves. What other kinds of things impact on your self esteem – positively/negatively? Give examples as prompts, e.g. life experience, relationships, education etc.

**Group Work**

- As you know the workshops will involve working with a group of women – is this the first time that you have participated in a group?
- Tell me about your other experiences of taking part in a group.
  - What kinds of groups were they
  - When were they, what about recent experiences
  - What were the good things about being part of those groups?
  - How did being part of the group influence your mental health and well-being?
- For me taking part in groups has good parts and difficult parts. Do you think there are challenges/difficulties in working in groups?
- What are you looking forward to about working in a group of women?

What would you like to achieve from the workshops?

Is there anything else you would like to add?
### Appendix 2 Programme Guide

**Name/Type of Group:** Self Esteem Group for Women

**Resources for Ideas:** Previous experience of successful workshops, service audit, occupational therapists, service users.

**Rationale**

<table>
<thead>
<tr>
<th>Present state of clients</th>
<th>Women with mental health difficulties, users of the mental health services who experience low self esteem and self confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evidence of Need</strong></td>
<td>It has been observed within mental health services that female service users have low self esteem</td>
</tr>
<tr>
<td></td>
<td>Literature – indicates that women with mental health difficulties experience lower self esteem than men</td>
</tr>
<tr>
<td></td>
<td>Previous positive experience of running the programme</td>
</tr>
<tr>
<td></td>
<td>Several references/queries re when it is running again</td>
</tr>
<tr>
<td></td>
<td>Identified in care plans e.g. CASIG</td>
</tr>
</tbody>
</table>

**Occupational Performance Area**

Social participation, self-care, leisure activities, occupational performance patterns, transformation through doing

**Frame of reference**

Psychosocial

**Activities to be used**

Creative activities, discussion, reflective activities – group and individual

**Evaluation/Outcome Measurement**

Research

**Group Aim**

To facilitate clients to explore the concept of self esteem and build positive self esteem through the use of meaningful creative occupations in a supportive environment.
Group Goals

1. To provide opportunities for social interactions with other group members – through shared activities
2. To develop therapeutic relationships with clients by ensuring they feel comfortable in the group
3. To provide a creative medium for self reflection and to facilitate clients in exploring the meaning of self esteem within their own lives
4. To produce a personal piece of artwork to bring home
5. To produce a personal piece of jewellery to bring home
6. To explore how engagement in occupation facilitates positive self esteem
7. To build positive self esteem through the process of engagement in the workshops

Group structure

- Four sessions of two hours each to be held over two weeks
- Up to ten participants and two facilitators to attend plus one guest facilitator
- Groups to be held in the rehabilitation centre St. Josephs

Resources/Materials/Equipment

Facilitators: Occupational Therapist x 2

Guest Facilitator: VEC Tutor

Venue: Music room in Rehab – prep layout – chairs, flip chart, table

Tea and coffee making facilities to be made available for each session

Materials: Flip chart, markers, check requirements for each session

Leader/Co-Leader Style/Role: Facilitative & participative

Session 1

Time: Monday 14\textsuperscript{th} October 10.30-12.30

Venue: Rehabilitation Centre

Materials
<table>
<thead>
<tr>
<th>Item</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flip-Chart &amp; Marker</td>
<td>Niamh</td>
</tr>
<tr>
<td>Time use chart</td>
<td>Niamh</td>
</tr>
<tr>
<td>Post its</td>
<td>Niamh</td>
</tr>
<tr>
<td>Pens</td>
<td>Niamh</td>
</tr>
<tr>
<td>Cards printed with words from interviews</td>
<td>Niamh</td>
</tr>
<tr>
<td>Glue</td>
<td>Niamh</td>
</tr>
<tr>
<td>Blue Tack</td>
<td>Niamh</td>
</tr>
<tr>
<td>Pictures of Doing</td>
<td></td>
</tr>
<tr>
<td>Paper</td>
<td></td>
</tr>
<tr>
<td>Kettle/cups/milk/tea/coffee/biscuits</td>
<td></td>
</tr>
<tr>
<td>Cushions/throws/tablecloths/candles</td>
<td></td>
</tr>
</tbody>
</table>

