Understanding consumers' initial expectations of community-based residential mental health rehabilitation in the context of past experiences of care: A mixed-methods pragmatic grounded theory analysis

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Understanding consumers' initial expectations of community-based residential mental health rehabilitation in the context of past experiences of care: a mixed-methods pragmatic grounded theory analysis.

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Understanding consumers' initial expectations of community-based residential mental health rehabilitation in the context of past experiences of care: a mixed-methods pragmatic grounded theory analysis.

Abstract

This study explores how consumers expect community-based residential mental-health rehabilitation to compare with previous experiences of care. Understanding what consumers hope to receive from mental health services, and listening to their perspectives about what has and has not worked in previous care settings, may illuminate pathways to improved service engagement and outcomes. A mixed methods research design taking a pragmatic approach to grounded theory guided the analysis of 24 semi-structured interviews with consumers on commencement at three Community Care Units (CCUs) in Australia. Two of these CCUs were trialling a staffing model integrating peer-support work with clinical care. All interviews were conducted by an independent interviewer within the first six weeks of the consumer's stay. All participants expected the CCU to offer an improvement on previous experiences of care. Comparisons were made to acute and sub-acute inpatient settings, supported accommodation and outpatient care. Consumers expected differences in the people (staff and co-residents), the focus of care, physical environ, rules and regulations. Participants from the integrated staffing model sites articulated the expected value of a less clinical approach to care. Overall, consumers' expectations aligned with the principles articulated in policy frameworks for recovery-oriented practice. However, their reflections on past care suggest that these services continue to face significant challenges realizing these principles in practice. Paying attention to the kind of working relationship consumers want to have with mental health services, such as the provision of choice and maintaining a practical and therapeutic supportive focus, could improve their engagement and outcomes.

Keywords

Rehabilitation, Schizophrenia, Residential services, Qualitative Research, Service-user perspectives

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Authorship statement

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and are in agreement with the manuscript.

Declaration of interest

No conflicts of interest are identified.

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Introduction

Residential mental health rehabilitation services work to achieve recovery outcomes for people who are predominantly diagnosed with schizophrenia and related disorders (Killaspy, 2014; Meehan et al. 2017). These services are resource intensive, and the small proportion of consumers who access them reflect a 'low volume high needs' group often characterised by treatment resistance, co-morbidity, challenging behaviours and cognitive impairment (Killaspy, 2014; Killaspy, et al. 2005; Meehan et al. 2017). Many of these consumers will have had multiple and prolonged inpatient admissions, and experienced problems in maintaining stable accommodation.

Internationally, there have been multiple calls for further increased proportionate funding of rehabilitation services (Bond & Drake 2016; Edwards, Meier & Killaspy 2010; Medibank Private Limited & Nous Group 2013; Wolfson, Holloway & Killaspy 2009). However, there has been limited evaluation of the acceptability and effectiveness of contemporary service models (Parker, Dark, Newman, Korman, Meurk, et al. 2016). Despite limitations in the evidence base, these services are subject to iterative changes in

response to shifting policy frameworks, such as the integration of peer support workers and partnership with non-government services in the delivery of rehabilitation care (Parker, Siskind & Dark 2017).

One of the known challenges in rehabilitation units is that of engagement (Cook et al. 2016; Meaden et al. 2014; Meaden et al. 2012), with consumers not necessarily fully utilizing the intensive support available. Many rehabilitation consumers will have had contact with multiple services and have often not adequately responded to routine care. Listening to and acting on their perspectives about what has and has not worked in previous settings, and what they think they need, may illuminate pathways to overcoming apparent 'resistance' to routine care (Leighton 2005; Tait 2005; Thornicroft & Tansella 2005). Seeking comparative expectations may also provide a way to overcome 'halo' effects that can be a limiting factor on consumers' acknowledgement of the negative aspects of care environments (Corrigan 2016). There has been limited research exploring consumers' experiences and perspectives on residential rehabilitation services (McKenna 2017; Parker, Siskind & Meurk 2017). This paper aims to overcome this gap by exploring consumers' expectations of community-based recovery-oriented residential rehabilitation units, in comparison to their previous experiences of mental health care.

Methods

Study protocol and related data

This paper presents one component of a longitudinal comparative evaluation of the equivalence of an integrated peer-support and clinical staffing models for residential mental health rehabilitation using a mixed methods protocol incorporating multiple stakeholder perspectives. A detailed description of the research team, methods and context are provided in the parent study protocol (Parker, Dark, Newman, Korman, Meurk, et al. 2016). The focus of the current paper is consumers' expectations on commencement at a CCU and how these compare with previous experiences of care. This paper explores the dynamic and contextual nature of how consumers' expectations are shaped; a companion paper is available that considers consumers' static concept of what consumers expect the CCU to be

(Parker, Dark, Newman, Hanley, et al. 2017). The qualitative analysis is supported by a quantitative description and statistical analysis of the comparability of participant characteristics across the three study sites.

