University of Huddersfield Repository

Lucock, Mike, Gillard, Steve, Adams, Katie, Simons, Lucy, White, Rachel and Edwards, Christine

Self-care in mental health services: a narrative review

Original Citation

Lucock, Mike, Gillard, Steve, Adams, Katie, Simons, Lucy, White, Rachel and Edwards, Christine (2011) Self-care in mental health services: a narrative review. Health and Social Care in the Community, 19 (6). pp. 602-616. ISSN 0966-0410

Self care in mental health services: a narrative review

Mike Lucock, PhD., South West Yorkshire Partnerships NHS Foundation Trust and University of Huddersfield,

Steve Gillard, PhD., Division of Mental Health, St George's, University of London

Katie Adams, BSc., National Institute for Health and Clinical Excellence

Lucy Simons, PhD., School of Health Sciences, University of Southampton

Rachel White, BSc., Institute of Psychiatry, Kings College London

Christine Edwards, BA MSc FCIPD., Kingston Business School

Address for correspondence:
Mike Lucock
Adult Psychological Therapies Service
South West Yorkshire Partnerships NHS Foundation Trust
APTS, Fieldhead,
Ouchthorpe Lane,
Wakefield,
WF1 3SP,
m.lucock@hud.ac.uk
01924327560
Fax: 01924328661

Running head: Supporting self care in mental health services

Abstract

Self care is an important approach to the management of long term health conditions and in preventing ill health by living a healthy lifestyle. The concept has been used to a limited extent in relation to mental health but it overlaps with the related concepts of recovery, self management and self-help. These related concepts all entail individuals having more choice and control over treatment and a greater role in recovery and maintaining their health and wellbeing.

This paper reviews qualitative empirical research that provides information of the nature of self care in mental health from the perspective of people experiencing mental health problems. The paper also highlights challenges to this approach in mental health and provides a conceptual framework of the relationships between self care support, self care behaviours and strategies, and wellbeing for the individual. It also highlights limitations in the current evidence base, and identifies areas for future research.

Keywords

Key words:
Self care
Mental health
Recovery
Self-help
Self management
Conceptual review

Declaration of interest: None.

Background to self care in health and social care.

The importance of self care has been highlighted in recent years as part of a patient-centred approach in the management of long term health conditions and in preventing ill health by living a healthy lifestyle. Orem (1991) promoted the concept of self care in nursing practice and referred to it as those activities performed independently by an individual to promote and maintain personal wellbeing throughout life. The World Health Organization (WHO) defined self care as "activities individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals." (WHO, 1983). In the UK self care has become an important principle underpinning services for people with long term health needs and includes greater choice and control over care (DH, 2006a,b). The principles of choice, control and shared decision making are also central to the new NHS strategy set out in “Equity and excellence: liberating the NHS” (DH, 2010). Although self care places an emphasis on the individual’s own contribution to their wellbeing, a patient perspective on self care highlights the role of health services in supporting self care: “The NHS cannot do self care to people, but what it can do is create an environment where people feel supported in self care” (DH, 2006a, page 2).

It is important to acknowledge that self care is a normal activity (Chambers, 2006) and most people are motivated to engage in self care. For example, a recent DH/MORI survey in England (DH, 2005a) found that 82% of those who had a long term health condition said they play an active role in caring for their condition, and that more than 9 in 10 people surveyed were interested in being more active self carers. The same survey found that more than 75% of respondents said if they had guidance/support from a professional or peer they would feel far more confident about taking care of their own health, clearly suggesting scope for more professional support to improve effective self care. Despite this, more than half of people who had seen a care professional in the previous 6 months said they had not often been encouraged to self care and a third said they had never been encouraged by the professionals to self care. This provides some evidence of a mismatch between the desire of people to use self care to manage long term health conditions and the self care support provided by professionals. It is therefore important to not only have a better understanding of self care but also to understand how services and professionals effectively support self care (DH, 2005b). These issues are particularly important given that some health care provision may not only fail to support self care but may conflict with the principles of self care.

Evidence base for self care

A review of the research evidence for the effectiveness of self care support across all health problems identified 160 systematic reviews and 240 primary research studies of self care support interventions, covering a range of health problems such as arthritis, asthma, cancer, depression, diabetes, mental health, obesity and pain (DH, 2007). Although at the time of writing this paper the review was in progress, the authors concluded that the evidence supports the view that self care support leads to improved health outcomes and more appropriate use of health and social care services. They therefore recommended that it is important to "…ensure that self care support becomes an integral part of an effective and efficient healthcare system throughout the country" (DH, 2007, page 3). Despite this, Chambers et al (2006) point out that robust evidence of the cost-effectiveness and impact on health outcomes of increased self care by patients is lacking. In relation to mental health, which is the focus for our review, they included a wide range of interventions, including formal psychological therapies, self-help approaches, group and family approaches and various other psychosocial interventions which have been extensively researched (e.g. Roth & Fonagy, 2005). The diverse nature of these interventions illustrates problems understanding self care and what should be considered a self care intervention in relation to mental health. We did not set out to review the effectiveness of self care interventions as we argue that it is necessary to develop a clearer understanding of self care in mental health before the scope of such a systematic review can be defined. There is therefore a need for clarity about what self care is in relation to mental health and for a framework to inform future service developments and research in this area. This is particularly important because we argue that the nature of mental health problems and services means that supporting self care for those with mental health problems presents particular issues and challenges which we will highlight in this paper.

In order to understand self care in mental health it is important to consider the experiences of those with mental health problems. This is self evident in relation to self care but is also consistent with the idea that an evidence base for mental health services should be developed as a partnership of service users with expertise by experience and expertise by professions (Faulkner & Thomas, 2002). This approach is similar with the coproduction of scientific knowledge which is a move away from conventional scientific research towards a model which involves a range of scientific and non-scientific expertise (Gibbons et al, 1994). The WHO definition also highlights the combining of knowledge and skills from both professional and lay experience (WHO, 1983). Consistent with this approach, our review of self care focuses on the experiences of those with mental health problems, which we access through a review of qualitative empirical research studies. This will help address the relative lack of empirical literature describing self care from the perspective of service users, patients, survivors or consumers

Aim and scope of the review

The aim of the review was to understand self care from a mental health service user/ patient perspective. In order to achieve this we carried out a 3 stage review process:

1. A search of the literature on self care, and related concepts, and mental health.
2. A review of qualitative empirical research studies that provide information about the self care in mental health from the perspective of people experiencing mental health problems.
3. Identifying key themes across the studies to understand the concept of self care in relation to mental health.

We will then develop a model of self care in mental health to inform future research and service developments and highlight and discuss how services can support self care.