**Objectives:**

1. To build a rapport with the clients
2. To facilitate the development of peer support through group work
3. Developing social skills be facilitating group interactions
4. To explore the meaning of self esteem for this group of women
5. To produce a plan for following sessions
6. To develop ground rules for the group
7. To build an atmosphere of trust in the group
8. To explore the relationship between occupation and self esteem
9. To provide opportunities for clients to transfer occupational knowledge into their daily lives
10. To set individual goals
<table>
<thead>
<tr>
<th>Stage</th>
<th>Plan</th>
<th>Person</th>
</tr>
</thead>
</table>
| Preparation of self   | Meet together to prepare for the group – discuss leadership roles at discreet points  
Meet Niamh prior to group to obtain relevant information from initial interviews | Jane Aoibhin   |
| Preparation of room   | Set out chairs in a circle  
Bring in and fill kettle/cups/milk/tea/coffee  
Set up flip chart and markers  
Paper  
Glue/blue tack/postits  
Pictures  
Table cloths/candles/throws/cushions |                |
| Introduction/Orientation 5 mins | Why we are here – shared experiences as women/therapeutic use of self/developing trust quickly  
Set out ground rules – facilitate  
To include:  
Respect for each other/ourselves  
Mobile phones switched off  
Try to be on time  
Listening to each other  
Confidentiality of the group  
Any other rules……. |                |
<p>| Warm-up 10 mins       | Break up into pairs. Talk to your partner for 5 minutes. Introduce your partner and tell the group 3 things that you have learned about them |                |
| Aims of the group      | As occupational therapists we believe that being active and doing things that are meaningful to you is good for you. This groups aims to help you to build positive self esteem through doing creative, social and feel good activities and through shared |                |</p>
<table>
<thead>
<tr>
<th>Women/mental health and self esteem</th>
<th>An acknowledgement of the impact of the experience of mental health difficulties on how we feel about ourselves – brief discussion/putting it out there</th>
</tr>
</thead>
</table>
| Main Activity 30 mins             | Card Activity – what does self esteem mean to you?  
Participants will select words from a stack of word cards and stick them on the wall under “positive” and “negative” headings and discuss  
Indicate that the words have been obtained through the “pre” interviews |
| Break 30 minutes                  | Picture Activity – Doing and feeling good  
Break into two groups – each group with stack of pictures or magazines. Individuals select pictures to represent activities that make them feel good. Group produces collage of healthy “doing” and add words and feedback to the group about the meaning |
| Close 5-10 mins                   | Time use charts – Participants fill out what an average day looks like  
Participants asked to circle the activities that make them feel good about themselves.  
What makes you feel good/what is a simple change?  
Make plans for next session – jewellery making and any questions/issues arising? |
| Reflection                         | Complete reflection sheet |
Time for discussion with co-facilitator
Query changes/requirements for next session

Session 2

Time: Wednesday 16th October 2pm-4pm
Venue: Rehabilitation Centre

Materials

<table>
<thead>
<tr>
<th>Item</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flip-Chart &amp; Marker</td>
<td></td>
</tr>
<tr>
<td>Time use charts</td>
<td></td>
</tr>
<tr>
<td>Pens</td>
<td></td>
</tr>
<tr>
<td>Camera</td>
<td></td>
</tr>
<tr>
<td>Kettle/cups/tea/coffee etc</td>
<td></td>
</tr>
<tr>
<td>Jewellery making equipment</td>
<td>Irene</td>
</tr>
</tbody>
</table>

Objectives

1. To continue to stimulate group interactions
2. To build a rapport with clients
3. To stimulate reflective thinking about the group and subject through doing creative occupations
4. Develop and encourage creativity through jewellery making
5. To facilitate opportunities for enhancing clients’ self esteem by participating in a group, developing friendships, learning new skills, communicating with others and having fun
### Plan