Study context

The study took place at three CCUs within a large Australian mental health service. These units provide community-based recovery-oriented mental health rehabilitation to people whose functioning is affected by serious mental illness, primarily those with a diagnosis of schizophrenia (Meehan et al. 2017; Parker, Dark, Newman, Korman, Rasmussen, et al. 2016). The service model describes the provision of 24-hour transitional rehabilitation support to consumers in clustered independent living units over a 6-to-24-month period. The support focuses on living skills development and community integration. Two of the CCUs are trialling an integrated staffing model, where more than half of staff are employed as peer support workers on the basis of their lived experience of mental health issues (Parker et al. 2016). This staffing configuration contrasts with the traditional clinical model, where nursing roles are the dominant staff type.

Participants and ethical clearance

Ethical approval was provided by the Metro South Human Research Ethics Committee (HREC/14/QPAH/62). All consumers admitted to the CCU between December 2014 and January 2016 were approached by either clinical staff or the independent interviewer (EN) to participate in the parent study. Forty-eight of the 64 consumers admitted (75%) provided voluntary informed consent. Participation in interviews was prioritised based on availability and balancing interview participation across the three sites. At the conclusion of the sampling process, eight participants from each site were interviewed (n=24). Participant characteristics are provided in the Results to contextualize the sample, and have also been reported elsewhere (Parker, Dark, Newman, Hanley, et al. 2017).

Interview process

Semi-structured qualitative interviews were used (Dicicco-Bloom & Crabtree 2006), and the interview schedule was developed by SP, CM, FD & EN. The interview schedule explored three topics: how participants came to be at the CCU; expectations of the CCU experience; and comparative expectations to previous experiences of mental health care (Parker, S., Dark, F., Newman, E., Korman, N., Meurk, C., et al. 2016). The third topic is the focus of this paper. After three interviews were completed at each study site SP, CM and EN met to review the adequacy of the interview schedule. Through this discussion, the interview schedule was adapted to include the instruction to the interviewer to not use the word 'recovery' unless this had introduced by the participant, and if used to explore their understanding of the concept (Parker, Dark, Newman, Hanley, et al. 2017). The rationale of this adaptation was to avoid leading participants, and to allow implicit recovery concepts to emerge.

All interviews were completed within the initial 6-weeks of the participant's stay at the CCU. This time frame was chosen as it coincides with the assessment phase before commencing formal rehabilitation work. An assumption built into the sampling approach was that the initial assessment experience and the associated expectations of rehabilitation are distinct from the experience of rehabilitation. An independent interviewer, employed as a research assistant, completed and audio-recorded all semi-structured interviews; these were then transcribed and de-identified by an external transcription company. EN's field notes were used to verify and enhance transcript understandability.

Analysis

The comparability of participant characteristics from the integrated and clinical staffing model sites was evaluated using independent measures t-tests and χ^2 tests in SPSSv22. The qualitative analysis followed a pragmatic grounded theory approach (Parker, Dark, Newman, Hanley, et al. 2017; Parker, Dark, Newman, Korman, Meurk, et al. 2016; Parker, Dark, Newman, Korman, et al. 2017), using an inductive-deductive interplay to analyse content with a view to developing, confirming, refuting, and refining emergent themes and

the relationships between these across transcripts. The data collection, analysis and associated theorizing occurred in tandem. This process was facilitated using an NVivo11 database (QSR 2016). The research team met after three interviews from each study site were completed to consider the adequacy of the interview schedule, the initial coding framework, and estimate the sample size required to achieve thematic saturation. Following agreement on the initial coding framework, all subsequent interviews were coded by SP. The research team collaboratively explored limitations in the coding and the extent to which the emerging theory was grounded in the data.

The thematic analysis was supplemented through quantification of the number of participants referring to a given concept and related content. This was done to increase transparency of pattern recognition and emphasis occurring through the analysis (Sandelowski 2001). The following quantifiers were applied in text: some (N=1-11); half (N=12); most (N=13-23) and all (N=24). Additionally, for concepts uniquely relevant to the integrated staffing model the following qualifiers were used: some (N=1-7); half (N=8); most (N=8-15) and all (N=16). Transcript excerpts best illustrating concepts were selected through author consensus.

A conceptual map outlining key themes emerging from the analysis was developed by SP. Key themes emerging from the data and the relationships between these ('conceptual relationships') reflect the research team's interpretation of the concepts best synthesising the data. 'Conceptual elaboration' provides links from our interpretations to specific participant-generated detail.