We decided to focus the review on the broad range of mental health problems, from mild to moderate common mental health problems and more severe and enduring problems such as psychosis. The reason for this was to understand self care across the range of mental health problems in terms of diagnoses and severity, in order to identify elements of self care that apply across this range. We focussed on working age adults, excluding studies with children and older adults because issues central to self care, such as autonomy and responsibility, are potentially different so self care may be different in those contexts.

In order to identify relevant studies we broadened the scope of our search, also looking at literature on the related concepts of recovery, self-help and self management, all of which emphasise a principle similar to that in self care - of the individual having more control and autonomy over their treatment, recovery and lives. This was justified from a preliminary look at the literature which indicated an overlap between self care and these concepts, in terms of identified studies and in a conceptual overlap. The understanding of these concepts in relation to mental health is also more developed than is the case with self care. *Recovery* is a term that has been increasingly used as an over-riding principle in mental health services (e.g. DH, 2001a) and reflects the desire to change negative perceptions of mental illnesses so the prospect of recovery is acknowledged and supported. It emphasises empowerment of individuals to manage fulfilling and meaningful lives and a more positive outlook on restoration, rebuilding, reclaiming or taking control of their lives. *Self management* is mainly used in the context of managing long term health problems and has led to developments such as Co-creating Health which aims to embed self management support within services (Health Foundation, 2008). Rethink, a mental health membership charity, have developed a self management programme and provided a definition of self management as: “whatever we do to make the most of our lives by coping with our difficulties and making the most of what we have” (Martyn, 2002, page 3). Finally, *self-help* approaches in mental health have tended to include more formal interventions such as guided self-help which is recommended by the National Institute for Health and Clinical Excellence (NICE) for mild to moderate anxiety and depression (NICE, 2007, 2009a) and computerised cognitive behaviour therapy (NICE, 2006). These self-help interventions are types of low intensity interventions to be provided in the new Improving Access to Psychological Therapies

(IAPT) services and have been promoted to address long standing problems of access (Richards et al, 2003). Reviews and meta-analyses of efficacy studies of self-help interventions for anxiety and depression provide support for their efficacy (e.g. Gould & Clum, 1993; Scogin et al., 2003). Although self-help and self management are very similar terms, self management has tended to be used to describe strategies people use to manage their lives and their health problems whilst self-help has tended to be used to describe the more structured, professionally led interventions.

Literature review

Although we did not set out to conduct a systematic review, systematic searches of the literature were undertaken. All the searches were carried out using Ovid Online and included the following databases: CINAHL (from 1982), British Nursing Index (from 1994), Ovid Medline(R) (from 1996), EMBASE (from 1996), PsycINFO (from 1967), AMED (from 1985).

Papers were excluded after reading abstracts if they were: not concerning self care, self management, self-help or recovery; primarily related to physical health problems, including papers looking at physical health problems where mental health was one of various outcome measures; not concerning adults (i.e. papers concerned with children, adolescence and older adults were discarded); primarily relating to drug misuse unless there was a clear focus on mental health problems. Self-help books were also excluded because of the vast number of self-help books available (for example a search of “self help” and “depression” on Amazon.co.uk revealed over 5000 books). Table 1 shows the number of papers identified in the initial search and then after excluding duplicates across searches and papers that did not fit the criteria.

----------------------------- Table 1 in about here --------------------------------------

These searches revealed a very wide range of papers, the most frequent being evaluations of interventions/services/ approaches, using arange of qualitative, quantitative and mixed methods. These included a range of methodologies such as controlled trials (e.g. Anzai et al.,2002; Rapee, 2007), qualitative studies (e.g. Muir-Cochrane, 2006; Rogers et al., 2004), mixed methods (e.g. Lawn et al., 2007) and some systematic reviews (e.g. Morriss et al., 2007). The other most frequent types of papers were editorial/opinion pieces and descriptions of approaches/service developments.

From these papers, twenty empirical studies of the views of people with mental health problems were found that identified important self care behaviours and strategies in a mental health context. These studies tended to be descriptions of the experience of recovery (e.g. Ridge & Ziebland, 2006), or the identification of self management strategies (e.g. Faulkner & Layzell, 2000).

Review of qualitative studies identifying elements of self care in mental health

Table 2 shows each of the twenty studies with the methods, study population and main findings. In order to accurately reflect the findings and the methods used, in some cases exact wording was used in these sections (Britten et al, 2002). We were interested in what the studies tell us about the experiences of self care in people with mental health problems. This is a narrative review so we did not conduct a systematic review and formal synthesis of the qualitative evidence. We did, however, identify the key themes arising from the research. Some researchers may resist synthesis of qualitative research studies, arguing that each study is a unique representation of different realities, but it is widely acknowledged that synthesis is appropriate and will contribute to an understanding of an underlying reality, consistent with the “subtle realism” position (Hammersley, 1992).

------------------------------------ table 2 in about here ------------------------------

It is important to critically appraise the quality of the studies identified in this review. Mays & Pope (2006) discuss ways of improving validity of qualitative research, including triangulation, respondent validation, clear exposition of methods, data collection and analysis, reflexivity, attention to negative cases and fair dealing. We have included information on these elements of the studies reviewed under the methods column in table 2. It is clear from the table that some of the studies provided limited information on the factors identified by Mays & Pope, making an evaluation of the quality of these papers difficult. It is noticeable, however, that the more recent studies tended to provide more information, suggesting a growing awareness of the importance of such detail to allow the quality of studies to be evaluated.

While the inclusion criteria for the review ensured that study populations were all adults with mental health problems, participants were recruited from a variety of treatment and service provision settings, with recruitment processes described in the papers in varying degrees of detail. In most studies participants were recruited through the mental health service they used, although in a number of studies participants were people who self identified as being on a recovery journey, or of having recovered (e.g. Brown & Kandirikiria, 2006; Nixon et al, 2010; Romano et al, 2010). It can be suggested that self-selection of participants constrains the variation in data elicited (Miles & Huberman, 1994). However it might also be argued that, in the context of a review paper such as this, the inclusion of studies with populations ‘in recovery' alongside those recruited on the basis of diagnosis or treatment increases variation in the meta data set. This variation in sampling and recruitment strategy constrains our ability to specify the population to whom the review findings apply while at the same time will enable us to produce a model of self care in mental health inclusive of elements which will be of relevance across the broad spectrum of adult experiences of mental health problems.

Most studies used individual interviews to elicit data (exceptionally, Lucock et al (2007) used focus groups, Martyn (2003) used interviews, discussion groups and writing, Khan et al (2007) synthesised the findings of existing qualitative research on depression management in Primary Care, and Yurkovich et al (1997) used participant observation alongside interviews). In most cases little detail was given of the sorts of questions asked in interviews, although a number of studies indicated that they used extended, open-ended or narrative interview in order to enable participants to tell their personal stories of recovery or self management (Smith, 2000; Cunningham et al, 2005; Ridge & Ziebland, 2006; Borg & Davidson, 2008; Nixon et al, 2010; Kartalova-O'Docherty & Kartlova, 2010). Some papers specified that interviews sought to identify self management strategies (e.g. Cunningham et al, 2005) or to elicit understandings of recovery (e.g. Borg & Davidson, 2008; Piat et al, 2009). It has been noted that 'priming effects' (Foddy, 1993) – the way interview questions are asked - can shape the responses of interviewees, although not enough information is given in papers to enable us to evaluate the extent to which interview schedules might have shaped study findings.