<table>
<thead>
<tr>
<th>Stage</th>
<th>Plan</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of self</td>
<td>Meet with co-facilitator – discuss roles and responsibilities for today’s session</td>
<td>Tanya &amp; Deirdre</td>
</tr>
<tr>
<td>Preparation of room</td>
<td>Set out chairs and tables for activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tea coffee etc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greet facilitator and help with set up</td>
<td></td>
</tr>
<tr>
<td>Introduction / orientation</td>
<td>Recap on last session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time use charts – anyone try new activities or changes?</td>
<td></td>
</tr>
<tr>
<td>Main activity – 1¼ hours</td>
<td><strong>Jewellery making</strong></td>
<td>Irene</td>
</tr>
<tr>
<td>Break</td>
<td>Jewellery making – sharing at end</td>
<td></td>
</tr>
<tr>
<td>Closure</td>
<td>Take pictures of end product – hands?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Make plan for next session</td>
<td></td>
</tr>
</tbody>
</table>

### Session 3

**Time:** Monday 21<sup>st</sup> October 10.30-12.30

**Venue:** Rehabilitation Centre

**Materials**

- Self esteem magazines – QUERY USE
- Sheets of A4 paper & pens
- Large sheets of paper
- Envelope for word game
- Magazines/Flowers
- Camera
Objectives

1. To continue to stimulate group interactions
2. To provide a forum for peer exchange and support
3. To stimulate reflective thinking about self esteem and doing through creative occupations
4. To consider affirmations in relation to self esteem and explore same using a creative medium
5. To facilitate opportunities for enhancing clients self esteem by participating in a group, developing friendships, communicating with others and having fun
<table>
<thead>
<tr>
<th>Preparation of self</th>
<th>Meet with co-facilitator</th>
<th>Deirdre &amp; Tanya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of room</td>
<td>Set out chairs and tables</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kettle, tea coffee etc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Music &amp; speakers</td>
<td></td>
</tr>
<tr>
<td>Introduction/orientation</td>
<td><strong>Word game</strong></td>
<td></td>
</tr>
<tr>
<td>20 mins</td>
<td>Participants select a slip of paper from the envelope and everyone must answer the question on it about themselves</td>
<td></td>
</tr>
<tr>
<td>Recap</td>
<td>Where have we come to?</td>
<td></td>
</tr>
<tr>
<td>20 mins</td>
<td><strong>Self Esteem Magazine</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer back to poster of positive words – everyone writes words into their own book</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer back to collage of positive doing – everyone writes feel good activities into their own book</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer back to poster of negative words, think about what challenges you – everyone writes things that challenge them into their book</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How do I counteract the challenges with the positive things</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jewellery making – recap – what was good about it/what did you learn from the experience?</td>
<td></td>
</tr>
<tr>
<td>10 min</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>Main activity</td>
<td><strong>Flowery Affirmations</strong></td>
<td></td>
</tr>
<tr>
<td>1hr 15mins</td>
<td>Introduce concept of affirmations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Everyone comes up with a self talk phrase</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two group – the groups work together to write in flowers on the big sheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Take photos of each individual one – for framing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At the end of the activity participants write self-talk phrases into their own books</td>
<td></td>
</tr>
</tbody>
</table>

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### Session 4

**Time:** Wednesday 23rd October 2pm-4pm  
**Venue:** Rehabilitation Centre

#### Materials

<table>
<thead>
<tr>
<th>Item</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self esteem magazines from last session</td>
<td></td>
</tr>
<tr>
<td>Prepared adverts</td>
<td></td>
</tr>
<tr>
<td>Pens, glue, scissors</td>
<td></td>
</tr>
<tr>
<td>Large sheets of brown paper</td>
<td></td>
</tr>
<tr>
<td>A4 sheets of paper</td>
<td></td>
</tr>
<tr>
<td>Magazines, pictures</td>
<td></td>
</tr>
<tr>
<td>Compliment sheet</td>
<td></td>
</tr>
<tr>
<td>Kettle, tea, coffee etc</td>
<td></td>
</tr>
<tr>
<td>Camera</td>
<td></td>
</tr>
<tr>
<td>Photo frames</td>
<td>Niamh</td>
</tr>
<tr>
<td>Goodie bags Debenhams</td>
<td>Niamh</td>
</tr>
</tbody>
</table>