The draft manuscript was circulated to two CCU staff with a lived experience of mental health issues (CF & IS) for feedback. Their feedback was incorporated into the revision of the manuscript and guided the development of the discussion. Respondent verification was used to enhance the trustworthiness of the analysis. Prior to finalisation, the conceptual map and conclusions drawn were explored with 29 current residents and 19 staff across the CCU sites.

Results

Participant and interview characteristics

Participant and interview characteristics are presented in Table 1. The high representation of males (75%) and prevalence of schizophrenia (87%) in the sample is consistent with established service utilisation patterns (Meehan et al. 2017). Characteristics of participants from the integrated and clinical staffing model sites were comparable except for the proportion admitted from the community rather than inpatient facilities, the chlorpromazine dose equivalence and the prescription of clozapine. As reported elsewhere, participants at the integrated staffing model sites were more likely to be admitted from the community ($\chi^2_{(1)} = 9.38$, $p<.05$), had lower chlorpromazine equivalent doses of antipsychotics ($t_{(22)} = -2.40$, $p<.05$), and were more likely to be prescribed clozapine ($\chi^2_{(1)} = 4.00$, $p<.05$) (Parker, Dark, Newman, Hanley, et al. 2017). The difference observed in the total chlorpromazine level was no longer significant after the exclusion of a single outlier from the clinical staffing model group. Despite differences between the mode of referral to the CCU most participants made comparisons in their interviews to psychiatric inpatient services (20/24). However, participants from the integrated staffing model site were more likely to make comparisons to outpatient services (10/16) than those from the clinical staffing model site (2/8). Comparisons to supported accommodation services were only present in transcripts from the clinical staffing model site (2/8).

[INSERT TABLE 1 HERE]

Table 1: Characteristics of consumers completing interviews from the integrated and clinical staffing model sites. Standard deviations are provided in brackets where relevant. Reproduced with permission from Parker, Dark, Newman, Hanley, et al. (2017).

Thematic analysis

Figure 1 provides a conceptual map outlining key themes and the relationships between them that emerged through the analysis. Figure 2 presents the coding framework which was

organised across up to four levels: Concept (Level 1); Feature (Level 2); Descriptor (Level 3); Descriptor – detail (Level 4). Despite differences in the mode of referral between participants from the clinical and integrated model sites, there was an overall consistency in the themes emerging from participants across the sites. On the basis of their initial experience, all participants expected that the CCU would differ favourably to the types of mental health services they had experienced previously (24/24), and which were generally construed negatively. Comparisons were made to acute and sub-acute inpatient settings, community mental health care and supported accommodation services.

[INSERT FIGURE 1 HERE]

Figure 1: Conceptual Map – Consumers' expectation that the community-based residential rehabilitation unit will be better than previous experiences of mental health support and care.

[INSERT FIGURE 2 HERE]

Figure 2: The final coding framework of expectations of a community-based residential rehabilitation unit in comparison to other experiences of mental health care and support.

People

Consumers expected to encounter different people (i.e. staff 24/24 and co-residents 13/24) and a different physical environment (11/24, compared to inpatient and supported accommodation settings), with these features anticipated to impact positively on how the unit is regulated (21/24). Most participants discussed the increased availability of staff (16/24); this included reference to the time pressures of inpatient settings and limitations in continuity and after-hours support from community teams.

> Um, it's been better 'cause you get more support and people listen to you properly… Yeah and even when you're not in the in-patient ward, like, sometimes it takes - it's a long process before you can sort of get real help. [INT082]

> [I]t's good here because… with the other mental health services… I've… [experienced where] you stay with someone and you tell them everything about your problems and what's going on with your head. And then they - a couple of months later you get a new case manager or something. [CLIN094]

> [T]hey're always around whenever you need them. And, yeah it's just good to have that 24-hour support. Whereas with my case manager you know I could only call her during work hours... [INT004]

The perception that staff would be less clinical in their approach was also raised by half the participants (12/24). This theme emerged more frequently in transcripts from the integrated staffing model (10/16).

> [I]t doesn't feel much like the medical model, like at the hospital… [CLIN010]

A key feature relating to this theme raised by some participants was the belief that staff at the CCU had a more genuine desire to help (10/24); additionally, some participants from the integrated staffing model believed staff to be more positive and hopeful (see Figure 3).