Some papers did provide details of the analysis process (e.g. Borg & Davidson, 2008; Nixon et al, 2010 and Kartalova-O'Docherty & Doherty, 2010). While all studies sought to organise understandings of recovery, self care and self management strategies into themes, or elements, a range of approaches to analysis were described. While many studies referred simply to ‘thematic analysis’, a number of studies (Yurkovich et al, 1997; Ridge & Ziebland 2006; Mancini, 2007; Romano et al, 2010; Kartalova-O’Docherty & Kartlova, 2010) employed Grounded Theory in some form; an approach to analysis of qualitative data that seeks to derive understandings of social phenomena that are grounded in the data rather than in existing literature or the perspectives of the researchers (Strauss & Corbin, 1998). Another set of studies (Muir-Cochrance et al, 2006; Pitt et al, 2007; Nixon et al 2010) used Interpretive Phenomenological Analysis (Smith et al, 1995) or similar approaches, designed to foreground the subjective experiences of individual participants. Both these approaches are appropriate for studies that are attempting to understand individualised experiences of mental health and mental health care and, not surprisingly, generate themes that are labelled and described in a wide variety of ways. Despite this variety it can be noted that those studies – the majority of studies – that employed a combination of semi-structured interview and thematic analysis generate themes that are largely descriptive of issues of self care and mental health; both the substantive issues concerning self care (e.g. medication management, social support) and the personal challenges faced by individuals in their self care (e.g. being in control, overcoming barriers). The smaller numbers of studies that take a more narrative approach to interviewing *and* are explicitly more constructivist in their approach to analysis (e.g. Mancini, 2007; Romano et al, 2010) generate understandings of the experience of self care and mental health that are more overtly conceptual (e.g. themes of ‘awakening’ and ‘lives interrupted’ respectively).

In some cases themes were checked with people with mental health problems or who had recovered (Borg & Davidson, 2008; Nixon et al, 2010) or neutral outside reviewers (Mancini, 2007). Respondent validation was also described in Yurkovich et al (1997) and some studies described analysis by more than one researcher before agreeing common themes (Brown & Kandirikirira, 2006:, Muir-Cochrane et al, 2006; Pitt et al, 2007; Nixon et al, 2010).

Mays & Pope (2006) also discuss the importance of relevance to a public concern and it is reasonable to say that the studies reviewed are indeed of relevance to a public concern – the understanding of self care in mental health – which is very prominent in concerns of policy makers, professional and managers.

As table 2 shows, the studies revealed strategies, supports and processes important in self care, self management and recovery, with a number of themes featuring across studies. A number of the studies identified a wide range of strategies, including employment, education, creative activity, physical exercise, healthy living, structured routine and spirituality (e.g. Faulkner et al, 2000; Martyn et al, 2003). The issue of control was a common feature, including control over their lives, over treatment and over their future (Yurkovich et al, 1997; Faulkner et al, 2000; Smith, 2000, Mancini & Rogers, 2007; Khan et al, 2007). This supports the importance of control, choice and joint decision making in policy developments (Department of Health, 2010) and confirms the assumptions that these are central concepts in self care. Support from others was another common finding, both professional, or formal, and non professional, or informal, although expressed in different ways (Brown & Kandirikirira, 2006; Mancini, 2007; Lucock et al, 2007). In the case of professional support it seems to be important that the support is flexible and responsive to changing needs (Brown & Kandirikirira, 2006) and Kahn et al (2007) highlighted the importance of a balance between support from professionals and autonomy, which can vary over time. The importance of peer group support is widely reported in narrative accounts (e.g. Lynch, 2000; Mead and Copeland, 2000) and a review of mutual support groups for mental health problems suggests psychological benefits (Pinstrang et al., 2008).

Given that some studies explored the experience of recovery, it is not surprising that some findings related to the process of recovery over time (e.g. Nixon et al, 2010), rather than strategies used at a particular time. The importance of a developing sense of self is highlighted (e.g. Romano et al, 2010) and described in different ways, such as an authentic self (Ridge and Ziebland, 2006) and positive identity (Brown & Kandirikirira, 2006; Mancini, 2007). Engagement with community activities (Cunningham et al, 2005) and living and working in the community where others could see beyond the illness (Muir-Cochrane et al, 2006) were identified and linked to the idea of living a normal, ordinary life (Borg & Davidson; Martyn, 2003) . Other issues highlighted in the studies were the importance of coping (Martyn, 2003: Rogers et al, 2004), hope (Mancini, 2007) and optimism about the future (Smith, 2000). A number of studies identified medication as important (Faulkner et al, 2000; Smith, 2000; Martyn, 2003) with Muir-Cochrane et al (2006) highlighting the importance of adherence and professional support.

It is interesting to compare the elements of self care identified in these studies with professionally led approaches. Lucock et al (2007) pointed out that few of the themes they identified featured in the evidence based self-help interventions available up to now, the exception being managing and structuring the day which is similar to behavioural activation approaches in cognitive behavioural therapy. Similarly, Roberts & Wolfson (2004) point out that although personal accounts of recovery feature factors such as spirituality, peer support and activities such as gardening, hobbies, creativity and the arts as well as satisfactory housing and finances and work, these tend not to feature in textbooks and guidelines.

Self care support in mental health services

Before we go onto develop a model of self care based on the review's findings, we will provide some examples of, and reflect on, the types of mental health services that have been developed that are consistent with self care. This will inform our consideration of how an empirically derived understanding of self care and can inform the development of mental health services supporting self care. Relevant service developments and interventions are clearly many and varied, but share common characteristics consistent with those identified in the review, such as increased control, shared decision making, developing self management strategies, and engagement with community based activities to improve integration into a 'normal' lifestyle and identity. Some developments, such as the expert patient programme (DH, 2001b), personalisation (DH, 2009) and advanced directives have their origins in policy initiatives. Others, such as mutual support groups and networks have their origins in the service user/survivor movements and may have no professional involvement. In some cases, consumer-led developments have been taken up and supported by professionals, such as the Wellness Recovery Action Plan (WRAP, Copeland, 1997) which focuses on self management of mental illness. A number of workbooks have also been developed to support self management and recovery from mental illness (e.g. Coleman et al., 2000; Ridgway et al., 2002) and to support self-help for common mental health problems such as anxiety and depression (e.g. Greenberger & Padesky, 1995). Also, many of the wide range of psychological and psychosocial interventions provided for people with mental health problems included in the review of research evidence on the effectiveness of self care support (DH,

2007) are consistent with the principles of self care and recovery we have identified. They share common features such as empowerment, a collaborative approach to understanding and dealing with problems and the development of self management strategies, particularly with cognitive behavioural therapies. To enable self care within mental health services it is important for staff to receive training consistent with the principles of self care and guidelines have been developed to inform staff training. For example, O'Hagan (2001) has developed recovery competencies for New Zealand mental health workers. The British Medical Association (BMA) has also acknowledged the need for education on facilitating self care in the medical curriculum (BMA, 2007).