#### Objectives

1. To continue to stimulate group interactions  
2. To continue to provide a forum for peer exchange and support  
3. To stimulate reflective thinking about self esteem and doing through creative occupations  
4. To identify and accept positive things about ourselves  
5. To offer an opportunity to share what we have learned about each other in a positive way  
6. To provide opportunities for enhancing client’s self esteem by participating in a group, developing friendships, communicating with others and having fun  
7. To provide opportunities for the women to continue the group  
8. To provide the goody bag to encourage self rewarding behavior.

### Plan
<table>
<thead>
<tr>
<th>Preparation of self</th>
<th>Meet with co-facilitator and assign tasks for the group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of room</td>
<td>Set up chair, tables, cushions etc</td>
</tr>
<tr>
<td></td>
<td>Music &amp; speakers</td>
</tr>
<tr>
<td></td>
<td>Kettle, cups, tea coffee etc</td>
</tr>
<tr>
<td>Introduction/orientation</td>
<td>Compliments – I like you because…. – getting each person to write one compliment about each other. Stick sheet onto back so can’t see till end.</td>
</tr>
<tr>
<td>15 mins</td>
<td>Based on compliments received each person will pick one compliment and share it with the group – why is it meaningful for them?</td>
</tr>
<tr>
<td></td>
<td>Give this time – it can be a very moving activity for people</td>
</tr>
<tr>
<td>Advertisements</td>
<td>What is an ad? What kind of ads are aimed at women? Have examples, discuss them….</td>
</tr>
<tr>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>Continue advertisements activity</td>
<td>Making my Ad</td>
</tr>
<tr>
<td></td>
<td>The individual’s task in this activity is to come up with and advertisement describing/selling the positive aspects of themselves (recap from word game if having difficulties)</td>
</tr>
<tr>
<td></td>
<td>Name e.g. Notoriously Nice Niamh</td>
</tr>
<tr>
<td></td>
<td>Picture – pic that represents you</td>
</tr>
<tr>
<td></td>
<td>3-5 key points</td>
</tr>
<tr>
<td></td>
<td>Present your ad to the group</td>
</tr>
<tr>
<td>Closure</td>
<td>Recall individual aims of the group members from the first session</td>
</tr>
<tr>
<td></td>
<td>Discuss how far we have come</td>
</tr>
<tr>
<td></td>
<td>Hand out photo frames and goody bags</td>
</tr>
<tr>
<td></td>
<td>Discuss how to continue the group</td>
</tr>
</tbody>
</table>
Appendix 3 Reflective Guide Facilitators

To be completed by the facilitator at the end of each workshop session

<table>
<thead>
<tr>
<th>Workshop No.</th>
<th>Brief summary of content</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What were the best things about today’s workshop?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What didn’t go so well?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What would I change for future sessions?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the group working well together – what can I do to facilitate this?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Did anything surprise me about today?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Are the chosen occupations working well for the group?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Any further comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
## Appendix 4 Daily Time Chart

### Time Use Chart

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Alone</th>
<th>With Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.00 – 06.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08.00</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>09.00</td>
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<td></td>
<td></td>
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<tr>
<td>10.00</td>
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<tr>
<td>11.00</td>
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<td></td>
<td></td>
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<tr>
<td>12.00</td>
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<tr>
<td>13.00</td>
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<td></td>
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<tr>
<td>14.00</td>
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<td>15.00</td>
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<td>18.00</td>
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<td>19.00</td>
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<td>21.00</td>
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<td>22.00</td>
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<tr>
<td>23.00</td>
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<tr>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5 Excerpts Self Esteem Journal

My Self Esteem Journal

Self Esteem Journal

Contents

1. Self Esteem – Feel Good Words

2. My feel good activities

3. Time Use Chart

4. What challenges me? How do I counteract it?

5. My jewellery

6. Compliments & Affirmations

7. Things that I am Grateful for

8. Blank Pages/Notes

216
Self Esteem
Feel Good Words

Can't
Can
My feel good activities

Challenges and Counteracts

<table>
<thead>
<tr>
<th>What challenges me?</th>
<th>What can I do to make this better?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
My jewellery

I trust my inner wisdom
Compliments & Affirmations

Things that I am grateful for
Appendix 6 Participant Interview Guide Post Intervention

As you know my name is Niamh Wallace and I am an occupational therapist.