> [T]he staff here really want to do anything they can to help… [Later elaborating] I thought it would be like the hospital and I thought that the, um, sort of - the living arrangements, um, would be a bit of a - like a farce. [CLIN090]

> I can imagine sometimes in inpatient units, the staff might be a little bit more stressed and a bit more abrasive… [at the CCU] I can see that they're - they just generally - genuinely want to help if you know what I mean?... [T]hey don't judge us… just there's no bullshit about them… [INT050]

In contrast, some participants (3/24) indicated that the staff would be 'the same' (CLIN053). Two of these participants reflected positively on past experiences of care and one of them negatively.

Focus of support

Most participants expected the focus of support would be different to that experienced in acute and sub-acute inpatient care (15/24). Participants spoke about specific features of the care they anticipated, such as the ability for the service to provide more active (11/24), practical (6/24) and individualised support (5/24), as well the desire for a focus on counselling/therapy rather than medication (4/24).

> [T]hey've got more stuff going on and happening [compared to inpatient care]. [INT056]

> [Y]ou get more support and people listen to you properly… They directly help you with, um, proper issues. Like issues that are arising daily [as compared to multiple inpatient admissions]. [INT082]

> When I was in… [a transitional housing program, I]… just felt like I was another number there. [CLIN100]

> I had no counselling [in the acute inpatient setting]. I wasn't offered anything, no support at all. And I found that one of the toughest things to deal with when I was in there. [INT056]

Physical environment

Consumers expected that the physical environment combined with more supportive and less clinical staff attitudes would enable a different focus of care. Distinctive features of the physical environment in comparison to inpatient and supported accommodation settings were its attractiveness (8/24), access to one's own space (5/24), and reduced density (crowding) (4/24).

> Better than anything I've known… [Later describing inpatient facilities as] Just horrible and place is dirty and just not - it's not a good place or an environment for old people. [INT082]

> [Y]ou get your own space… it is a kind of freedom having your own space. [CLIN022]

> I think on the inpatient ward it is very crowded… so you see a lot more illness… and maybe a little bit of bad behaviour… I haven't encountered any of that here. [CLIN090]

Participants anticipated that less clinically focused staff, combined with more space and independent living units, would permit a focus on more practical support and opportunities for recreational activity. The privacy afforded in this setting (compared to inpatient units) and perceived availability of willing and helpful staff appeared to be linked to more individualised and therapeutically focused support.

Rules and regulations

Differences in staff attitudes were expected to contribute to fewer rules and regulations by most participants (21/24); this included 'having choices' (14/24), as illustrated by descriptions of the opportunity to make your own decisions (12/24) and to make mistakes (2/24), as well as being provided with more options (2/24).

> [L]ike being given more freedom you're able to get your life on track, opposed to sort of being restricted… [Comparison to inpatient facilities, INT005]

> [I]t's not like other rehab facilities or anything… if you make a mistake you sort of pick yourself back up and learn from the mistake and stuff… It's really good. [CLIN094]

> [Y]ou get more options here, but in hospital, you don't get as many… you have to go through a fair few steps in order to get… where you want to get. [CLIN041]

Some participants described the CCU as a more relaxed and casual environment (10/24); including reference to it being less strict and rule-driven (6/24), less intrusive (5/24), and less stressful or chaotic (4/24).

> [I]t's been great. I thought it would be a lot more stricter than what it is [laughs] to be honest. [Later elaborating about freedom to leave the unit in contrast to inpatient care, INT050]

> [I]t goes down to the freedom thing as well… it's a lot better here… [In inpatient care] I'm constantly being watched… [INT066]

> [N]ot stressful compared to our mental health units. You know, like I can never relax in a mental health unit. [CLIN053]

Increased freedom in the CCU setting appeared to be linked, for consumers, to the expectation of being able to make choices, which was in turn linked to the expected focus of support being more individualised and facilitative of achieving desired changes.

The physical environment of the CCU, as well as the different ways the different rules and regulations operated in this space, were linked to the expectation of different interactions with co-residents for most participants (13/24). Freedom, an attractive environment and less co-residents having less severe symptoms was linked to consumers' beliefs that co-residents would be easier to get along with (7/24) and that there would be more natural opportunities for friendship formation (5/24).

> [Co-residents at the CCU compared with co-patients in the inpatient unit, are] a lot more open. They're quite friendly. [INT069]

> Well, with CCU, you get to know them a little bit more. You get to have conversations and hang out a little more, so you understand who they are as a person, and unlike in hospital… you don't get as much time to get to know them… [CLIN041]

In contrast, a single participant discussed the negative impact of the individualised treatment focus at the CCU on opportunities for 'group unity' amongst co-residents compared to other treatment settings.

> [I]t's not like places I've been before where you have that… group unity… Where everyone is… like… we're all doing something at like any group, um to kind of break down that social barrier… [INT050]

Some participants discussed the opportunity for mutual support with co-residents that would be facilitated by the CCU setting (4/24, see Figure 3 for additional detail).