Conceptual model

In order to conceptualise self care we have developed a model, based on our review and shown in figure 1. The review suggests that self care in mental health is a broad, inclusive concept, not distinct from but encompassing those related concepts of recovery, self-management and self-help so the model should encompass these concepts. The model places the individual at the centre and shows reciprocal relationships with self care support, self care behaviours and strategies, and wellbeing and functioning. Recovery is identified as a key process leading towards wellbeing and functioning. Choice, control and engagement are shown as key processes determining the individual's appropriate and effective level and type of self care support. Knowledge (of self care behaviours and strategies), self efficacy (the person's belief they can achieve their goals) and capacity are identified as factors determining which self care behaviours and strategies the individual adopts. We have placed these elements within an overall context of the person's life situation which will of course vary over time and influence all the other elements. The model reflects the complex, dynamic and reciprocal relationships between the elements. For example, the appropriate level and type of self care support that a person can engage with will vary from time to time for each individual depending on their physical and mental health, their beliefs and attitudes to self care, and motivation, with personal choice being important in enabling the individual to have some control over the support.

------------------------------- figure 1 in about here ---------------------------------

Discussion

This review set out to understand the concept of self care in relation to mental health. Although the term self care may not be a frequently used concept within mental health services, the principles of self care underpin service developments which use self management, self-help and recovery approaches. The conceptual model sets out a framework that might usefully inform the provision of appropriate self care support and highlight some of the complexities involved in ensuring the level and type of support is right at any given time. Although we have provided examples of a number of service examples that are consistent with the principles of self care, there are a number of issues and practical difficulties that may impede the widespread application of the concept of self care to inform the development of mental health services.

Firstly, there is the difficulty of developing services that strike the right balance between providing care, support and treatment for the individual when required and the autonomy of the individual. There are concerns that self care approaches may on the one hand deny the level of disability caused by mental illness, leaving individuals unsupported (Roberts & Hollins, 2007), or that they will be taken over by professionals and lose the user-centered focus, on the other (Davidson et al., 2006). Certainly there are potential contradictions and conflicts in the idea and practice of professionally led self care. For example, services can undermine self care and autonomy by being too prescriptive and controlling. It is clear from the research reviewed in this paper that, although some key themes have been identified, self care is a very individual thing and so service users should be allowed to find the self care activities that work for them, rather than having them imposed. Self care should therefore provide choices to match the needs, capabilities and interests of individuals. In providing support, professionals should relinquish some control and work in partnership with the service user in a more enabling role (Roberts & Hollins, 2007). It is likely that self care support will be unsuccessful if on the one hand it ignores the needs and autonomy of the individual or at the other extreme if it provides too little support. Successful self care support will achieve a balance between these two extremes. We acknowledge that this balance can be difficult to achieve in practice, for example in risk management where there is a tension between safety and autonomy (Heyman & Huckle, 1993). Despite concerns about risk and litigation, positive risk-taking has been promoted (Titterton, 2005) and Deegan (1996) argues that allowing service users the right to take risks and perhaps fail is an important part of the recovery process.

The medical model is often cited as the antithesis of a self care, recovery orientated approach. The literature suggests, however, that there is a place for a balance between the requirements of medical treatment and self care, for example in medication management where people can understand and value the role of medication in their own self care (Roberts & Wolfson, 2004). Thus the implementation of self care practice requires a re-orientation of the role of professionals from one of direction towards that of partnership. (e.g. Laugharne & Priebe, 2006; Morgan, 2000; Schauer et al 2007). Clarity and guidance for professionals and users on what can be expected of this new role, setting out boundaries and expectations would seem to be a fundamental requirement for self care to progress.

The second issue impeding the widespread application of the self care approach is the variable quality of the evidence available. Despite the large number of papers identified in our review, there is limited systematic empirical research underpinning practice and very few longitudinal studies that clearly demonstrate which aspects of self care support are most effective. Thus there is insufficient evidence on the facilitators and barriers to effective self care on which to base policy and practice. Moreover, the philosophy of evidence-based medicine may also conflict with a self care approach. In evidence-based medicine a disorder is identified and the most effective treatments are revealed through clinical trials. Treatment guidelines then guide the professionals in the treatments they provide. The self care approach, on the other hand, puts the emphasis with the individual themselves and the evidence that informs this approach tends to be based on more qualitative research, personal narratives, and the views of ‘experts by experience’. This type of evidence is given relatively low status in the development of NICE guidance although there is some acknowledgement of the value of cross sectional and qualitative research on patients’ experiences to inform review questions as long as it meets quality standards (NICE, 2009). Thus there is a need for both more research and some agreement on what constitutes “evidence” in this context.

Thirdly, consideration should be given to the organisational, resource and change management implications of providing effective self care support. Achieving more flexible partnership working with service users to enable care to match their needs presents a challenge to health services. Large scale public organisations typically regulate and standardise services in order to enhance quality control, accountability, and equity, to minimise risk and to realise economies of scale (Cinate, Duxbury & Higgins, 2009). Self care on the other hand requires flexible services that are responsive to individual needs. Self care support also requires cooperation and collaboration across the different professional groups and across organisations in the health, social care and voluntary sectors (Ferlie et al, 2005; Currie et al, 2009). Thus inter-professional and cross organisational working presents challenges to the effective delivery of self care, including issues of funding and identifying who should provide the self care support and monitor changing needs.

Conclusion

This paper has identified and reviewed some of the existing research into important elements of self care for people with mental health problems. Although this enabled us to develop a self care model, we acknowledge limitations in the extent and quality of the available research. We therefore recommend more research into service users' views of the key elements of self care and what constitutes effective self care support. We have also highlighted some of the challenges of self care support in mental health and suggest more research is required into the barriers and facilitators to effective self care at individual, service and organisational levels and more evaluations of the impact of self care initiatives on wellbeing, quality of life and functioning, including economic evaluations. We hope the conceptual model provided in this review will support such further research.

References

Anzai N., Yoneda S., Kumagai N., Nakamura Y., Ikebuchi E., & Liberman R.P. (2002). Training persons with schizophrenia in illness self-management: a randomized controlled trial in Japan. *Psychiatric Services, 53(5),* 545-547.