The purpose of this research project is to understand the experience of self esteem for women who use mental health services. It also to explore how what you do impacts on your experience of self esteem.

Before we begin:

- To ensure that we aren’t disturbed during the interview I am going to turn off my mobile phone. Can you do the same? We should not be disturbed during the interview but if we are I will turn off the voice recorder to deal with the interruption.

- Feel free to interrupt or ask for more information and let me know if you need to take a break during the interview.

- If I take notes during the interview it is form me to use as a prompt as part of a question – to assist my memory

- I am interested in your opinions and personal experiences, there are no right and wrong answers to the questions.

Is that ok?

Again, can I please have your permission to record this interview?

Warm Up Questions

- You have attended the workshop programme on self esteem for women. How may sessions did you attend?
- The sessions were held in the rehabilitation centre in St. Joseph’s Hospital, what did you think of that space?
- All of the sessions included a warm up activity, discussion and a variety of creative activities. How did you find the structure of the workshops? Is there something we could have done differently that you think would have helped things to flow better?

The workshop sessions

- There were 4 workshops in total over 2 weeks. Was there a particular session that you really liked, why?
- Tell me about the different occupations/activities that you did in the workshops – what ones did you like and why?
- Were there any activities that you didn’t like as much? Why?
- Were there any parts of the workshop programme that were surprised by (unexpectedly enjoyed)?
**Group work**

- This set of workshops was group based. What was that like for you? Did your feelings about this change over time?
- Each session involved a good bit of sharing. Tell me about hearing others experiences and sharing your experiences.
- Some people really enjoy group sessions and others find them quite complicated. What are your thoughts?
- Was there anything that was unique about working with this group of women? Was there anything special about it?

**Defining Self Esteem**

- Has how you would define self esteem changed since participating in the workshop programme?
- Has how you feel about yourself changed? What has changed?

**“Doing” and Self Esteem**

- The workshops included activities and discussions regarding how our self esteem is affected by what we do on a daily basis – what did you think of these discussions?
- Have you a greater awareness of this in your life?
- Have you made any changes/considered any changes in what you do as a result of the workshops?
- Has your daily routine changed – tell me how you spend your time – week day/weekend.
- Did you discover anything new that you enjoy doing as a result of the workshops?

What was your favourite thing about the workshops?

What would you change about the workshops?

Have you anything else you would like to add?
Appendix 7 Facilitator Interview Guide Post Intervention

As you know my name is Niamh Wallace and I am an occupational therapist.

The purpose of this research project is to understand the experience of self esteem for women who use mental health services. It also to explore how what you do impacts on your experience of self esteem.

Before we begin:

• To ensure that we aren’t disturbed during the interview I am going to turn off my mobile phone. Can you do the same? We should not be disturbed during the interview but if we are I will turn off the voice recorder to deal with the interruption.
• Feel free to interrupt or ask for more information and let me know if you need to take a break during the interview.
• If I take notes during the interview it is form me to use as a prompt as part of a question – to assist my memory
• I am interested in your opinions and personal experiences, there are no right and wrong answers to the questions.

Is that ok?

Again, can I please have your permission to record this interview?

Warm Up Questions

• You are a qualified occupational therapist – can you tell me how long you are qualified and the areas you have worked in to date?
• Tell me how you became involved in the workshop programme for women on self esteem.
• Were you involved in the establishment of the group – in what capacity?
• What were the aims in establishing the group?
• How did you feel about it before you became involved?
• What attracted you to the project?
• Have you facilitated workshops like this in the past?

