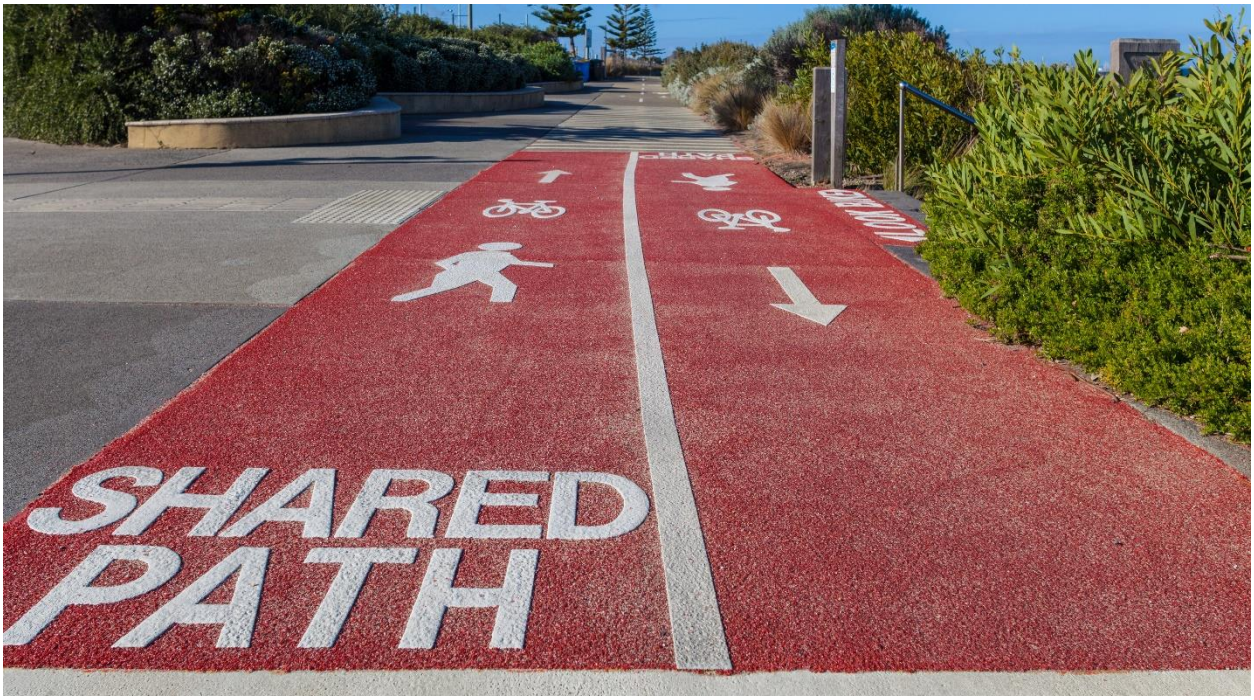
The Path Runs Through Connection:

The Primacy of Connectedness in a Regional Mental Health Recovery Center



Mental Health Recovery and Social Inclusion Project Report
July 20, 2020

Principal Author: Tamra J. Huesers

Research Team: Tamra J. Huesers, Dawn Olson, Melanie Johnson, Wayne Monson, Brent Emerson

Tamra J. Huesers
Mental Health Recovery and Social Inclusion Project Report, University of Hertfordshire

Table of Contents

Tamra J. Huesers
Mental Health Recovery and Social Inclusion Project Report, University of Hertfordshire

The Path Runs Through Connection: The Primacy of Connectedness in a Regional Mental Health Recovery Center

Abstract

User-led and user-driven community mental health organizations have served as advocates and purveyors of personal mental health recovery in the United States for several decades. Though positive strides have been made in recovery and social inclusion over the years, some old barriers remain, and new ones have arisen. This indicates that user-led/driven community mental health organizations—some of which are called recovery centers (RCs), as in this examination--are by no means obsolete, but also that they cannot stand still. Evident in myriad iterations throughout the years, RCs must continuously evolve in order to bring their members ever closer to the realization of recovery and social inclusion in modern society. Essential to that evolution is the full involvement of members in determining the function and direction of their RCs (Brown, 2009b; Nelson & Lomotey, 2009; Ochocka et al., 2006; Tritter & McCallum, 2006).

This project originated with a desire to gather and employ the views of the membership of a regional mental health RC regarding the programs and services of the center moving into the future. Mental health recovery is recognized by the RC as the personal, individual way a person moves beyond their illness to discover a "new and valued sense of self and purpose" (Deegan, 1988) and create a full and satisfying life (Anthony, 1993; Deegan, 1988, 1996). The RC is one of eight regional recovery centers in the state that are built upon a philosophy of personal mental health recovery and function as user-guided (though not consumer-run), community-based support centers for those living with mental health issues.

Unexpectedly altering the future of this and other RCs has been the advent of the Covid-19 pandemic. On March 17, 2020, the RC under study was forced to modify its services to members to a primarily remote-support model due to the onslaught of the Covid-19 pandemic. Suddenly, the future of RC's looks different not purely due to changing society, the advancement of community inclusion, and the maturation of the mental health recovery concept (Slade et al., 2012). Added onto that is a new world in which the global nature of life and the risks that come with it add complications that change how people connect and relate.

The study was a mixed-methods, grounded theory type (Charmaz, 2008, 2014; Ward et al., 2015), participatory study conducted in two segments: a photography-based initial project (the *Recovery Photo Project*) that sought members' personal views of the things that promote their mental health recovery (Budig et al., 2018; Cabassa et al., 2013; Lorenz & Kolb, 2009; Thompson et al., 2008; Wang et al., 1998); and a second, survey-based inquiry (the *Initial Social Distancing Survey)* into RC member support during the initial weeks of the Covid-19 pandemic, during which the services of the RC were necessarily modified. This stage honed in on particular findings regarding *connectedness* (Hare-Duke et al., 2018; Leamy et al., 2011; Tew et al., 2011) realized in the photo project, and focused on those due to the particular impact of the pandemic on connectedness and relationship as part of the essential functions of the RC.

The two phases of the study asked two overarching questions: 1) What things aid members in the pursuit of their own personal mental health recovery (Compton & Shim, 2015; Deegan, 1988, 1996; Leamy et al., 2011; Sederer, 2016; WHO, 2014)? and 2) What must the RC do now and into the future to maintain and foster the essential process of *connectedness* (Hare-Duke et al., 2018; Leamy et al., 2011; Tew et al., 2011), in light of the 'new normal' introduced by a global pandemic?

The project revealed that the things that RC members found most important to their recovery were those things that supported the processes of connectedness, hope and optimism, identity, meaning, and empowerment, or CHIME (Leamy et al., 2011). Foremost of all process to members was connectedness. The second phase of the project found that members felt that they had largely been able to maintain connection to the RC, to peers, and to others in their lives during social distancing related to the pandemic. Some felt that support they received had increased as new routines and methods of connection were utilized. The survey also found that virtual means of contact, including telephone contact and online meeting platforms, were effective in promoting connectedness. These findings bear meaningful implications for the RC's provision of services moving into the future.

Initial Literature Search and Review

The literature review for this project was broad and was re-engaged throughout the process, as the intended grounded theory approach calls for themes to be allowed to arise out of the research without undue presupposition and in a constant comparative manner (Charmaz, 2014). An initial search found that there is little specific research out there regarding organizations with the particular structure and functions of the RC targeted by the study. Though the RC is member-focused, non-clinical, and essentially runs like a community consumer-run organization, its management and accountability

structures and funding mechanism are inconsistent with accepted definitions of consumer-run organizations (Slade, 2009, pp.110-111). The variability of organizations that are considered "peer-run organizations" in the US and the scarcity of research regarding such organizations is noted by Ostrow & Leaf (2014).

The literature search commenced with a review of various articles regarding recovery, peer support, social inclusion, and consumer-run services encountered in the author's academic study over the preceding several months. Subsequently, a literature search utilizing the *CINAHL Plus*, *Medline*, and *Humanities Complete International* databases was performed. Only articles written in English or with English versions and published from the year 2000 forward were sought. Some of the key terms utilized were mental health, recovery, social inclusion, recovery centers, consumer run organizations, community mental health centers, self-help organizations, community psychosocial rehabilitation centers, service-user or member opinions or views, and governmental funding. With definitions of consumer-run organizations in mind, the literature that was most applicable to the exploration to be undertaken was found utilizing the Boolean phrase "consumer run organizations OR community mental health centers AND inclusion." From 98 articles produced, 19 were found to be accessible and relevant to the topic. Several significant articles were later pulled from reference lists associated with the initial literature search articles.

In an effort to ascertain broad presence of relevant literature, searches were also conducted through *Academia* and *Google Scholar*. Through a systematic sorting and review, 14 additional sources were located. In total from all sources, 45 relevant articles were retrieved. In addition, three books were accessed, one containing a compilation of several applicable chapters by different authors/researchers.

Relevant literature addressed topics that included characteristics of community/consumer-run mental health organizations (Holter et al., 2004; Mowbray et al., 2008; Ostrow & Hayes, 2015; Reinhart et al., 2005; Scholz et al., 2016; Shaggott et al., 2013; Tanenbaum, 2011), determinants of engagement in such organizations (Hardiman, 2016; Nelson & Lomotey, 2009), how consumer-led organizations promote recovery processes or provide consumer outcomes (Austin et al., 2014; Brown & Meissen, 2008; Corrigan, 2006; Nelson et al., 2004; Segal et al., 2011; Thomas & Salzer, 2017), the relationship of levels of participation to outcomes (Ochocka et al., 2006), measures of fidelity to core principles of user-led organizations (Mowbray et al., 2005), impacts of consumer-run organizations (Atterbury & Rowe, 2017; Janzen et al., 2007), organizational and sustainability needs of such organizations (Ostrow & Leaf, 2014), and public policy as it pertains to consumer-run organizations (Borkman et al., 2009; Nelson et al.,

2008). A series of articles out of another similarly fiscally- and socially-conservative state examined various aspects of state-supported consumer-run organizations in that state that maintain activities and services and have origins similar to the targeted RC, but which have evolved to show more fidelity to true definitions of consumer-run organizations (Brown, 2009a, 2009b; Brown & Townley, 2015; Shagott et al., 2013; Wituk et al. 2008). It was expected that the applicability of the literature retrieved would gain focus as the initial phases of the research developed.