Borg M., & Davidson L. (2008) The nature of recovery as lived in everyday experience. Journal of Mental Health, 17 (2), 129-140:

Britten N., Campbell R., Pope C., Donovan J., Morgan M., & Pill R. (2002) Using meta ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research and Policy*, 7, 209-215.

British Medical Association (2007). *Improved self care by people with long term conditions through self management education programmes.* Report of Patient Liaison Group and General Practitioners Committee. Available at: http://www.bma.org.uk/patients_public/selfmanagementpolicy.jsp Accessed January 2011.

Brown W. & Kandirikirira, N. (2006). Recovering mental health in Scotland. Report on narrative investigation of mental health recovery, Glasgow: Scottish Recovery Network. Available at: http://www.scottishrecovery.net/Narrative-Research-Project/narrative-research-project.html Accessed January 2011.

Chambers R. (2006). The role of the health professional in supporting self care. Guest Editorial. *Quality in Primary Care*, *14,* 129–31

Chambers R., Wakley G. & Blenkinsopp A. (2006) Supporting Self Care in Primary Care. Oxford: Radcliffe Publishing.

Cinate I, Duxbury L and Higgins C. (2009). Measurement of Perceived Organizational Readiness for Change in the Public Sector British. Journal of Management. 20, pp. 265–277.

Coleman R., Baker P., & Taylor K. (2000). *Working to recovery. Victim to Victor III*. Gloucester: Handsell Publishing.

Copeland M. E. (1997). *Wellness Recovery Action Plan*. Dummerston: Peach Press.

Cunningham K., Wolbert R., Graziano A., & Slocum J. (2005). Acceptance and Change: The Dialectic of Recovery. *Psychiatric Rehabilitation Journal*, *29(2)*, 146-148.

Currie G., Finn R and Martin G. (2009). Professional competition and modernizing the clinical workforce in the NHS. Work Employment Society, 23, pp. 267-284.

Davidson L., O'Connell M., Tondora J., Styron T., & Kangas K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services* , *57*, 640–645.

Deegan P. (1996). “Recovery as a Journey of the Heart” *Psychiatric Rehabilitation Journal*, *19(3)*, 91-97.

Department of Health (2001a). *The Journey to recovery – The Government’s vision of Mental Health Care*. London: DH.

Department of Health (2001b). *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*. London: DH.

Department of Health (2005a). *Public attitudes to self care*. *Baseline survey*. Available at:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4111263.pdf Accessed January 2011.

Department of Health (2005b). Self Care – A Real Choice. Self Care Support – A Practical Option. London: DH. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4101702.pdf Accessed January 2011.

Department of Health (2006a). *Supporting People with Long Term Conditions to Self Care: A Guide to Developing Local Strategies and Good Practice*. London: DH.

Department of Health (2006b). *Our health, our care, our say: a new direction for community services.* London*:* DH.

Department of Health (2007). *Research evidence on the effectiveness of self care support (work in progress 2005-07).* London: DH. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080689 accessed January 2011.

Department of Health (2009). *Putting People First: Personalisation Toolkit*. London: DH.

Department of Health (2010). *Equity and Excellence: Liberating the NHS*. London: DH.

Faulkner A & Layzell S. (2000). *Strategies for Living: A Report of User-Led Research into People's Strategies for Living with Mental Distress*. London: Mental Health Foundation.

Faulkner A. & Thomas P. (2002). User-led research and evidence-based medicine. *The British Journal of Psychiatry,* 180**,** 1-3.

Ferlie E., Fitzgerald L., Wood M., & Hawkins C. (2005). The nonspread of innovations: The mediating roles of professionals. Academy of Management Journal, 48, pp. 117-134.

Foddy W. (1993) Constructing questions for interviews and questionnaires: theory and practice in social research. Cambridge: Cambridge University Press.

Gibbons M., Limoges C., Nowotny H., Schwatrzman S., Scott P. & Trow M. (1994). *The New Production of Knowledge,* London, Sage

Gould R.A. & Clum G.A. (1993) A meta-analysis of self-help treatment approaches. *Clinical Psychology Review, 13,*169-186.

Greenberger D & Padesky C. (1995). *Mind Over Mood.* Guilford Press. New York.

Hammersley M. (1992) *What's Wrong With Ethnography? – Methodological Explorations*. London: Routledge.

Health Foundation (2008). *Co-creating Health*. Briefing paper, May 2008. Available at: http://www.health.org.uk/publications/co-creating-health-briefing-paper/ Accessed January 2011

Heyman B. & Huckle S. (1993) Not worth the risk? Attitudes of adults with learning difficulties and their informal and formal carers to the hazards of everyday life. *Social Science & Medicine* , *12* , 1557 – 1564 .

Kartalova-O'Docherty Y. & Doherty DT. (2010) Recovering from recurrent mental health problems: Giving up and fighting to get better International Journal of Mental Health Nursing,19(1), 3-15.

Khan N, Bower P and Rogers A (2007) Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience, The British Journal of Psychiatry 191: 206-211

Laugharne R., & Priebe S. (2006). Trust, choice and power in mental health. . Social Psychiatry and Psychiatric Epidemiology, 41 (11), 843-852

Lawn S. Battersby M. W. Pols R. G. Lawrence J. Parry T. & Urukalo M. (2007) The mental health expert patient: Findings from a pilot study of a generic chronic condition self-management programme for people with mental illness. *International Journal of Social Psychiatry*. *53(1)*, 63-74.

Lucock M.P., Barber R., Jones A. & Lovell J. (2007). Service users' views of self-help strategies and research in the UK. *Journal of Mental Health*, *16 (6)*, 795 – 805

Lynch K. (2000). The long road back. *Journal of Clinical Psychology*, *56(11)*, 1427-1432.

Mancini M. A. and Rogers R. (2007). Narratives of Recovery from Serious Psychiatric Disabilities: A Critical Discourse Analysis. Critical Approaches to Discourse Analysis across Disciplines. 1 (2), 35-50

Mancini MA. (2007). Qualitative Analysis of Turning Points in the Recovery Process American Journal of Psychiatric Rehabilitation, 10: 223–244

Martyn D. (2002). The Rethink Self-Management Project - Summary of Initial Report. Mental Health Foundation.

Martyn D. (2003). Self Management. *The experiences and views of self-management of people with a diagnosis of schizophrenia* Mental Health Foundation.

Mays N., & Pope C. (2006). Quality in qualitative health research. In *Qualitative research in health care*. Pope, C., & Mays, N. (Eds.). BMJ books & Blackwell Publishing.

Mead S & Copeland M.E. (2000), What Recovery Means to Us: Consumers' Perspectives. *Community Mental Health Journal*, *36(3)*, 315-328.