I am aware that you kept a reflective log after each workshop session. This may help you in answering the questions that follow.

Workshop sessions

• The workshops took place in the Rehabilitation Centre in St. Joseph’s hospital, how did you feel about this space?
• How did the structure of the workshops work for you as a facilitator – i.e. the use of activities to promote discussion, to promote reflection and to develop self esteem?
• Is there anything that you would change about the structure of the workshops to make them work better?
• Do you think that 4 x 2 hour sessions was adequate to meet the aims and objectives of the programme?
• What are the things that worked well from a structure point of view; what would you change?

Group Work

• Have you experience of facilitating group work?
• What types of groups have you facilitated in the past?
• For you what are the components of groups that make them a useful therapeutic tool?
• How did the participants in the group respond to working as a group?
• Were there any challenges associated with working with this group?
• What were the successful components of groupwork with this group?
• Do you think that the women benefited from sharing their experiences? Why?
• Do you think that women work differently in groups to men?
• What was unique about this group?

“Doing” and Self Esteem

• The workshops focussed on how what we do can affect our self esteem – how successful do you think the workshops were in this regard?
• Tell me about how the activities used promoted discussion.
• Tell me about how the activities used promoted self esteem.
• Tell me about how the activities used promoted reflection.
• Is there a particular activity that you thought was very effective and why?
• Is there a particular activity that you thought didn’t work so well and why?
• Are there other activities/occupations that would work well in these workshops?

Development

• In your own life have you made any changes based on taking part in and facilitating these workshops? Have you learned about your own self esteem?
• Do you think the group has changed how you see yourself?
• Did your reflective log help in the facilitation of the sessions?

Is there anything else that you would like to add?

Do you have any questions?
Feeling Good Through What We Do!

A series of workshops for women

Do you have self esteem difficulties?

Do you find it difficult to do things that make you feel good about yourself?

Do you have low self esteem?

Our group workshops could be just for you!

How does it work?

These workshops are run by the occupational therapy department. In the workshops activities will be used to help promote discussion, develop coping skills and encourage reflection on self esteem issues for women in today's society.

When and where?

Mon 14th & Mon 21st Oct 10.30am to 12.30pm
Wed 16th & Wed 23rd Oct 2.00pm to 4.00pm
Rehabilitation Centre, St. Joseph's Hospital, Mulgrave Street, Limerick.

Interested?

If you are interested in taking part in these workshops please contact:
Niamh Wallace, Senior Occupational Therapist
087-6618981.

Research Project

There is a study about your experiences of the workshops. The research involves taking part in an interview before and after the workshops and being in a focus group at the end. You can participate in the workshops without being in the study. Ask Niamh for further information.
Appendix 9 Information Leaflet

Participant Information Sheet

Title of Project: Feeling good through what we do – Exploring the impact of workshops on self esteem for women with mental health difficulties

Introduction

You are invited to take part in a study to explore the impact of a series of four workshops on self esteem for women who use the mental health services. This study is conducted by Niamh Wallace, Senior Occupational Therapist with the Limerick Mental Health Services.

Procedures – What's involved

The research involves:

- Taking part in two interviews. On interview before the workshops take place and another interview when the workshops are completed.
- The interviews will last for no more than 60 minutes and will be digitally recorded.
- The interview will take place in a room in your day hospital at a time that is convenient for you.
- If you wish, a summary of the key points from your interview will be sent to you to review and comment on within four weeks of the interview.
- You are also invited to take part in a focus group after the workshop programme. This focus group will enable everyone who took part in the workshops to discuss their experience. This discussion will be digitally recorded.

Benefits

There may be no direct benefits to you from taking part in the study. However, the information you provide will help us to make the workshops better for the next group of women.

Risks

There is little risk with taking part in this study. You may feel awkward discussing self esteem. If this is the case you can take a break or stop the interview at any time. All the information from your interview will be kept private. Given that there are several people in a focus group we encourage everyone to keep the details from this discussion private as well.
Anonymity & Confidentiality

Your name will be kept private. You will be asked to tell us a fake name to use instead of your real name. The only details that we will share with others is the location of the group (Limerick Mental Health Services). All information will be stored in secure filing cabinets and password protected and encrypted computer files. Only the researcher, Niamh Wallace, will have access to the information collected.