> [Co-residents are] just not afraid to talk about what they are going through… and wanting to help and everything… [INT066]

The value of integrating peer support with routine clinical care

While there was overall congruence in consumers' discourses, differences emerged between participants from the integrated and clinical staffing model sites with regards to their expectations of staff being less clinical and the expected impact of peer support workers on the experience of care. The value placed on the expectation that staff would be 'less clinical' emerged more strongly in transcripts from the integrated staffing model sites (10/16 compared to 2/8 of the clinical staffing model participants). Participants from the integrated site explicitly referred to notions of 'clinical' or 'medical model' care, associating it with a distant or 'standoffish' interpersonal style; being analysed, judged or mistreated; 'aggressive' questioning; staff preoccupation; 'panic' around medication; and repetitive focus on symptoms.

Most participants from the integrated staffing model sites independently discussed the expectation that integrating peer support workers into routine clinical care would improve the experience of care (see Figure 3). Additionally, the expectation that staff would be more positive and hopeful at the CCU was only evident in the transcripts from the integrated staffing model sites. Interestingly, few participants discussed the role of informal peer support from co-residents (4/24), and the proportion considering this was higher at the clinical model site where formal peer support was absent (2/8 versus 2/16).

[INSERT FIGURE 3 HERE]

Figure 3: Expectations of the integration of peer support with routine clinical care under the integrated staffing model for residential mental health rehabilitation.

Discussion

The desire to be supported in the CCU in a different way to past experiences of care was pervasive, as was dissatisfaction with previous care settings. These findings have important implications for mental health nurses and other staff working in inpatient and community mental health services. The differential support consumers hoped to receive at a CCU was consistent with the principles of 'support for personally defined recovery' and the characteristics of the 'working relationship' articulated internationally in policy frameworks defining recovery-oriented mental health care (Le Boutillier et al. 2011). These recovery principles were mirrored in the expected focus on individualised, practical support and the articulated value of 'having choices' evident in participant transcripts. Consumers want to be supported in a manner consistent with what current policy frameworks suggest services should be providing, but their narratives suggest that other mental health care and support settings are failing to deliver this. The misalignment between consumer expectations and past experiences of care suggests ongoing challenges in translating mental health policy into recovery-oriented care.

The expectations that consumers in this study had of a CCU align with the positive aspects and facilitators of recovery identified by consumers reflecting on their experiences in mental health services generally (Lietz et al. 2014) and other Australian sub-acute community-based residential settings (Lee et al. 2014; Thomas & Rickwood 2016). Reflections on the positive aspects of residential services include the promotion of independence, a more relaxed and social environment, provision of practical help, and the availability of 'supportive and caring' staff (Lee et al. 2014). Such settings were viewed as facilitative of recovery through the availability of individualized support, fostering personal responsibility through involvement in decision making, as well as opportunities for peer support and social intraction in a 'community context' (Thomas & Rickwood 2016). This convergence adds further weight to the relevance of listening to and acting on consumer perspectives about services to better support them in their recovery journey.

Enthusiasm about the availability of peer support through an integrated staffing model suggests that this may provide a pathway to actualising recovery-oriented mental health

service delivery and improving consumer engagement at rehabilitation services. This finding is consistent with the positive expectations consumers have expressed about the availability of peer support in other studies (Lietz et al. 2014), as well as emphasis on the importance of finding common ground in the case management literature (Buck & Alexander 2006). Consumers entering the sites trialling the integrated staffing model emphasised the hope that care would be 'less clinical', and the theme of staff being 'more positive and hopeful' emerged only in their transcripts. These differences suggest that participants were aware of differences in the staffing composition and expected that these to change their working relationship with staff.

Mental health services have struggled to transform existing services in line with recovery principles, and the availability of formal peer support has been proposed as one way to facilitate this (Lloyd-Evans et al. 2014; Parker, et al. 2016; Slade et al. 2014). While the limitations in the quality of the existing evidence base supporting the role of peer support in mental health service delivery must be acknowledged (Lloyd-Evans et al. 2014), our findings support this proposition. Whether the integrated staffing model is robust enough to overcome the risk of assimilation of values with the clinical paradigm (Parker et al. 2016) remains to be tested (Parker, Dark, Newman, Korman, Meurk, et al. 2016).