Research Philosophy, Methodology, and Methods

This study was a co-produced qualitative study that adopted an interpretivist paradigm, which recognized the complexity and nuance of human experience (Denscombe, 2017). It further followed a constructivist view, which "brings subjectivity into view and assumes that people, including researchers, construct the realities in which they participate" (Charmaz, 2014, p. 342). These viewpoints are apt in the examination of personal mental health recovery, as recovery processes are also complex, rich with relationship, and heavily contextually-influenced. In addition, as all co-researchers of this study were also members or member-employees of the RC that is the venue of the study, it is essential to recognize the various influences their positions within the context created.

The CHIME framework of recovery processes (Leamy et al., 2011) aided in fleshing out personal recovery process exploration and analysis as it relates to personal recovery needs and RC programs and services. CHIME provides a framework for personal recovery, its pillar processes being *connectedness, hope and optimism, identity, meaning, and empowerment.* As CHIME has been discussed and examined at the RC in peer groups, recovery education, and newsletter articles, it was important to consider to what degree these themes arose spontaneously from the data and whether pre-knowledge of CHIME was a contextual influence. Conceptual focus was expected to sharpen or change—and did--as data analysis progressed (Charmaz, 2008; Seale, 1999), causing CHIME to gain prominence as the project proceeded.

A theoretical model that influenced the approach to this research and the application of findings was *social determinants of mental health*. This model heavily informed the state's recent expansive *Behavioral Health System Study* (HSRI, 2018a, p. 2) and is a familiar and preferred context for state legislative bodies. Acknowledging this viewpoint will simplify the application of study results to legislative policy-making. More importantly, giving attention to social determinants of mental health supports a rounded view of mental health that allows personalization in approaches to mental health intervention while also recognizing societal influence and responsibility and contextual factors (Compton & Shim, 2015; Sederer, 2016; Townley and Terry, 2018; WHO, 2014). Social determinants are significant

to the opportunities, inclusion measures, educational efforts, stigma correction, service collaboration, referral, and other functions that are or should be found in the state's RCs.

The project adopted a grounded theory methodology that reflects the constructivist view of Charmaz (2006, 2008, 2014). Though grounded theory can appear daunting, it can be a very productive methodology for small scale research, as well as research that examines complex relational and contextual situations and personal points of view (Denscombe, 2017). Tie et al. (2019) identify that grounded theory can be a good fit for novice researchers despite its complexities.

The study used mixed methods within two project phases, with the intention of providing several and varied opportunities for members of the center to provide input. The initial phase of the study consisted of the *Recovery Photo Project*, which examined what members view as important to their mental health recovery. RC members were invited to photograph things and people that help them in their personal mental health recovery journey, and to comment briefly on what those photos represent to them. The photo project was completed in parallel with a RC-developed satisfaction survey—the *RC Recovery Survey*--that asked about the center's promotion of recovery principles. Themes derived from this phase of the study informed the latter survey phase of the inquiry.

The second portion of the project was initially planned as a set of semi-structured interviews following an intensive interviewing style (Lotfi, 2018), along with one to two focus groups that explored major themes discovered in the photo project phase. However, the approach was altered due to the loss of in-person interview capacity and closure of the physical facility of the RC due to Covid-19-related precautions for the foreseeable future. Utilization of remote personal interview/focus group methods such as conference calls or use of online video platforms was considered, but this possibility was rejected by the project team due to a perceived inequity of availability to all members that might skew study results. Development and administration of this survey will be described more extensively later in this writing.

The project embraced the value of co-production in knowledge generation and service planning, and was undertaken by a project team consisting of the primary investigator, who is a member-employee of the RC and served as project lead and was responsible for most of the writing involved with the project, and four additional RC members who volunteered to take part in planning, implementation, and review of the project and its findings. These are all individuals with lived experience of mental health issues. Team members did not participate in all portions of the project, but contributed according to their

strengths and choices (Cahn, 2004; Fisher 2016). Team members shared in idea generation, survey development, RC member education, data review and coding, theme development, review of written reports, and other aspects of the project. Some implementation aspects of the project were also assisted by the RC Director, who is not a person with lived experience but who has over 30 years' experience within the RC and with promoting recovery principles.

Cahn (2004) envisioned co-production as a mechanism of social justice, which shifts power and control to stakeholders and values each person's strengths, abilities, and contributions to society. In mental health, co-production is increasingly seen as essential to successful, engaging, recovery-oriented service planning and research (Clark, 2015; INVOLVE, 2019; Lozano-Casal, 2017; Pinfold et al., 2015), though institutional barriers (Carr, 2006), co-production as a tick-box exercise (Kirkegaard & Andersen, 2018), and implementation complexities exist (Clarke et al., 2018 Gheduzzi et al., 2019; Oliver et al., 2019). Markkanen & Burgess (2016) site that, "Co-produced evidence and knowledge is generally believed to be more socially robust, truthful, comprehensive, inclusive, and overall a more accurately [sic] representative of reality" (p.5).

Gantt Chart

Please see Appendix C for the initial and amended Gantt charts. These illustrate the change in process that the project undertook due to the Covid-19 pandemic and other factors.

Ethical Issues

As this project was accomplished within a state-funded RC, state and organizational consents to move forward were explored. On the state level, the Department of Health (DOH) Office of Human Research Protections indicated that the project would not require Institutional Review Board submission, as it consisted only of surveys or interviews that collect information on opinions. It also does not involve use of DOH data, funding, or resources (NDDOH, 2017, p, 4). To ascertain this interpretation was correct, corroborating opinion was sought and received from the RCs managing agency (a local hospital) and its oversight agency (a regional Human Services Center, or HSC).

Written consent was sought from all persons contributing photos to the *Recovery Photo Project* or appearing in such photos (see Appendix B). Individuals were given the opportunity to select an alias for use if participant photos or comments are referenced in written reports. Any public display of photos has been and will continue to be anonymous. For any persons with alternative guardianship, appropriate consents were sought.

Project Preparation and Precursors

The co-research team for the project was formed of volunteers from the RC who were recruited by word of mouth, signs posted at the RC, and the RC's monthly newsletter. Four RC members plus the member-employee primary investigator formed the project team. Project volunteers participated in an informational session about the project, what it would entail, and their possible roles.

As soon as the team had its first meeting in September, 2019, they were diverted and tasked by a state-wide group of RC directors--through their primary investigator--with developing a simple satisfaction survey that could be used by all RCs in the state. Building on the writings of personal recovery founders such as Anthony (1993) and Deegan (1988,1996), and informed by concepts of recovery processes consistent with the CHIME conceptual framework (Leamy et al., 2011; Piat et al., 2017; Recoveryplace, 2017; Slade et al., 2012), the team developed a brief, recovery-sensitive, anonymized Likert scale satisfaction survey—the *RC Recovery Survey*--that asks members about how the RC facilitates their mental health recovery journey (see Figure 1).

The team chose to test the survey for statewide feasibility at the RC as part of the comprehensive project plan. This occurred from December 2, 2019 through February 7, 2020. Surveys were offered to all RC members, and participation was voluntary and anonymous. Surveys were made available in the center only, and advertised by in-center signage, the RC newsletter, and word of mouth. The results of this will be discussed later in this writing. (Note: With only two minor wording changes, the survey was adopted for state-wide RC use in February of 2020.)

During the development of the *RC Recovery Survey,* the project team focused on the questions, "What is recovery?" and "What promotes recovery?" They contemplated the best way for individuals to, in addition to the *RC Recovery Survey*, express those things in a meaningful way that could also direct the planning of activities and services at the center. A team member noted that snapping and sharing photos is now a widely accepted way of communicating, and maybe something could be pursued in that vein. This prompted the *Recovery Photo Project*.

Recovery Center Member Survey

Please complete the following survey, rating each statement on a scale of "strongly agree" to "strongly disagree".

	Statement	Strongly Agree	Agree	Neutral/ Don't Know	Disagree	Strongly Disagree
1	The Recovery Center is a place where I can freely express myself and discuss issues related to my life.					
2	At the Recovery Center, I feel valued and as if I belong.					
3	The Recovery Center staff treat me with respect.					
4	Recovery Center staff are friendly and approachable.					
5	I feel safe at the Recovery Center.					
6	The Recovery Center promotes personal mental health recovery.					
7	Recovery Center staff demonstrate knowledge about mental health recovery.					
8	The Recovery Center offers opportunities for members to have meaningful input and/or leadership roles.					
9	The Recovery Center acknowledges the importance of having purpose and meaning in my life.					
10	I have been able to form connections with other people through participation in the programs, activities, or services of the Recovery Center.					
11	The Recovery Center focuses on my strengths.					
12	The Recovery Center helps me overcome mental health stigma and helps me feel positive about myself.					
13	The Recovery Center offers specific activities that interest me and are valuable to me.					
14	The Recovery Center is a good place for me to be regardless of if I am feeling healthy or experiencing difficulties related to my mental health.					

Please list comments about any of the above statements here, indicating the statement number you are commenting on before your comment. You may also add comments regarding other matters pertaining to the recovery center that may not be covered by the above statements. If you need more room, continue your comments on the back of this sheet.