Voluntary Participation

You will be asked to sign a consent form to take part in the study. You may chose to withdraw from the project at any time without any consequences or explanation. If you withdraw from the study, interviews already done will only be used if you agree.

Sharing of the Results

If you wish, a summary of the findings from the project will be sent to you. There may be talks in Ireland and abroad and a paper written about this project. This results of this study will be used to inform future research.

Contact Name and Project Investigators

You may contact:

Niamh Wallace, Senior Occupational Therapist, niamhp.wallace@hse.ie; 061-461500

If you have any concerns about this study and wish to contact someone independent, you may contact:

Ms. Cynthia Carroll
Occupational Therapy Manager,
Limerick Mental Health Services,
St. Ann’s Day Hospital,
Roxborough Road,
Limerick
Cynthia.carroll@hse.ie
Appendix 10 Field Note Guide

Interviewer:

Participant:

Date of Interview:

1. Describe the environment where the interview took place in as much detail as you can (e.g. time, space, lighting, sound)

2. Describe the participant in as much detail as you can (e.g. appearance, body language, tone of voice, comfort level)

3. Describe the interview process (e.g. flow, depth of participant responses, rapport, change over the course of the interview)

4. Were there any unexpected interruptions that need to be explained to the transcriber?

5. Think back over the interview. Were there any keywords or phrases used by the participant that struck you in some way? If so, list them here.

6. Summarise the key points from this interview in 2-3 paragraphs

7. Consider your main interview question. In what ways does this interview help you respond to this question?

8. Now think about the aims of your study. Describe how this interview connects to those aims.

9. Now turn your attention to your own experience of the interview itself. How did you respond throughout the session? Did you hear pretty much what you expected to hear? If so, explain. Did anything about the participant’s experience surprise you or make you feel uncomfortable? If so explain.
Transcriber Confidentiality Agreement

“Feeling good through what we do”

I, ___________ , transcriber, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Niamh Wallace in relation to her research study “Feeling good through we do”. Furthermore I agree:

- To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio taped interviews.
- To not make copies of any audio files of the recorded interviews.
- To not make copies of any of the computerized files of the transcribed data.
- To store the encrypted memory stick and any other research related materials in a safe, secure (locked) location as long as they are in my possession.
- To return the encrypted memory stick and any other research related materials to Niamh Wallace in a the timeframe agreed.
- To delete any transcripts from my computer hard drive when complete.
- I have read and understand the HSE policy regarding safe use and storage of encrypted memory sticks (Appendix).

I understand that a copy of this document will be held both by the principal investigator and the HSE ethics committee.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access. If there is any breach of any of the above items, this work relationship will be terminated immediately.

Transcriber’s name: _______________________________________

Transcriber’s signature: ____________________________________

Date: ____________________________  Principal Investigator
Appendix 12 Ethical Approval

6th June, 2013.

Ms. Niamh Wallace,
Senior Occupational Therapist,
Rehabilitation Service,
St. Joseph’s Hospital,
Malgrave St.,
Limerick.

Re/ Protocol Title
Exploring the impact of occupation based workshops on self esteem for women with mental health difficulties.

Dear Ms. Wallace,

I am in receipt of your study as above submitted for review by our Research Ethics Committee. I have reviewed the contents of same.

I wish to advise that I have given your study Chairperson ethical approval.

You should note that your study cannot commence until you also receive approval from the Risk Management Department. You are obliged to inform us as soon as your study is completed or if it terminates early for any reason. This approval will be issued to you shortly.

I wish you every success with your study

Yours sincerely,

Marie Hickey Dwyer,
Consultant Ophthalmic Surgeon,
Chairperson, Research Ethics Committee.
30th July, 2013.