It is interesting that the availability of informal peer support did not emerge strongly in consumers' comparative expectations. This could be because participants have not experienced mutual peer support in past residential settings as a basis for comparison. The possibility that availability of formal peer support under the integrated staffing model inhibits informal peer support from developing also needs to be considered. The value of the professionalisation of a peer workforce remains unresolved (Beales & Wilson 2015) and it is important to acknowledge the risk that formalizing peer 'work' may limit the development of naturalistic support networks sustainable beyond the service context. Further research is warranted to explore the impact of increased availability of formal peer support on the role of informal peer support in residential care.

It is important to emphasise that expectations and hopes of participants on commencement at a CCU should not be confused with the reality or outcomes of care in this setting. Future

qualitative and quantitative research exploring the impact of expectations on engagement and outcomes of care is needed. Based on this sub-study we propose the hypothesis that positive initial expectations may enhance engagement with relevant rehabilitation support. However, a service failing to meet these expectations may also contribute to consumer disengagement over time.

Limitations

The findings of this study are context dependent, and case-to-case transferability to other settings should be undertaken with consideration of contextual similarity. Several factors may have influenced participant disclosure and the analytic process. The completion of interviews in the initial six weeks of the participant's stay means that the comparative expectations provided were influenced by the initial experiences of care. The extent to which these expectations are similar to those held before commencement with the service cannot be determined. Furthermore, retrospective biases and state-dependent recall may have impacted participants' comparative expectations. Additionally, the interview situation may have inhibited disclosure of negative expectations of the CCU due to power differentials between residents and staff, and the dual roles of several members of the research team. Alternatively, a honeymoon effect relating to change in care environment (Leon et al. 2016), may have contributed to the favourable comparative expectations. However, the independence of the interviewer and the use of respondent verification with residents who were both within and outside of this trial period, work to enhance the trustworthiness of the analysis.

The initial coding framework was developed by SP who held dual roles as a clinician-researcher at the two integrated staffing model sites, and had previously held a clinical role at the other site. As such he was theoretically sensitised to the relevant literature and organisational context. However, the grounding of analytic inferences in the data was encouraged through the diversity of the analytic team (including multiple outsider and lived experience perspectives) and use of respondent verification. Furthermore, sampling was completed in this study on the basis of thematic rather than theoretical saturation (O'Reilly

	Integrated staffing (n=16)	Clinical staffing (n=8)	Total (N=24)	Test	p

& Parker 2012). Regardless, a cohesive theory of key concepts and their inter-relationships emerged through the analysis.

Conclusions and relevance for clinical practice

Consumers commencing at three Australian CCUs expected that their experience would differ favourably from previous experiences of mental health care and support. Participants described multiple challenges associated with the care experiences in community and inpatient mental health settings. Their hopes for the rehabilitation experience aligned with many of the principles outlined in policy frameworks for recovery-oriented practice. This finding suggests that mental health services continue to struggle to translate recovery oriented policy initiates into recovery oriented practice. Nursing and other mental health staff should pay attention to the kinds of working relationships consumers want to have with rehabilitation services, including emphasis on the provision of choice and support that is practically and therapeutically focused. Better alignment between consumer expectations and staff practices has the potential to improve both engagement and outcomes. Further research is needed to confirm the hypothesis that the substantive integration of peer support workers with clinical staff in these services will provide a pathway to achieving recovery-oriented practice and improved consumer engagement.

Demographics	Mean	%	Mean	%	Mean	%		
Age at admission (years)	28(7.2)	-	33(8.2)	-	30(7.8)	-	$t_{(22)} = -1.51$;	.15
Proportion male sex	-	69	-	88	-	75	$\chi^2_{(1)} = 1.00$	.32
Unemployment	-	100	-	100	-	0	n/a	n/a
Admitted from the community	-	88	-	25	-	67	$\chi^2_{(1)} = 9.38$	**.00**
Interview length (minutes)	20(6.9)		20(4.4)	-	20(6.0)	-	$t_{(22)} = 0.09$	.93
Primary diagnosis								
Schizophrenia spectrum disorders*	-	94	-	75	-	87	$\chi^2_{(1)} = 1.71$	.19
Secondary diagnoses								
Substance use disorder (non-tobacco)	-	63	-	38	-	54	$\chi^2_{(1)} = 1.34$	.25
Personality disorder	-	13	-	0	-	8	$\chi^2_{(1)} = 1.09$	.30
Obsessive compulsive disorder	-	6	-	0	-	4	$\chi^2_{(1)} = 0.52$	.47
Acquired brain injury	-	0	-	13	-	4	$\chi^2_{(1)} = 2.09$	.15
Autistic spectrum disorder	-	6	-	13	-	8	$\chi^2_{(1)} = 0.27$	.60
Treatment								
Involuntary Treatment Order	-	50	-	50	-	50	$\chi^2_{(1)} = 0.00$	1
Chlorpromazine equivalent dose (mg)	517(256.9)	-	906(538.9)	-	646(411.5)	-	$t_{(22)} = -2.40$	**.03**#
Depot prescribed	-	50	-	50	-	50	$\chi^2_{(1)} = 0.00$	1
Clozapine prescribed	-	38	-	0	-	25	$\chi^2_{(1)} = 4.00$	**.05**
Antipsychotic polypharmacy	-	38	-	75	-	50	$\chi^2_{(1)} = 3.00$	.08
Mood stabiliser prescribed	-	19	-	38	-	25	$\chi^2_{(1)} = 1.00$	.32
Antidepressant prescribed	-	44	-	38	-	42	$\chi^2_{(1)} = 0.09$	.77
Routine outcome measures								
Total HoNOS score (mean)	12(6.4)	-	11(6.7)	-	12(6.4)	-	$t_{(22)} = 0.53$	.60
Total LSP-16	12(6.6)	-	15(9.0)	-	13(7.5)	-	$t_{(22)} = -1.09$	.29
Total MHI (%)	57(19.3)	-	64(18.6)	-	59(19.0)	-	$t_{(22)} = -0.80$	.43