_____

_____

_____

_____

_____

_____

Figure 1 – The RC Recovery Survey

Phase I: The Recovery Photo Project

Introduction

Significant literature exists on the use of photo-based research methods as valid tools of qualitative research (Budig et al., 2018; Cabassa el al., 2013; Clements, 2011; Flanagan et al., 2016; Lorenz & Colb, 2009; Thompson et al., 2008; Wang et al., 1998; Werremeyer et al., 2017), though there are critiques of its use (Creighton et al., 2018; Fairey, 2018). Padgett et al. (2013) differentiate various types of photo-involved research and note the lack of standardization in methods used. The method employed in this study does not strictly follow Photovoice (Wang, 1998), photo elicitation interviewing (PEI)--which utilizes a photo as an element of a research interview (Harper, 2002)--or other specific methods. Photovoice (Wang, 1998) asks participants to create the photos, but involves significant interview and follow-up for which this team did not have resources, training, or capacity. Though PEI often utilizes photos that have not been produced by research participants, Padgett et al. (2013) utilized "individualized PEI" in their study, giving study participants control over the content of the photos presented in interviews. Fairey (2018) emphasized that, no matter what form of "giving voice" (p. 111) is afforded to a group or community, it is irrelevant if we choose or sensor what is seen, thereby maintaining old power structures and failing to fully "listen" to what is being expressed.

The Recovery Photo Project arose out of our exploration of photo-based research approaches. Our method incorporated abbreviated elements of both Photovoice and PEI methods, asking persons with lived experience to take photos of things that they see as important to their mental health recovery, then commenting with one to several short, active phrases indicating what the photo represents. In essence, the photo with its comments became a condensed interview.

The project was introduced to members through word of mouth, the RC newsletter and Facebook page, signage at the RC, and information provided to case managers involved with many of the RC's members. Team members also produced an informational video about mental health recovery (Harmony Center, 2019), and a "Kick-off Party" that showed the video, provided a presentation on recovery, furnished information about the project and instructions regarding participating, gave out door prizes, and provided a time for socialization. Examples of related publicity/instructional flyers can be found in Appendix A.

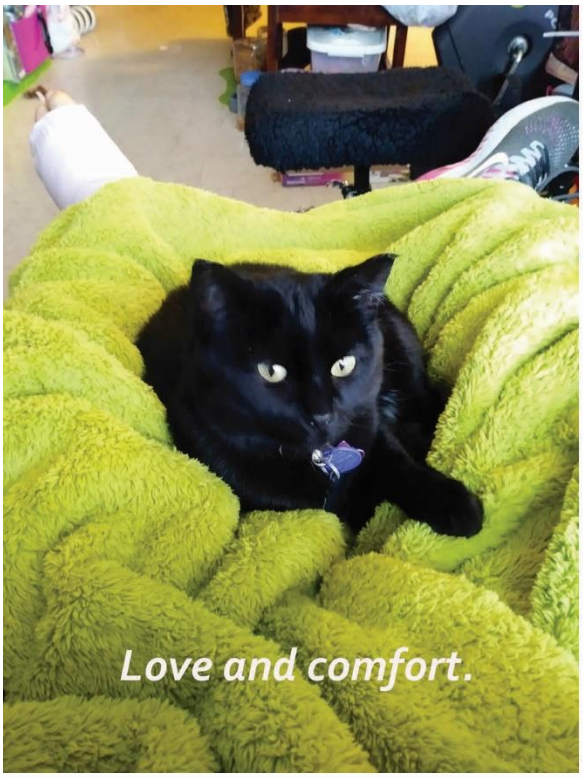
All RC members were invited to participate in the project. Those who did not have access to cameras or photo-capable cell phones were offered free loaner digital point-and-shoot cameras, with instruction by

staff on how to use them. Participants were asked to supply initial photos and their related comments to the principal investigator in person, via thumb drive, through email, or through text or messaging application. Large file sizes were preferred in order to promote printability for the later display. Participants were asked to provide their photos and comments and submit consent forms by the end of January, 2020.

Once submitted, photos and their accompanying descriptive phrases were transferred onto summary sheets marked for each respondent. Three participants designated an alias for alternate identification in reports. The project team participated in educational and practice sessions led by the principal investigator regarding coding of qualitative data (Charmaz, 2014), then reviewed photos and comments as a group.

Results and Analysis

Thirteen RC members submitted from one to eight photos each, for a total of 59 photos. Two of these photos, which contained images of persons other than the respondent, lacked sufficient consent for display. Photos encompassed subjects from family members to pets to nature scenes to hobbies and interests. A few of the photos are presented starting on this page, along with part or all of their accompanying descriptive phrases. The original intention of the project team was to utilize the photos and descriptions submitted in the project to create a photo installation at the RC for viewing and comment by members and the general public, with a special event reception to initiate the public viewing. This, however, was delayed into early March by technical issues, then altered due to mandated pandemic-related distancing practices. As a result, the photo display was transformed into a slideshow-based video presentation for public view that summarizes the project and contains all consented photos along with their descriptive phrases (Huesers, 2020). Please see this video for the photos in total.


Love and comfort.


My family is my strongest mindset support for me because they center me.


"CHRIST IS THE ANSWER"
1255 S. ASHLAND AVE
CHICAGO, IL 60608
312-226-4823
Spiritual support, loving support, giving support. Those I can talk to when I can't talk with anyone else.

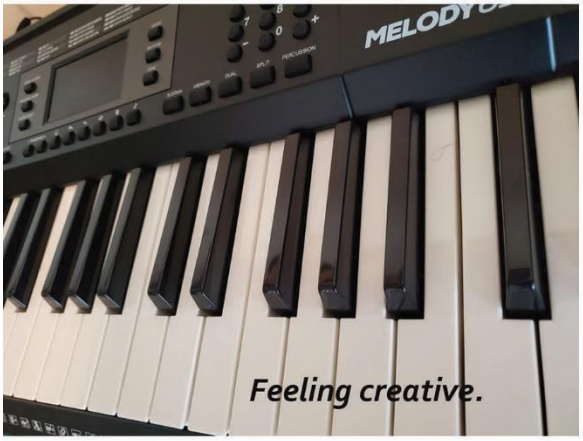

Having good memories of Great-grandpa. Feeling my history and connection.


Having understanding peers.
Feeling connected.


Feeling funny.


Providing unconditional love.


My medicine makes me
feel myself again.

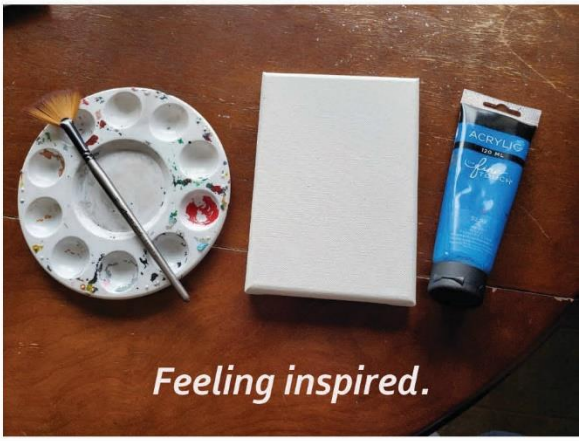

Feeling creative.

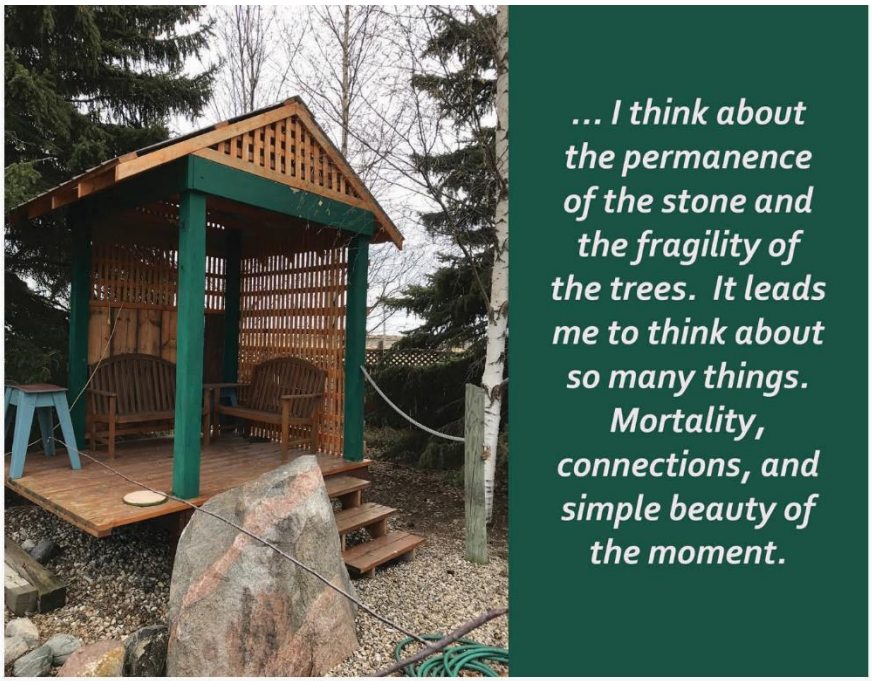

Enjoying plants and nature.


My first doll that Mom bought me. Good memories.


Mind trips. Exploring so many places, things. Learning what there is to learn all from books.

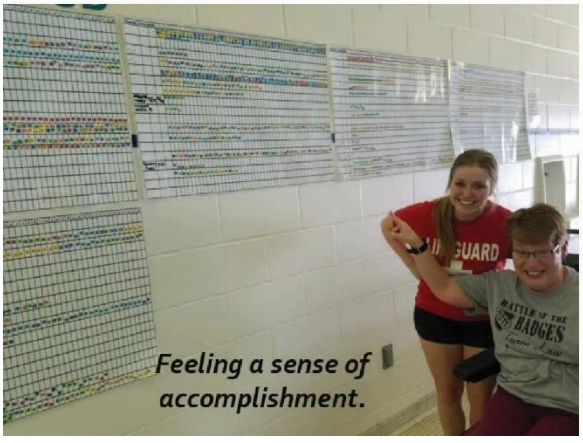

These guys really help me in my life because no matter what they love me.