Miles M.B., & Huberman A.M. (1994) Qualitative data analysis: an expanded sourcebook. Sage, Thousand Oaks CA

Morgan, S. (2000) Risk-making or risk-taking? Openmind, 101,16-17

Morriss R.K., Faizal M.A., Jones A.P., Williamson P.R., Bolton C. & McCarthy J.P. (2007). Interventions for helping people recognise early signs of recurrence in bipolar disorder. *Cochrane Database Systematic Review*. *24;(1)*:CD004854.

Muir-Cochrane E. (2006). Self-Management of medication for mental health problems by homeless young people, *International Journal of Mental Health Nursing*, *15*, 163-170

National Institute for Health and Clinical Excellence. Anxiety (amended): Management of anxiety (Panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE, 2007.

National Institute for Health and Clinical Excellence. The treatment and management of depression in adults. NICE, 2009.

National Institute for Health and Clinical Excellence (2006). *Computerised cognitive behaviour therapy for anxiety and depression*. Review of technology appraisal 51.

National Institute for Health and Clinical Excellence (2009). *The guidelines Manual*.

Nixon, G, Hagen B., Peters, T. (2010) Recovery from psychosis: A phenomenological inquiry International Journal of Mental Health and Addiction, 8(4), 620-635

O'Hagan M. (2001). *Recovery Competencies for New Zealand Mental Health Workers*. New Zealand Mental Health Commission. Available at: http://www.maryohagan.com/resources/Text_Files/Recovery%20Cometencies%20O'Hagan.pdf Accessed January 2011.

Orem D.E. (1991). *Nursing: Concepts of practice.* (4th ed.). St. Louis, MO: Mosby-Year Book Inc.

Piat M., Sabetti J., Couture A., Sylvestre J., Provencher H., Botschner J., & Stayner D. (2009). What does recovery mean for me? Perspectives of Canadian mental health consumers, Psychiatric Rehabilitation Journal , 32 , 199-207

Pistrang N., Barker C. & Humphreys, K. (2008). Mutual help groups for mental health problems: a review of effectiveness studies. *American Journal of Community Psychology, 42 (1-2),* 110-121.

Pitt L., Kilbride M., Nothard S., Welford M. & Morrison A. (2007). Researching recovery from psychosis: a user-led project. *Psychiatric Bulletin*. *31*, 55-60.

Rapee R.M. (2007). Treatment of social phobia through pure self-help and therapist-augmented self-help, *The British Journal of Psychiatry*, *191*, 246-252.

Richards D., Lovell K. & McEvoy P. (2003). Access and effectiveness in psychological therapies: self help as a routine health technology. *Health and Social Care in the Community*. *11 (2)*: 175–182

Ridge D., & Ziebland S. (2006). "The Old Me Could Never Have Done That": How People Give Meaning to Recovery Following Depression. *Qualitative Health Research*, *16*, 1038-1053.

Ridgway P., McDiarmid D., Davidson L., Bayes J. & Ratzlaff S. (2002). *Pathways to Recovery: A strengths Recovery Self-help Workbook*. Lawrence, KS: University of Kansas School of Social Welfare.

Roberts G. & Wolfson P. (2004). The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment*, *10*, 37-48.

Roberts G. & Hollins S. (2007). Recovery: our common purpose? *Advances in Psychiatric Treatment*, *13*, 397-399.

Rogers A., Oliver D., Bower P., Lovell K. & Richards D. (2004). Peoples' understandings of a primary care-based mental health self-help clinic. *Patient Education and Counseling*. *53(1)*, 41-46.

Romano, DM., McCoy, E., Goering, P., Boydell. K., & Zipursky, R. (2010) Reshaping an enduring sense of self: The process of *recovery* from a first episode of schizophrenia. Early Intervention in Psychiatry, 4(3), 243-250.

Roth A. & Fonagy P. (2005). *What works for Whom? A Critical Review of Psychotherapy Research*. 2nd Edition. .New York: Guilford Press.

Schauer C., Everett A, del Vecchio P., Anderson L. (2007). Promoting the value and practice of shared decision-making in mental health care. Psychiatric Rehabilitation Journal 31 (1):54)

Scogin F., Hanson A. & Welsh D. (2003). Self administered treatment in stepped-care models of depression treatment. *Journal of Clinical Psychology,* 59, 379-391.

Smith J.A., Harre R., & Van Langenhove L. (1995) Rethinking Methods in Psychology. London: Sage

Smith, M. K (2000) Recovery from a severe psychiatric disability: findings of a qualitative study. Psychiatric Rehabilitation Journal. 24 (2), 149-158

Strauss N.C., & Corbin J. (1998) Basics of Qualitative Research: techniques and procedures for developing grounded theory. Sage: Thousand Oaks, CA

Titterton M. (2005). *Risk and Risk Taking in Health and Social Welfare* . London: Jessica Kingsley.

World Health Organization (1983). *Health Education in Self-care: Possibilities and Limitations.* Geneva: WHO.

Yurkovich E., Buehler J, & Smyer T. (1997). Loss of Control and the Chronic Mentally Ill in a Rural Day-Treatment Center. *Perspectives in Psychiatric Care*, *33 (3),* 33-40.

Yurkovich E. & Smyer T. (1998). Strategies for maintaining optimal wellness in the chronic mentally ill. *Perspectives in Psychiatric Care. 34(3),* 17-24.

Table 1. Number of papers identified in the search

Search terms	Number of papers identified in initial search	Number of papers after exclusion criteria applied
Self care and mental health or psychiatry	566	133
Self management and mental health or psychiatry	423	45
Self help and mental health or psychiatry	1962	268
Recovery and mental health or psychiatry	334	129

Table 2. Details of 20 empirical qualitative studies of the views of people with mental health problems, identifying important self care behaviours and strategies.

Study	Methods	Population	Findings
Yurkovich et al (1997). Loss of Control and the Chronic Mentally Ill in a Rural Day Treatment Center.	Semi-structured interviews and participant observation. . Open-ended questions used to stimulate free responses about the views on the meaning of health and their health-seeking behaviours. Grounded theory analysis. Description of coding process. The "core variables" identified from the analysis were fed back to participants to check credibility.	7 "chronic mentally ill people", 3 male, 4 female. Variety of diagnoses.	The issue of control was central to the findings. Concluded chronic mentally ill clients prevent loss of control by using informal relationships to adapt behaviours, attitudes, and feelings within a supportive environment. If this fails, they turn to formal sources of control such as therapists, case workers, or other mental health providers.
Yurkovich & Smyer (1998). Strategies for maintaining optimal wellness in the chronic mentally ill.	A further analysis of Yurkovich et al (1997) study. Investigated strategies for maintaining optimal wellness outside the hospital setting.	As in Yurkovich et al (1997).	Identified 4 properties related to preventing loss of control: relationships, feelings, good attitude, and functional activity. These properties must be examined within the context of the therapeutic environment as well as the nurse-patient relationship.
Faulkner et al (2000). Strategies for living: a report of user-led research into people's strategies for living with mental distress.	Individual interviews and thematic analysis.	Purposive sampling of 71 people with experience of mental health problems.	Key theme was the role and value of relationships with other people. Other themes included finding meaning or purpose; the importance of acceptance and shared experience; finding ways of taking control; and achieving peace of mind. A range of helpful strategies were identified, including medication, relationships with professionals, self-help strategies, religious and spiritual beliefs, complementary therapies, sport and physical exercise, and creative expression.
Smith (2000). Recovery from a severe psychiatric disability: findings of a qualitative study.	Qualitative analysis of extended semi structured interviews relating personal stories of recovery. Recruitment via newsletter advertisement seeking participants to describe personal stories of recovery from severe psychiatric disability. Thematic analysis.	10 participants (aged 38–60 yrs) "beset by persistent and severe psychiatric disability".	Helpful factors in recovery were medication; a group of supportive people; meaningful activities; a sense of control and independence; strong determination to maintain recovery; positive outlook on the present; optimism about the future. Barriers to recovery were stigma, symptoms, lack of financial resources, and limited access to services and occasional eruptive responses to life's pressures. Strategies for recovery were accepting disability, believing in recovery, being stabilized, accepting responsibility for disability, establishing a structure for daily life, seeking support, taking care of yourself, keeping active, educating