* ICD10 diagnoses F20.x & F25.x

$p > .05$ when a single outlier was excluded from the analysis.

Table 1: Characteristics of consumers completing interviews from the integrated and clinical staffing model sites. Standard deviations are provided in brackets where relevant. Reproduced with permission from Parker, Dark, Newman, Hanley, et al. (2017).

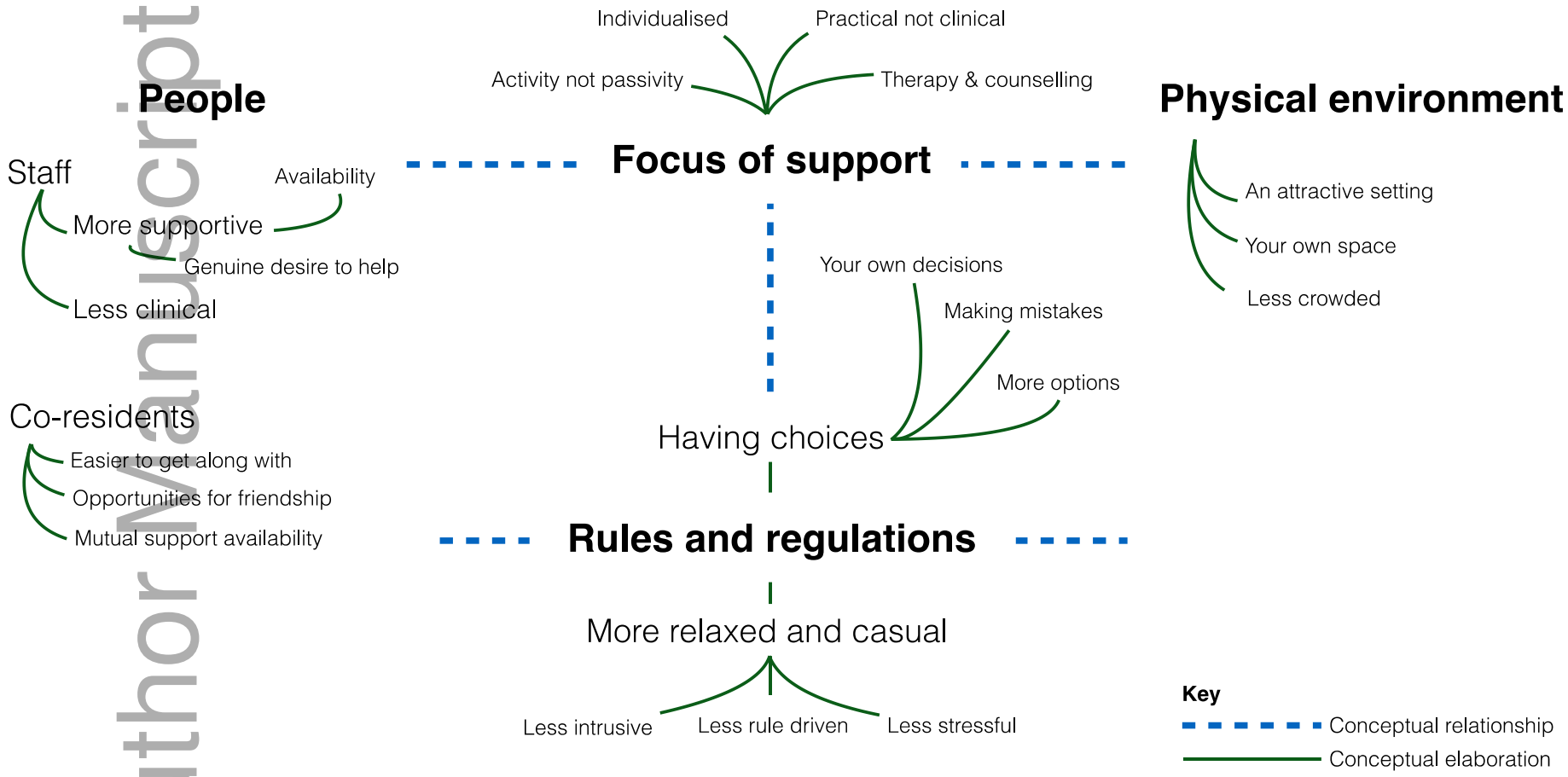

Figure 1: Conceptual Map – Consumers' expectation that the community-based residential rehabilitation unit will be better than previous experiences of mental health support and care.

Level 1: Concept	Level 2: Feature	Level 3: Descriptor	Level 4: Descriptor (detail)
People (24/24)	Staff (24/24)	More supportive (21/24)	Availability (16/24)
			Genuine desire to help (10/24)
		Less clinical (12/24)	-
		More positive / hopeful (6/24)^	Non-judgemental (3/24)
		The same (3/24)	Positive (2/24)
			Negative (1/24)
	Co-residents (13/24)	Easier to get along with (7/24)	-
		Opportunities for friendship (5/24)	-
		Mutual support available (4/24)	-
Environmental regulation (21/24)	Having choices (14/24)	Making your own decisions (12/24)	-
		Being allowed to make mistakes (2/24)	-
		You get more options (2/24)	-
	A relaxed & casual environment (10/24)	Less intrusive (5/24)	-
		Less strict or rule driven (6/24)	-
		Less stressful or chaotic (3/24)	-
Focus of support (15/24)*	Activity not passivity / boredom (11/24)	-	-
	Practical not clinical (6/24)	-	-
	Individualised treatment (5/24)	-	-
	Counselling & therapy > medication (4/24)	-	-
Physical environment (11/24)#	An attractive setting (8/24)	-	-
	Own space (5/24)	-	-
	Less crowded / more space (4/24)	-	-

^ Only evident in integrated staffing model transcripts
* Compared to acute / sub-acute inpatient care
# Compared to acute / sub-acute inpatient care and supported accommodation

Figure 2: The final coding framework of expectations of a community-based residential rehabilitation unit in comparison to other mental health care and support settings.

Level 1: Concept	Level 2: Feature	Level 3: Descriptor	Illustrative transcript extracts
People (24/24)	Staff (24/24)	Peer workers are people you can relate to (7/16)	I think peer workers are… the biggest addition to [the CCU model, I] just find that you can relate to them a lot more… I think just having… the peer support workers is like […a] really good step… because they've lived through it… [INT045]