Feeling inspired.


... I think about the permanence of the stone and the fragility of the trees. It leads me to think about so many things. Mortality, connections, and simple beauty of the moment.


I like our home. It makes me proud. I have a home base. We've got it the way we want it.


Feeling appreciated and valued.


Feeling a sense of accomplishment.

Since respondents were asked to describe their photos with brief, active phrases, in many ways initial data coding was done by the respondents themselves. The project team, as a group, further fleshed out gerund-based coding (Charmaz, 2014, pp. 120-124) with attention to the content and the context of the photos. Some comments consisted of several components and, likewise, yielded several codes. At this level, a clear tendency of the data toward CHIME framework (Leamy et al., 2011) was evident. A review of this secondary level of codes found all codes to fit readily into CHIME categories. Figure 2 presents the gerund codes, by both respondent and by reference, as well as how they corresponded with CHIME categories. Figure 3 provides a visual representation of the proportion of references to each of the CHIME categories of *connectedness*, *hope & optimism*, *identity*, *meaning*, and *empowerment* (Leamy et al., 2011). The CHIME process that by far eclipsed the other categories represented was *connectedness* (Leamy, 2011), though all others were well represented.

Given the intention of this project as a directive for services, acceptance of its corroborating stance toward CHIME framework was considered instructive and further coding was not performed. The video presentation of the photos embraced CHIME categories, which were used as a scaffold for its organization. It must be noted that the project had no original intent of substantiating or disproving CHIME processes, and a discussion of application versus discovery of theory is apt (Charmaz, 2014) (see *Discussion* section).

While the *Recovery Photo Project* showed that RC members placed a high value on connectedness, the *RC Recovery Survey,* done in parallel with the photo project, showed its lowest average score on a question directly addressing connectedness. As noted earlier, the *RC Recovery Survey* consists of 14 questions on a Likert scale that asks for ratings from 1 for “strongly disagree” to 5 for “strongly agree”. It also offers an open-ended comment section. Fifteen surveys were collected over a two-month period parallel to the photo project, though persons who completed the survey were not necessarily the same ones who were photo project contributors. Figure 4 shows the average score rating for its respective questions. Only six surveys contained a written comment, and all comments were positive in nature. One person described the RC as “a great place to interact with others” specifically in a comment, but also rated the RC’s promotion of connectedness lower than all other aspects on the Likert scale.

Recovery Photo Project Code Breakdown

Code	Files (respondents)	References
Connectedness	0	0
Belonging	1	1
Enjoying nature	4	6
Feeling connected	5	6
Connection with pets	10	11
Having close family relationships	5	9
Having friends, peers	2	3
Having someone to talk to	2	2
Feeling love	6	10
Giving love	2	3
Unconditional love	2	3
Feeling supported	2	2
Feeling comforted	1	3
Finding emotional support	2	2
Finding general support	1	3
Finding loving support	1	1
Finding spiritual support	1	1
Giving support	2	2
Healing relationships	1	1
Being given to unconditionally	1	1
Relieving Anxiety	1	2
Totals	52	72
Empowerment	0	0
Caring for our bodies	1	1
Caring for our spirits	1	1
Coping with limitations	1	1
Feeling accomplishment	3	4
Feeling appreciated	2	3
Feeling comfortable	1	1
Feeling empowered	2	2
Feeling grounded, stable	1	1
Feeling healthy	1	1
Feeling ownership	1	1
Feeling responsibility	2	2
Feeling safe	2	2
Feeling self-reliant	1	1
Feeling stable	2	3
Feeling grounded	2	2
Feeling strength	1	1
Feeling in control	1	2
Feeling independent	1	1
Learning from others	1	1
Meditating	1	1
Totals	28	32

Figure 2 – Breakdown of initial and secondary coding and its correlation with CHIME.

Hope & Optimism		0	0		
Feeling creative, imaginative		2	2		
Feeling curious		1	1		
Feeling happiness		6	8		
Avoiding sadness		1	1		
Feeling inspired		1	1		
Feeling motivated		2	4		
Feeling peace		2	2		
Hoping for an active future		1	1		
Observing someone who is lively and active		1	1		
Striving for personal goals		1	1		
Totals		18	22		
Identity		0	0		
Being curious		1	1		
Being my best self		1	2		
Cultivating wisdom		1	1		
Embracing traditions		1	1		
Feeling important		1	1		
Feeling intelligent		1	1		
Feeling knowledgeable		1	1		
Feeling like myself		1	1		
Feeling Proud		3	4		
Feeling Valued		1	1		
Finding the good in ourselves		1	1		
Having hobbies and interests		1	1		
Totals		14	16		
Meaning		0	0		
Appreciating beauty		3	4		
Finding enjoyment		1	1		
Enjoying positive memories		4	4		
Enjoying the moment		1	1		
Enjoying things		2	2		
Finding purpose		5	8		
Life is fragile, temporary		1	1		
Observing innocence		1	1		
Sensing mortality		1	1		
Sensing permanence		1	1		
Valuing life		1	1		
Totals		21	25		

Figure 2 (cont.) - Breakdown of initial and secondary coding and its correlation with CHIME

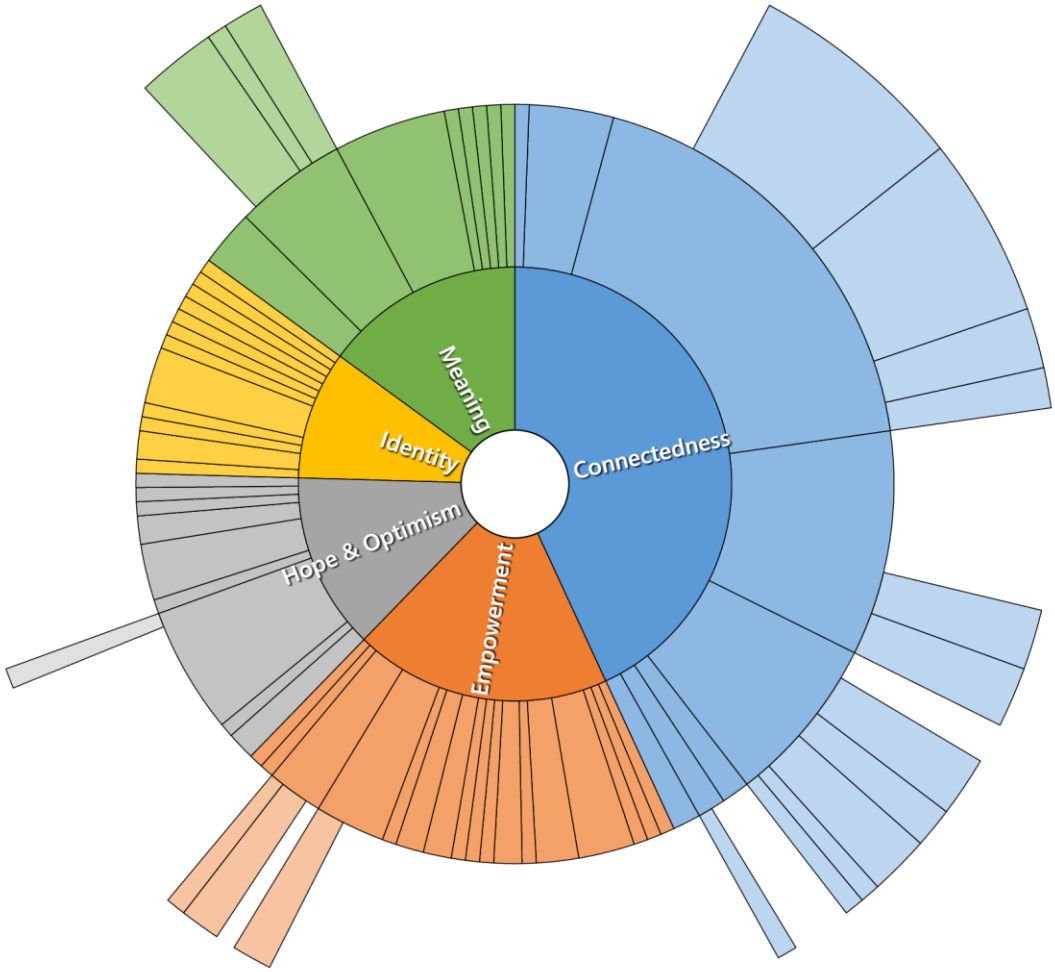


Figure 3 –CHIME process representation in photos and their related comments, by number of references.