			yourself.
Martyn (2003). Self Management. The experiences and views of self-management of people with a diagnosis of schizophrenia	Thematic analysis of interviews, discussion groups and writing exploring self management for people with a diagnosis of schizophrenia.	52 people with a diagnosis of schizophrenia.	Identified five broad headings related to self management: a) maintaining morale and finding meaning; b) relationships with other people; c) an ordinary life: coping; d) an (extra)ordinary life: thriving; and e) managing ‘having schizophrenia. Themes included occupation in its broadest sense, including education, voluntary work, art and creative work and paid employment; relationships with other people; personal qualities, attitudes and beliefs involved in maintaining morale; coping strategies for the experiences of schizophrenia; managing medication; exploring and understanding the experience labeled schizophrenia, including getting information; religion and spirituality; counselling and psychotherapy; complementary therapies; and healthy living, such as diet and exercise.
Rogers et al (2004) Peoples’ understandings of a primary care-based mental health self-help clinic.	Semi-structured interviews exploring patients' understandings of the use of a UK primary care-based self-help clinic. Thematic analysis.	15 people who had attended the self-help clinic for one or more sessions.	People understand their problem as one of having lost an ability to cope, and that the ethos underlying the clinic is well matched to restore a sense of coping, by motivating patients to re-establish and retain control over their everyday lives.
Cunningham et al (2005). Acceptance and change: the dialectic of recovery.	Qualitative narrative study aiming to identify the illness management strategies used by mental health consumers transferred to less intensive services. Convenience sampling. Researchers coded the narratives, testing codes and coding assumptions to maximise inter-coder reliability.	13 Assertive Community Treatment (ACT) and 14 Community Treatment Team (CTT) consumers (aged 27-70).	CTT consumers were more likely to be engaged in the community, working, somewhat more likely to be attending church, and more likely to have a clear understanding of their illness. Importance of acceptance of illness and need for effective strategies for managing it.
Brown & Kandirikirira (2006). Recovering mental health in	Individual interviews. Thematic analysis of recovery narratives. Use of semi structured narrative interview. Initial themes were checked with narrators after which interviewers	Purposive sampling of 67 people	Identified six internal elements associated with a recovery journey: Belief in self and developing a positive identity; knowing that recovery is possible; having meaningful

Scotland. .	and principal researchers collaboratively constructed broad interview themes. Transcripts double coded by the two principal researchers using the broad themes. Themes further refined through inductive thematic analysis.	who described themselves as 'recovered or in recovery from a long-term mental health problem' (aged 28-70).	activities in life; developing positive relationships with others and your environment; understanding your illness, mental health and general wellbeing; actively engaging in strategies to stay well and manage setbacks. Six external elements were: having friends and family who are supportive, but do not undermine narrator's self-determination; being told recovery is possible; having contributions recognised and valued; having formal support that is responsive and reflective of changing needs; living and working in a community where other people could see beyond your illness; having life choices accepted and validated.
Muir-Cochrane et al (2006). Self-management of medication for mental health problems by homeless young people.	In-depth interviews of experience of mental health and well being. Thematic analysis informed by Benner's work in interpretive phenomenology. Participants offered the opportunity to review the transcripts, but not taken up. The transcripts were reviewed by the two researchers who had also conducted the interviews and a conceptual map of the key issues was formulated. This paper focuses on central issue of medication use and management.	10 young people aged 16-24, who were homeless and had experienced mental health problems	Medication use and management was a central issue. Medication non-adherence influenced by unwanted side-effects, issues of access and storage, and lack of support from health and social agencies. These problems were compounded by everyday stresses of homelessness. Medication adherence facilitated by social support, consistent contact with supportive health services, and regular medication supply.
Ridge & Ziebland (2006). 'The old me could never have done that': How people gibe meaning to recovery following depression.	Modified grounded theory approach to analysis. Open-ended, unstructured and semi-structured interview phases with participants talking about their lives, living with depression and getting better. Analysis was a cyclical process: the first author continually moved between reviewing the literature, data collection and coding, linking codes, and revising and reshaping the analysis. The analysis was scrutinized by both authors through regular meetings and electronic exchanges.	38 men and women who had previously experienced depression.	Identified various meanings associated with recovery, including correcting chemical imbalances, types of insight, developing authentic self and living, assuming responsibility for recovery and struggling with recover and the strategies deployed to revitalize life following depression.
Mancini. & Rogers (2007). Narratives of Recovery from Serious Psychiatric Disabilities: A Critical	Critical discourse analysis of in-depth, semi-structured interviews with in order to demonstrate the complexities of the recovery process. Coded each of the interviews for *genre, discourse, and style*. These analyses included a content analysis for themes in the interviews, a contrastive, narrative analysis, and a critical discourse analysis.	Selected 2 interviews for critical discourse analysis, from study of 16 leaders in the consumer	Identified two phases of the recovery process: *Despair and anguish*, marked by a sense of hopelessness and helplessness where the person feels dominated by their condition and sees little hope for recovery; *awakening* characterised by a sense of hope that recovery is possible empowerment whereby a person begins to recognize that they have some control over