			[Peer workers] have a good understanding of what mental illness is like and… how they as a helper and me as a patient should respond to it. [INT072]
			[T]hose peer support workers here. I think that was the best idea… [the service] has ever had because its really hard for someone without mental illness to understand what you're going through… so they've got pretty much… hands on experience, from personal experience. And they don't freak out… Like they know just as much as the clinical staff, if not more because they experience these things. [INT056]
		Breaking down traditional barriers to rapport and communication (5/16)	[Y]ou only really see the [clinical] staff when it's – you know got an appointment or something… Whereas the peer workers, you know they're here 24/7… so you can actually get more of a chance to sit down and talk to them about… just about anything… All the [clinical] staff and the peer workers do talk so you know you talk to the peer workers and they get to know you and they sort of communicate that to the staff. So the staff [are] getting to know you better as well. [INT004]
			[In describing what is good about the CCU compared to previous care] [I]t makes me feel like yeah, you know, they want to help out, you know, without doing… just paperwork and all what doctors do. [The doctor] actually comes out and be's in a group with us. [INT047]
		More positive / hopeful (6/24)	[Peer workers] give me hope because I look at them and think, you know, that could be me one day. I could be working for… [the service] teaching other people to live… [INT056]
			[Peer workers] have a good understanding of what mental illness is like and… how they as a helper and me as a patient should respond to it… if I start whining and being pessimistic about what I'm doing, I… get the positive feedback that explains look that's the wrong way you're looking at it. [INT072]
			[CCU staff are] always positive, un they're always saying hi and how/re you going, you know and just being supportive, which is a really good thing. Sometimes, I need that to just get out of my own bad headspace you know. [INT050]

Figure 3: Expectations of the integration of peer support with routine clinical care under the integrated staffing model for residential mental health rehabilitation.

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