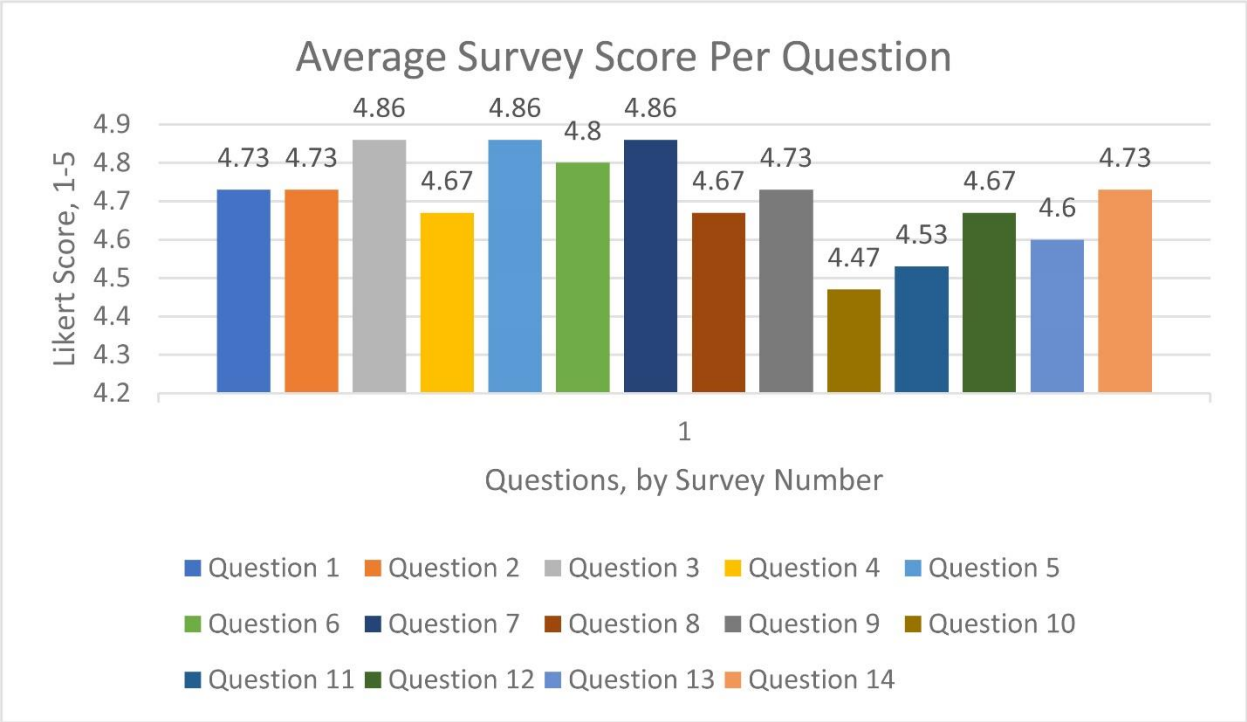


Figure 4 – Average score per question on the RC Recovery Survey

Discussion

The *Recovery Photo Project* proved to be a revelatory and beneficial experience for the RC in which it took place. At the very least, it introduced the RC's members to the idea that they have power within their RC, and can examine topics and issues relevant to them and have those findings heard and acted upon. Having 13 members participate directly in the project, with many others acting peripherally (anything from participating in associated classes and meetings to viewing results of the project), evidenced a cohesion-producing undertaking.

Honey et al. (2019) speak of how their consumer-led service evaluation project produced "a culture of respect for others' skills, appreciation for others' efforts, determination to avoid dominating others, and a willingness to share leadership, hear everyone's ideas and reach consensus or compromise" (p. 699). The project team found similar benefits. The primary investigator and author, who is a member-employee of the RC, wrote in her process notes: "I am beginning to understand how co-produced research changes power dynamics. As much as I identify as a person with lived experience, I still very much related to people at the [RC] in an employee-to-member way." She went on to state, "I realize

that I need them, and that each is adding a perspective that I could not. Because I do need them, I am finding that I am more likely to hold up my end of the reciprocal relationship..."

Challenges presented themselves along the way in this portion of the project. The RC serves persons with a broad range of intellectual and functional abilities, as well as with varied opportunities to have learned technical skills or own electronic devices. This offered the prospect of a wide range of viewpoints, but also meant that some members are technically savvy, while others struggled with sharing through a photographic format. Most members utilized their own photograph-capable devices. Only a few members attempted use of the loaned cameras, and they experienced difficulties even with personal instruction. Camera use difficulties were overcome with both intensive personal coaching and acceptance of photos for what they are, whether considered technically "good" or not. Minimal photo editing was performed--other than improving coloration or lighting for presentation or cropping photos where participants requested or approved--in order to maintain the authenticity of the contributor's viewpoint.

A related issue was that of obtaining photos of sufficient file size to produce the printed photographs that were to make up the planned in-center photo installation. Because many members initially shared their photographs through messaging applications and had been encouraged to do so in order to obtain as much data as possible in a timely manner, file sizes were often too small to create a satisfactory printed image. Much time was spent pursuing photos from the original sources/devices, and the ability to create a visually satisfying physical display, though still planned after the RC returns to in-center services, remains in question. Production of an online slideshow display allowed the incorporation of photos of varied file sizes, so this solution offered a benefit in addition to making photos accessible during the pandemic and social distancing. If this photo approach is again used in the future, more time should be spent instructing contributors on device use, ways to take visually pleasing photos, what is needed to produce a clear printed photo, and how to obtain and transfer photos successfully.

Obtaining consents for photos in which persons other than the contributors appeared was also a logistical problem. Much time was spent pursuing these ends. However, leaving out photos for which obtaining consent was difficult would clearly have skewed the results of the project, as it would have primarily minimized the representation of connectedness, which turned out to be a major focus of member contributions.

It is notable that persons with co-occurring mental health and substance use issues, while not absent from this phase of the project, were under-represented. According to the RC Director, persons who self-identify as having dual concerns represent about half of the current RC membership. However, they made up less than one third of photo project participants. This phenomenon was accentuated in the second phase of the RC project, and is examined more extensively in that section.

The process of coding of the qualitative data was approached consciously, influencing even the way in which contributors were asked to supply their photo descriptions. Though the project team reviewed basic coding strategies as defined by Charmaz (2014), this was a confounding process, especially to those who had no prior research background. One team member related that it was awkward enough in itself to review contributions of others with whom one is acquainted, and intimidating to try to extract meaning and themes from those contributions. For these reasons, an interactive team coding process was pursued. Elliot (2018) lays out coding as a decision-making process that may be influenced by certain research traditions, but that must be context-informed and pursued with purpose in mind. The team approached coding from this viewpoint.

Because constructivist grounded theory (Charmaz, 2014) embraces the idea of emergent coding and theme development, the project team wrestled with whether attributing second-level codes to CHIME categories (Leamy, 2011) reflected a loyalty to the data or a preconception based on prior knowledge of the CHIME framework. We contend that it represents both, and that this is not problematic as long as this is acknowledged and examined (Charmaz, 2014; Elliot, 2018). Charmaz (2014) notes that identifying preconceptions in research is an essential part of the grounded theory process, and that, "A fine line exists between interpreting data and imposing a pre-existing frame on it" (p.159). The project was not set up for adherence to *a priori* themes (Elliot, 2018), specifically CHIME processes (Leamy et al., 2011), nor was it intended as a proof or disproof of CHIME. However, RC members and the principal researcher have an intimate familiarity with CHIME and have utilized it within the RC as one means of understanding and teaching the concept of personal mental health recovery. Charmaz (2014) offers a series of questions that researchers may ask themselves before applying existing concepts during coding and theme development (p. 159). We believe that the answers to these questions support the applicability of CHIME to our process, and given that the end purpose of the project was to aid in service planning for the RC and not pure theory development, we accept the role that CHIME has played and can play in that purpose.

With this in mind, it would be safe to contend that the *Recovery Photo Project* does represent support for the legitimacy of the CHIME framework. As this project asked contributors to share photos of things that aid in their personal mental health recovery, it was essentially a positive-facing project that looked at aids and not barriers. Such a perspective is often a criticism of CHIME itself, as noted by Stuart et al. (2017) who purport that the difficulties in recovery are diminished or overlooked by such a positive stance and support the expansion of CHIME to "CHIME-D" (p. 302), or CHIME plus difficulties. Our data only contained one negative comment, that being "hiding, masking my identity" in accompaniment to a photo in which a member was wearing a silly mask and held an additional comment that read "feeling funny". In this instance, a difficulty could be seen as a barrier to realizing a CHIME process, rendering the framework still applicable. It may be constructive in further investigation to view "difficulties" in this light.

The photo project offered several other revelations. Only two photos referenced treatment or therapy, supporting the idea that recovery is a much broader concept that may include treatment, but which is not synonymous with it (Deegan, 1988; Slade et al., 2012). Though this has been a long-held principle guiding the programs of the RC, the adoption of recovery language by mental health services that collaborate with the RC and by the state's Department of Human Services (NDDHS, 2014) constantly threatens to pull recovery back toward a clinical, linear view of recovery (Castillo et al., 2013; Deegan, 1988; Mead & Copeland, 2000; Ramon et al., 2009; Yates et al., 2011).

The project also showed the importance of pets in the lives of members, disclosing a source of connection and meaning that is often overlooked in mental health recovery. This topic could be an area of study in itself, and has implications for RC activities that might include pets and animals. The inclusion of pets within the concept of connectedness was initially passed over, but this relationship is recognized in the literature (Borg & Davidson, 2008; Davidson et al., 2005; Mental Health Foundation, 2020; Stuart et al., 2017) and it was included as the iterative coding process advanced.

Perhaps most striking and most significant in the photo project data is contributors' emphasis on the connections in their lives they see as important to their recovery. Figures 2 and 3 reveal that 43% of responses in the photo project pertained to connectedness. It is likely that this number may even be a bit low, as members related that they did not submit some photos they had initially wished to because they knew that getting consent would be problematic. Tew et al. (2012) emphasize that the processes of CHIME are interrelated, and all are intertwined with connectedness. Hare-Duke et al. (2019) identified components of connectedness in their CIVIC framework, specifically: *Closeness, shared Identity, Valuing*

the relationship, socially Involved, and *Cared for and accepted.* It is evident, then, that connectedness is complex but essential to mental health recovery.

Phase II: The Initial Social Distancing Survey

Introduction

The project team pondered whether narrowing the focus of study in the planned interview/focus group second phase of the project was warranted, but initially decided to continue on while still attending to a broader range of recovery processes, with the primacy of connectedness in mind. The planned theme for the interview/focus group phase was based on the main question, "What does or should the RC do to assist you in your mental health recovery?" However, as noted previously, once the services of the RC changed due to the Covid-19 pandemic, the focus of the project necessarily narrowed. The team chose to follow the data into an examination of whether the RC was able to facilitate connectedness processes during the pandemic, and to do so through a brief, open-ended survey to be completed by members. The *Initial Social Distancing Survey* was undertaken in order to take an early look at how members were perceiving and adjusting to the center's modified services, implemented in light of the pandemic. The focus of the survey was on *connectedness.*

The focus on connectedness in the survey was undertaken for two reasons: First, the earlier, photography-based study done at the RC in December 2019 through February 2020 revealed that those things that members found important to their mental health recovery fell into five recovery process categories consistent with those outlined by Leamy et al. (2011) in their CHIME framework. Of the five processes, things that promoted *connectedness* were by far the major recovery-aiding elements that members identified. That study left a clear opening for the further evaluation of connectedness in mental health recovery.