Discourse Analysis.		provision of mental health services. Both had "psychiatric disability".	their fate.
Mancini (2007). A Qualitative Analysis of Turning Points in the Recovery Process	Grounded theory analysis of semi structured interviews. Participants asked to share their theories about what factors influenced their recoveries and to discuss the key turning points influencing their recovery. In order to provide a reliability check and to mitigate biases of the researcher, neutral outside reviewers were used to triangulate and cross-check codes and categories and debrief regarding the development of interview questions and the codes and categories that emerged from analysis of the data.	16 psychiatric survivors who were providers of consumer-operated services.	Participants played an active role with the help of supportive allies in initiating and sustaining their recoveries and that recovery consisted of a complex and ongoing struggle against multiple constraints to establish more positive identities.
Pitt et al (2007) 'Researching recovery from psychosis: a user-led project'.	User-led study using interpretative phenomenological analysis of individual interviews exploring people's experience of psychosis and recovery. Initially, each researcher carried out thematic analysis independently for each transcript. The two researchers then met jointly to agree the themes and members of the steering committee were then involved in deciding upon the final themes.	7 people (5 male, 2 female), with experience of psychosis, aged between 18 and 65 years.	Recovery from psychosis found to be a complex and idiosyncratic process, which often involved rebuilding life, rebuilding self and hope for a better future (each of these themes consisted of subthemes). Highlighted importance of continuity of care, the need for greater choice in approaches, access to stories of recovery and encouragement, and the importance of more individualised recovery care plans.
Borg & Davidson (2008) The nature of recovery as lived in everyday experience.	Narrative, phenomenological approach involving in- depth interviews about the processes of recovery**.** The research process also included a reference group of five individuals with experience with recovery. A thematic and step-wise approach was taken to analysis of the interviews, involving analysis of individual interviews for units of meaning related to everyday life, analysis across individual interviews, followed by grouping the material into provisional thematic categories. Third step involved returning to the interview transcripts to verify and supplement key findings. Findings continually discussed with reference group.	13 participants in recovery interviewed twice, 10 had been treated for schizophrenia, 1 for reactive psychosis, 1 for manic depression, and 1for paranoia.	Four areas of everyday life experiences in recovery were identified: (i) having a normal life, (ii) just doing it, (iii) making life easier, and (iv) being good to yourself. The findings suggest that recovery unfolds within the context of "normal" environments and activities. As one implication of this study, everyday life expertise should be included in the practitioners' agenda.
Piat et al (2009). What does recovery mean	Semi-structured interviews exploring meaning of recovery from the perspectives of consumers receiving mental health	54 mental health consumers	Two contrasting meanings of recovery emerged. The first definition strongly attached recovery to illness and cure

for me? Perspectives of Canadian mental health consumers.	services. Interviews coded independently by 2 members of the research team with inter-rater reliability of 80-90% and iterations of coding scheme. Efforts to ensure the trustworthiness of the study were described such as shared process of analysis amongst research team and with an advisory committee.		involving medication and returning to former self. The second definition linked recovery to self-determination, taking responsibility for life recovery as a process and evolving toward a new self. They discuss the need to find common ground between these two perspectives.
Lucock et al (2007) Service users' views of self-help strategies and research in the UK	Thematic analysis of focus groups. The views recorded on the day were categorised under themes. Initial themes were derived through reviewing the views and discussion and analysis by planning team members. These themes were used to provide a framework to review the material again and the themes were refined through an iterative process, with full agreement for the final themes by all planning team members.	50 mental health service users	Identified the following self management strategy themes: managing and structuring the day; empowerment; engaging others to help yourself; physical health and wellbeing; and spirituality.
Khan et al (2007). Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience.	A meta-synthesis of published qualitative research of patient experience of depression management in primary care in order to develop an explanatory framework, and apply this to the development of a guided self-help intervention for depression.	Patients with depression and managed in primary care.	Identified themes in literature such as patients' understandings of self-help interventions, personal experience in depression; help-seeking in primary care; control and helplessness in engagement with treatment; stigma associated with treatment. Patients reported the use of coping strategies, such as distraction or use of locations associated with feelings of safety and control. Patients tended to seek help when their own strategies were failing. Use of medication could lead to a tension between the benefits and perceived loss of personal control. Ambivalence about the role of the therapist vs patients' own use of self-help. Control and the importance of the restoration of social functioning were important issues.
Nixon et al (2010). Recovery from psychosis: A phenomenological inquiry.	Interpretative phenomenological approach using a narrative interview method to explore recovery from psychosis. Audiotape interviews transcribed and then reviewed with research participants for further clarification and input. Thematic analysis with 3 authors independently identifying surface themes from each of the interviews from which higher order themes were agreed across interviews. Procedures to enhance the overall reliability and validity	17 participants, self-identified as having recovered from some form of psychosis.	Found four major themes and seven subthemes that described the experience of recovery from psychosis. The four major themes included: (i) pre-psychosis childhood traumatic experiences, (ii) the descent into psychosis, (iii) paths to recovery, and (iv) post-recovery challenges. Subthemes of the paths to recovery were: a) working with traditional and non-traditional healers; b) embracing creativity and spirit; c) reaching out to others.

	included checking interpretations for goodness of fit, and presenting a coherent and convincing argument for the themes. They checked how the themes resonated with people who had similar experiences, with willing participants and a number of recovering people in the community.		
Romano et al (2010). Reshaping an enduring sense of self: The process of recovery from a first episode of schizophrenia.	In depth, semi structured interviews. Charmaz's constructivist grounded theory methodology. Interview topic's included impact of illness, support systems and coping strategies that influence recovery. Detailed description of data analysis using constant comparison method. Included exploration of negative cases, verification by members of the research team and an audit trail of analytic transformation of data. Reflexive stance throughout the research process.	Purposeful sampling of 10 young adults who self-identified as recovering from first episode of schizophrenia (FES).	Findings provided a theory of the process of recovery from FES with the following phases: 'Who they were prior to the illness'; 'Lives interrupted: Encountering the illness'; 'Engaging in services and supports'; 'Re-engaging in life'; 'Envisioning the future'; and a core category, 'Re-shaping an enduring sense of self', that occurred throughout all phases.
Kartalova-O'Docherty, & Doherty (2010). Recovering from recurrent mental health problems: Giving up and fighting to get better.	A grounded theory study with individual open ended interviews to understand the process of recovery. The first author studied the transcripts and field notes of six interviews and performed line-by-line coding. The emergent themes were grouped under broader concepts and codes and were constantly compared with a similar output of participants. Second author independently coded selected excerpts of the first six interviews containing definitions of recovery and the start of improvement. The two authors compared results of coding and labelling and agreed on labels of 13 broad concepts. Further recruitment of nine participants, some of whom did not use mental health services, were living in the community, and were participating in peer support or advocacy groups. More coding was performed and combined with the results of the first stage of the analysis.	15 participants included mental health service users or participants of peer support groups who have experienced recurrent mental health problems for two or more years and consider themselves in improvement.	They identified two open codes of 'giving up' and 'fighting to get better'. Giving up was associated with accepting a passive identity of a patient with a chronic mental illness and a lack of intrinsic motivation to get better. Fighting had both positive (fighting for) and negative (fighting against) dimensions. The fight for recovery entailed substantial and sometimes risky effort and required strong, self-sustained motivation.

Figure 1. A model of self care in mental health