Ms. Niamh Wallace,
Senior Occupational Therapist,
Rehabilitation Service,
St. Joseph’s Hospital,
Mulgrave St.,
Limerick.

Re: Protocol Title
Exploring the impact of occupation based workshops on self esteem for women with mental health difficulties.

Dear Ms. Wallace,

The Research Ethics Committee at the Mid-Western Regional Hospital, Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Research Ethics Committee:

- Application to the Research Ethics Committee
- Appendix 1
- Participant Interview Script – Pre-Intervention
- Participant Interview Script – Post-Intervention
- Facilitator Interview Script – Post-Intervention
- Appendix 2 - Reflective Log – Feeling good through what we do
- Appendix 3 – Poster (A3 Size) Leaflet (same as poster but A4 size)
- Appendix 4 – Participant Information Sheet
- Appendix 5A & B – Participant Informed Consent Form
- Facilitator Informed Consent Form
- Appendix 6 – Script Focus Group

Approved

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions.

Yours sincerely,

[Signature]

Niamh O’Brien,
Clinical Programmes Co-Ordinator,
(For and on behalf of the Research Ethics Committee & the Risk Management Department).
Appendix 13 Consent Forms

Participant Informed Consent Form:
Feeling Good Through What We Do

I, __________________________, am invited to take part freely in a research study evaluating occupational therapy workshops for women who use the mental health services, designed to build self-esteem.

• I have read and understand the volunteer information sheet.

• The purpose of this research is to assess the effectiveness of 4 workshops on self esteem for women who use the mental health services.

• My participation and responses will be kept private at all times. I will not be identified, nor will identifying information about me be reported in any publications or presentations arising from the research.

• I agree that what I say can be included in talks or papers about this research as long as my name is kept private.

• If I agree to participate, I can withdraw at any time without explaining why. It won’t affect Niamh’s work if I choose to stop taking part.

• If I do withdraw from the study I can still remain in the occupational therapy intervention programme.

☐ I agree that my interview can be recorded.
☐ I agree to take part in 2 interviews – one before the workshops and one after the workshops. The interviews will be no more than 60 minutes each.
☐ I would like to have a summary of my interview; sent to me ☐ or emailed to me ☐
☐ I agree that the work created by me and pictures of this work can be used in presentations associated with the research (i.e. pictures, affirmations, collage, jewellery, my card)

I UNDERSTAND THAT BY SIGNING THIS FORM I AM GIVING MY CONSENT TO TAKE PART IN THE STUDY DESCRIBED ABOVE
I was given a copy of this form to keep

Signature of Participant __________________________ Date _______

Printed Name _______________________________

Signature of Researcher __________________________ Date _______

Printed Name _______________________________
Facilitator Informed Consent Form
Feeling Good Through What We Do

I, _______________________________, am invited to take part voluntarily in a research study evaluating occupational therapy intervention for women who use the mental health services on building self esteem through the use of occupation.

- The purpose of this research is to assess the effectiveness of 4 activity based workshops on self esteem for women who use the mental health services.
- I will be involved in facilitating 4 workshops with another qualified occupational therapist over 2 weeks.
- The research involves taking part in one interview following the completion of the workshop programme, this interview will be up to 60 minutes.
- To facilitate the interview I will be asked to keep a reflective log of the group activities following each workshop. This log will not be used as data but is intended to facilitate my recollection of the group experience.
- My participation and responses will be kept confidential at all times. I will not be identified, nor will identifying information about me be reported in any publications or presentations arising from the research.
- My participation in this research is completely voluntary and I am free to refuse to participate.

If I agree to participate, I can withdraw at any time without consequences.

☐ I agree that my interview can be recorded.
☐ I would like to have a summary of my interview sent to me ☐ or emailed to me ☐

I UNDERSTAND THAT BY SIGNING THIS FORM I AM GIVING MY CONSENT TO PARTICIPATE IN THE STUDY DESCRIBED ABOVE

I was given a copy of this form to keep

Signature of Facilitator ____________________ Date _____________
Printed Name ______________________________

Signature of Researcher ____________________ Date _____________
Printed Name ______________________________