Second, the onset of the Covid-19 pandemic took aim at the very heart of connectedness with the implementation of social distancing to prevent viral spread. The RC transitioned from in-center services to distancing-conscious member interaction. This included intensive telephone contact, institution of peer support groups through an online video platform, contacts through messaging applications and social media, conventional mail outreach, and limited in-person interaction utilizing protective measures.

In light of these considerations, it seemed imperative that the RC think comprehensively about support being provided to members during the pandemic and into the future's "new normal".

Supplemental Literature Search

A supplemental literature search was performed using the terms *mental health recovery* and *connectedness.* The search sought journal articles published within the past 15 years in English. Only articles regarding adult mental health were considered. The search utilized the *Medline, CIHAHL Plus,* and *Humanities International Complete* databases. The search revealed 42 non-duplicated articles, of which a check of accessibility and review-by-title narrowed to 18. A review of the abstracts of the remaining articles yielded 13 articles to be studied in their entirety. An additional 12 articles, gleaned from the references of other applicable articles, were added, resulting in a total of 25 relevant articles.

Central to both mental health recovery (Schön et al., 2016; Tew et al., 2012; Topor et al., 2006) and to recovery-oriented services (Happell, 2008; Ness et al., 2014; van Weeghel et al., 2019; Webber et al., 2015) is relationship, also often explored in applicable research as *connectedness.* Connectedness encompasses a range of relationships, support from others, and community participation (Piat et al., 2017) and incorporates interpersonal relationships and social inclusion (Tew et al., 2012). Leamy et al. (2011) establish connectedness as an essential process of mental health recovery within their CHIME conceptual framework (Leamy et al., 2011, Slade et al., 2012). Hare-Duke et al. (2019) further define five dimensions of connectedness, referred to with the acronym *CIVIC*. Yuen et al. (2019) see social connectedness as an indicator of recovery, while Happel (2008) sees promotion of connectedness as a recovery approach. Some (Schön et al., 2016; Topor et al., 2006; van Weeghel et al., 2019) define recovery as an essentially social process. A number of researchers identify recovery-oriented interventions—such as participatory arts, housing support, and occupational assistance--as promoting connectedness (Doroud et al., 2015; Hui et al., 2019; Piat et al., 2017; Stickley et al., 2018). Brown et al. (2008) identify that the "socially supportive participation experience" (p. 167) of consumer-run organizations—organizations with functions similar to the RC--leads to positive recovery outcomes. Yates et al. (2011) identify iterations of connectedness among the "ecological processes involved in recovery" (p. 8), and find that people benefit from "half-way points" (p. 8) between segregated services and full community inclusion; places such as the RC.

Based on recovery concepts of connectedness, the survey developed by the project team was a brief open-ended questionnaire that asked RC members questions about contact with the center, who

members were maintaining connection with during social distancing, what means of maintaining contact and connection with others were being used, what supports were being experienced, and more (see a copy of the survey as Appendix D). Several studies support the use of open-ended survey questions and find them valuable in research, service evaluation, program planning, and policy development, noting that the use of this qualitative tool stands alone or adds value to quantitative data (Marcinowics et al., 2007; Rich et al., 2018; Riiskjær et al., 2012). Marcinowicz et al. (2007) state that open-ended survey questions provide, "information that answers to closed questions may not elicit." The survey was created by the center's Recovery Coordinator, and was reviewed and developed by the five-member co-research team utilized for the preceding photo study, with insight from the center's director, prior to being operationalized.

The study was directed specifically at all members of the RC. It was made available online, in paper format, and by telephone call-in to the center. Fifty-three members, those for whom we had some form of contact information, were personally invited via mail, text, email, or verbal invitation to participate in the survey. Verbal invitations were also given in all online support groups. An invitation, a printable copy of the survey, and a link to the online survey were posted on the center's Facebook page (Harmony Center, 2020). Respondents were given the option of identifying themselves and giving contact information on the survey for feedback or response to their in-survey requests, or submitting it anonymously. This summary considers survey responses submitted from April 2 to May 15, 2020, though the online version of the survey remains available as an input mechanism for members and as ongoing information for the center. No inducements were provided to people for completing surveys.

Results and Analysis

Twenty surveys were returned to the RC. Twelve were completed online, three by mail, five via call-in. Fifteen respondents provided their names and contact information. Five submitted anonymously. The 15 identified surveys and three that indicated anonymity but whose respondents voluntarily and spontaneously identified themselves to center staff were completed by persons personally invited in some manner to do so. We are unable to determine if the remainder received personal invitation or were aware of the survey through social media or other means. Therefore, it is not possible to accurately calculate a rate of survey completion. However, we view the approximate rate of response of 38% as encouraging, especially since "People with mental illness can be wary of participating in research because of their experiences with stigma, marginalization, and oppression" (O'Leary et al., 2017). No additional demographic information, such as gender or age, was collected for this survey. See Figure 5

for examples representative of answers to the survey. A full record of responses is available upon request.

In addition to reviewing the answers to the specific questions, the contents of responses were analyzed for themes (Charmaz, 2014). Because of the short time frame required in the process and the limitations of contact with the research team during social distancing, theme coding for the survey was performed by the primary investigator and later sent to team members for review and comment . Specific codes that corresponded closely with the data were noted initially, followed by identification of primary themes (Charmaz, 2014). Once themes were recognized, the data was reviewed to ascertain that all references to these themes had been adequately considered and to check for themes that may have been missed.

It should be acknowledged here that the "themes" developed in analysis of the survey are utilitarian and serve the purposes of an evaluation of services for the RC. They likely represent underdeveloped thematic analysis of the qualitative data. This, again, corresponds with Elliot's (2018) assertion that coding decisions should be made with consideration to the context of a study and its designated purposes. Expanded, more concept-centered than task-centered coding and theme development (Charmaz, 2014) may be revelatory and should be pursued in the planned follow-up investigation.

Five major theme categories arose from the results:

1. Difficulties encountered
2. The RC maintains connection with members—how it helps.
3. In what manner are members experiencing support and connection right now?
4. With whom are members staying connected?
5. Suggestions for further assistance.

Figure 6 breaks down those categories by number of respondents (files) and number of total cumulative references to that topic throughout the responses. Figure 7 is a visual representation of the number of references to these items, with the most references being gained regarding the means by which members are experiencing support and connection right now, and with whom respondents are maintaining connectedness.

Survey Question	Yes/No Responses or Responses representative of answers to this question.
1. Have you been able to stay in touch with RC staff since services were modified due to the Covid-19 Virus?	18 Yes ☑ No* (*Please see the "Discussion" section for comments on this question.)
2. If you said yes in #1, how have you been in touch, and how has this helped you?	"By phone and messaged…calmed my anxiety." "Peer support through Zoom" "Talked on the phone twice with staff at the RC. Helped me feel not as bored." "I have been able to stay connected with the RC through Zoom. This has been very helpful because I know I have someone to talk to at least once a day. A person can join in on the zoom meeting at 1 o'clock every day." "The Zoom conferences have been nice. The RC sent us something in the mail and went from there." "Through Zoom. I enjoy being with the group for companionship and new ideas about emotional illness."
3. If you said no to #1, do you want to be in contact? How, when, and how often would you like to be in contact? (For example: by phone call or text, once a week, in the afternoon.) How would this help you?	"[It helps] Emotionally." "Text every couple of days please and anytime." "No."
4. In what ways has the RC supported you during the time of social distancing so far?	"Just them being there to talk to has helped. And knowing I can contact them any time comforts me." "Peer support group" "I've been able to call you." "Phone calls. By checking up and seeing how I'm doing. I always like to hear your laugh." "The RC is keeping us connected to each other and being supportive." "I love our zoom meeting. I love seeing everyone still. I miss everyone. But even virtually – which I'm not into – wow, it's great. We can talk about the situation and it makes me feel we still are connected and can support each other and care about each other. This so hard for everyone and our virtual meeting is a lifesaver."
5. What other things could the RC do to support you? (Be creative in your suggestions. No suggestions are bad.)	"I can't think of anything else, they do a good job." "Any type of suggestion on elevating [sic] boredom." "I'd say maybe just keep on calling, and I know I can call you. Keep checking in. I'd like a call more often—maybe every other day." "They're doing a lot—calling me, giving me projects to do. I've talked to J. and to you and both of you have been checking on me."

Figure 5 – Initial Social Distancing Survey Answer Representative Examples

6. Have you been able to stay connected to other people--such as family, friends, counselors, clergy, and so on--in some way during social distancing?	18 Yes 2 No
7. If you said yes to #6, how? Tell us about the support you're receiving.	"By phone and brief contact at North Central [Human Services Center]." "I watched church service; my therapist is online; I've been able to phone my family and friends; peer support through the RC." "Support from family." "I have been connected to my family and staff and my cat Elly." "By phone. Getting out some. Going on walks with my friend helps a lot, too. Haven't been in touch with my worship group. I should get in touch with them." "My mom and I have gone for a walk outside and others have offered to pick up groceries for me and have been willing to run to the food pantry for me. This has been very helpful. I don't have to worry about going hungry."
8. If you said no to #6, why? How might the RC be able to help you with this?	"Evening zoom peer support or just hanging out in Zoom to just talk, see another face. I am still able to volunteer from home but my volunteering keeps me from peer support which I really miss as I work during the daytime. The evenings get long, boring, and too much time to brood." "I'm not sure."
9. Do you have other needs that are not being met during social distancing, for which the RC could provide assistance or help you find other resources? If so, what?	"Again like I said just to have a way to see others and visit in the evening or weekends when it's easy to run out of things to do if you don't drive and leaves too much time to dwell in the dark places." "I need something to pass my time." "Could do with more assistance around my panic attacks, they are more frequent and I need reassurance sometimes that I am not dying or alone." "I am unsure at this time." "I'm pretty antisocial but I am having a hard time with the few social things I had that I'm too worried to do now. I don't think RC can help with that. It's a hard time for all of us." "I could use ideas on a new doctor." "No, I'm doing good. Doing the best I can with social distancing. I've been wearing a mask when I have to go out. It's been wonderful, really. I've never had so much support."
10. If you would like, please provide us with your contact information so that we can get back to you about needs you've expressed. Your contact information will always be kept confidential.	15 of 20 respondents provided name and contact information for the survey. Three additional persons spontaneously and voluntarily identified themselves to RC staff.

Figure 5 (cont.) – Initial Social Distancing Survey Answer Representative Examples

Difficulties encountered. Though not asked for specifically in the questions, respondents revealed the types of difficulties they were experiencing early in the pandemic during social distancing. Most often, respondents indicated that they were missing family, friends, or support systems, missing activities or feeling boredom, or were encountering undefined difficulties, expressed as "this is hard" or "I want this to be over."

The RC maintains connection with members—how it helps. Respondents indicated a number of ways in which continued connection with the RC, despite modification of services, was helpful to them. Foremost among these was a general sense of connection and support, and simply—and most cited--just having someone to talk to.

With whom are members staying connected? Respondents indicated that they were mainly staying connected with family or with peers. The largest number of references was to peers and peer support. Respondents did not allude to a great extent to continued contact with case management or other mental health services, though a few references were present.

In what manner are members experiencing support and connection? Members identified that they were experiencing support in a number of ways, both traditional and new. Most frequently, support and connection were being maintained through telephone contact. Second to that, respondents identified that they were utilizing the Zoom online video conferencing platform to stay connected with the center staff and with peer groups. Three respondents were specifically noted to use the survey as a vehicle for expression and a source of support in itself.

Suggestions for further assistance. Though asked directly, respondents did not offer extensive opinion on what the RC could do additionally to enhance connectedness and support. Most often, they indicated that they would like more contact. There were singular requests for information about/help with symptom management, technical assistance with the Zoom platform, a request for a referral, and suggestions for online group recreational activities.

Name **Survey Themes by Number of Surveys in Which the Item is Referenced, and by Number of Total References Throughout the Surveys**	Files	References
D -- **Difficulties encountered**	0	0
D1 - Experiencing fear or worry	1	2
D2 - Feeling out of control	1	1
D3 - General difficulties	3	4
D4 - Missing activities or feeling boredom	3	4
D5 - Missing family or friends or support systems	3	5
HH -- **HC maintains connection with members--how it helps**	0	0
HH1 - Delivers activities, supplies to me	1	2
HH10 - Someone to talk to; companionship	9	9
HH2 - Eases boredom	1	2
HH3 - Feel calmed and reassured	2	2
HH4 - Feeling accepted	1	1
HH5 - Helps us with technology	1	1
HH6 - I am not alone	1	1
HH7 - I know they are available if I need	3	3
HH8 - Keeps us connected and supported	6	7
HH9 - Provides education and new ideas	1	1
SC -- **In what manner are members experiencing support and connection right now**	0	0
SC1 - Support and-or connection in person with precautions	4	5
SC2 - Support and-or connection through mail	3	3
SC3 - Support and-or connection through phone	14	25
SC4 - Support and-or connection through text, email or social media	6	6
SC5 - Support and-or connection through Zoom	10	11
SC6 - Using other modes of support	5	6
SC7 - Using survey as source of support, vehicle of expression	3	3
SC8 - Working as a supportive activity	1	1
W -- **With whom are members staying connected**	0	0
W1 - Connected with family	10	11
W2 - Connected with friends	2	2
W3 - Connected with peers, peer support	9	17
W4 - Connection with pets	1	1
W5 - In touch with clergy, church	3	3
W6 - In touch with Human Services Center	2	2
W7 - In touch with therapist or counselor	2	2
W8 - Receiving direct care services or other similar	1	1
X -- **Suggestions for further assistance**	0	0
X1 - Different times for support	1	2
X2 - Help with symptoms	1	1
X3 - Need a referral	1	1
X4 - No other needs; can't think of anything	10	10
X5 - Other types of support wanted	3	3
X6 - Technical assistance with Zoom	1	1
X7 - Want more contact	3	3
X8 - What is needed not in the scope of the Harmony Center	1	1

Figure 6 – Survey Themes by Respondent (file) and Total References.

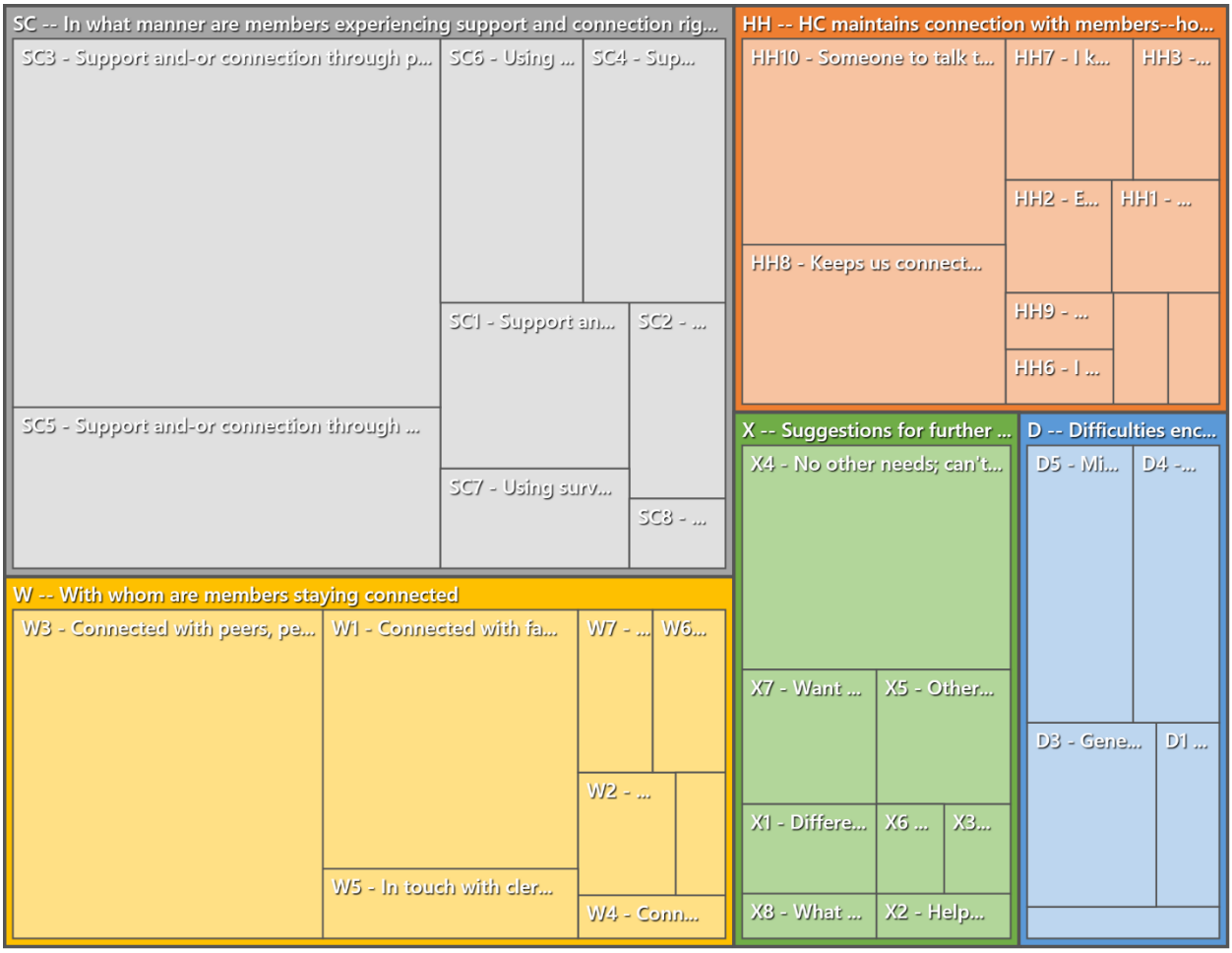


Figure 7 –Theme Categories by Proportion

Discussion

The *RC Initial Social Distancing Survey* showed that center members value and desire connectedness and are utilizing various ways to stay connected with the center, peers, family, and others during the pandemic and social distancing. The primary parties with whom members continue to connect are family and peers. This validates findings of *The Recovery Photo Project* (Huesers, 2020), which found connectedness to be a major aspect of individuals' personal mental health recovery and identified family and peers as relationships of major importance to members who had contributed photos. It also correlates with research findings by Schön et al. (2009) which concluded that, "recovery processes are social processes in which social relationship play a key role" (p. 336).

The survey also shows that technology can play a major role in facilitating connectedness during social distancing. Telephone contact presents in the survey as a vital lifeline. Though it is considered a mainstream support tool, telephone contact in this instance moved from an "add-on" mode of contact to a primary vehicle for support. A study by Travis et al. (2010) affirmed the effectiveness of telephone support in a mental health context by showing that telephone support proved to be a valid, beneficial support mode for persons with chronic depression.

In addition to telephone support, use of online video meeting platforms is revealed through the survey as feasible and beneficial among the population served by the RC. A study by O'Leary et al. (2017) found that persons with mental health concerns used and benefitted from a number of technology-based support modes for peer support, and that technology helped them feel empowered, let them find the type of support they needed at the time at which it was needed (as opposed to waiting for services), and allowed individuals to define themselves in terms other than diagnostic labels. It is interesting to note that the RC did not simply convert its peer members from in-person peer support groups to online groups, but added members who would not normally access in-person groups to its peer support rolls during the time of social distancing and modified services. This points to a need for such a mode of support participation outside of and beyond the pandemic.

A barrier to utilization of these beneficial technology-based communication modes is *access,* with cost and user knowledge of how to use devices as major components of this barrier. Access could be enhanced with assistance programs to help members obtain devices such as cells phones or laptop computers, or to provide discounts or assist with payment of internet and telephone service subscriptions. Technical set-up assistance and simple device use tutoring could make technology-based remote communication methods feasible for a broader swath of individuals. Access to technology-based services and support is impacted by governmental funding and health care reimbursement, and it is imperative that governments and funding sources recognize and pay for technology-based forms of support, or their use will not be broadly feasible.

Other barriers to access could include cognitive impairments such as memory problems or learning disabilities (O'Leary et al., 2017)--though these do not rule out the use of technologies—and accessibility for persons with hearing, vision, or other physical differences. The O'Leary study emphasized user involvement in developing technology use strategies, matching peers on similarities beyond diagnosis, attending to accessibility, and providing peer training in order to optimize usage and mitigate risks such as excessive criticism and bullying or over-disclosure and self-destructive interactions.

Survey respondents identified that the RC was maintaining connection with them and that it was helpful to them. Among the difficulties that members were seeking to address included missing family or friends, anxiety, boredom, fear or worry, and feeling out of control. Some statements of how the center's ongoing connection was helpful included feeling calmed and reassured, easing boredom, providing information, being available if they are needed, and so on. Most identified by respondents, however, were a general sense of feeling connected and supported and simply having someone to talk to. Hare-Duke et al. (2018) identify the prevalent nature of loneliness among persons with mental disorders and emphasize the importance of having a researched, coherent framework that informs approaches to cultivating connectedness. This, combined with the recognition that personal mental health recovery is not primarily about treatment and interventions, but heavily dependent on relationship and connectedness (Leamy et al., 2011; Schön et al., 2009; Slade et al., 2012; Tew et al., 2012; Topor et al., 2006; Van Weeghel et al., 2019), validates the essential place of community-based recovery centers such as the RC in mental health recovery and directs its services to maintain a focus on the promotion of various aspects of connectedness.

Survey respondents did not offer a great number or range of suggestions for further interventions or support they would like to see provided by the RC. This could be a function of the limited time and space offered by the survey for a relatively complex question. The topic warrants further specific and in-depth investigation. The dearth of recommendations could also arise out of the fact that persons with mental health issues are not accustomed to having a say in what their services look like and how they are run (Beresford, 2019; Clark, 2015; Gilbert, 2020). The latter of these has implications for the center with regard to its planning and decision-making structure and general organizational format.

With regard to the structure of the survey itself, it was limited in nature due to the need for immediate information relative to the pandemic and its effects on recovery center members, as well as the need to minimize cost and utilize an online survey platform's (Survey Monkey) basic, cost-free functions. It might be beneficial to expand the survey in order to make the questions easier to respond to. This would, however, involve further expense to the RC. The open-ended nature of most questions was revelatory, so this aspect should be maintained.

In addition, the initial yes/no question of the survey may have lacked clarity for respondents. The two individuals who answered *no* to this question were persons who identified themselves and who *had*

been in contact with center staff. The confusion seemed to be related to respondents thinking the survey asked if they had *initiated* contact with the center. Question clarity should be reviewed if this questionnaire is utilized in the future.

One glaring gap in the RC survey is the virtual absence of survey participation by members who currently struggle with active or intermittent substance use in addition to other mental health concerns. This reflects a heightening of an effect seen in the photo project. Central to this lack of participation is the personal instability brought by substance use. There are also other related components immediately visible. First, center members who are struggling with substance use tend to have frequent changes in residence, phone numbers, and other contact information, which they do not routinely think to update with the RC. These individuals also often do not have the resources to take advantage of technology, and may have difficulty owning and keeping devices for various reasons. This made it difficult for us to provide an invitation to survey participation to some members who fall into that category. It also lessens the likelihood that such individuals would pursue connectedness and support through technology-based means or through the mail.

Second, the RC has noted a long-standing deficit in engagement by persons who have substance use issues. The phenomenon could have several contributors, and it is ripe for further investigation. One possibility is that persons with substance use concerns may defer to other services first, such as 12 step programs, dual-diagnosis services, or addiction-specific peer programs, though anecdotal reports from such services have indicated that they have also seen a drop-off of engagement during the pandemic. In addition, the RC does not currently have an individual with lived experience of substance use on staff, though several peer support group members have substance use histories and engage openly in discussions about it. Chinman et al. (2018) found a significant difference in the amount of reliable change on measures of psychiatric symptoms for dual-diagnosis persons who experienced high engagement with peer specialists with similar lived experience, and lack of reliable change for those with low engagement. Relevance may be a factor.

Another possible factor could be that persons with substance use disorders prefer a different type of engagement and connectedness. As one of our members with a history of alcoholism but years of sobriety indicated to the principle investigator: “Those of us who are addicts don’t thrive on this technology stuff. We need to look people in the eye and be with them. That’s what we built our sobriety on, and it’s hard to change that.” Interpersonal engagement preferences among persons with substance use issues is a topic that warrants further exploration.

Overall, a follow-up investigation once the Covid-19 pandemic is under control and services are normalized--even if changed in some ways--would be instrumental in fleshing out connectedness needs of members and informing the evolution of services. It would also allow a more intensive dive into the factors underneath engagement gaps for some RC members.

Cross-project Outputs and Conclusions

Outputs

The two-phase RC project yielded a number of outputs. The first product developed was a RC satisfaction survey (see Figure 1) utilized for this study in this particular RC, and adopted state-wide by regional RCs as a brief, repeatable evaluation of services and their recovery focus. In addition, the project produced a 6-minute video containing member statements about what recovery means for them (Harmony Center, 2019); a 15-minute slideshow-based video for member and public view summarizing the *Recovery Photo Project* and exhibiting the member photos collected (Huesers, 2020); the development and use of the *Initial Social Distancing Survey* (see Appendix D) and a report regarding that survey, submitted to the RC's managing and supervisory agencies through the RC Director, as well as to the membership of the RC.

The results of the full project have also been an integral part of discussions within the RC regarding modification of services moving into the future, particularly in light of the post-pandemic "new normal" facing the RC. The RC has already made the decision to keep technology-based peer support methods in place after the RC physical facility is reopened to member traffic. Both fully remote and hybridized remote/in-person groups will be offered. Planned telephone support and calling trees with also continue post-reopening, as they have been found to be constructive and supportive for many members. A post-Covid-19 survey and/or series of member interviews is in the planning stages, and this is expected to supply the RC with further information regarding what activities and services truly support connectedness and processes of recovery for its members.

The full report of this project will be supplied to the RC and its managing and supervisory agencies, and will be utilized as supporting information in legislative testimony in the state during the 2021 legislative

session. The RC also continues to plan for a physical display of member photos and their associated comments collected in the *Recovery Photo Project,* once the RC's physical building reopens.

Summary Discussion and Conclusions

This project was undertaken in order to assist an RC to evaluate the activities and services it provides to persons with mental health concerns. The RC sought to evaluate whether they were facilitating members' recovery needs, providing the types of services that meet current needs and promote inclusion, and moving adequately toward the future while advancing inclusion and the normalization of attending to mental health concerns.

The project initiated the use of systematic co-production in research and service development within this RC. The RC is not a fully user-run organization, making any inroads to member control important to its recovery focus and balance of power (Beresford, 2019; Clark, 2015; INVOLVE, 2019). The project team undertook an evaluation exercise utilizing the *Co-Production Evaluation Schema* (Eisenstadt, 2015), finding that, though the fidelity to complete co-production principles (Beresford, 2019; Carr, 2016; Clark, 2015; Fisher, 2016; INVOLVE, 2018; Kirkegaard & Andersen, 2018; Pinfold et al., 2015) was fair at best, this initial foray into co-production was meaningful and empowering to participants and created a starting-point for further co-produced work (See Appendix E). As one team member stated, "I never would have even imagined that I could play a role in research. It seemed out of reach, but now we know it's not." Co-production in services is essential in recovery-supportive entities such as the RC, as it imparts relevance and promotes engagement (Carr, 2016; Ostrom, 1996), something that has been waning at this RC. Co-production in this project was functionally diminished by the nature of the principal investigator's connection to the project (as an educational requirement for their MSc degree), as well as by the Covid-19 pandemic and the difficulties it created with time-frame, communication, and personal and emotional demands on involved individuals.

The *Recovery Photo Project* created an innovative way for RC members to participate in research that affects their own RC and potentially others across the state and beyond. The question, "What things help you in your mental health recovery?" was a first step in a process of transformation in the RC, as it seemed essential to start from the very roots of defining personal mental health recovery and what aids it. Educational and technology issues arose in the project. However, the project provided the RC with a valuable glimpse into what is important to its members, and provided some succinct revelations. Recovery aids, to the RC's members, presented primarily as things that make up everyday life. Though

therapy and treatment were identified as recovery helps, they made up a small portion of the comment-accompanied photos. This reinforces a definition of recovery that is non-clinical and individual-oriented (Anthony, 1993; Deegan, 1988; Leamy et al., 2011; Mead & Copeland, 2000; Ramon et al., 2009; Slade, 2009; Slade et al., 2012; Wallcraft, 2013). With this, a distinct correspondence with CHIME recovery processes (Leamy et al., 2011) was seen in the resulting data.

Eclipsing the other recovery processes seen as important to RC members in the photo study was the concept of *connectedness* (Leamy et al., 2011). Connections with family, peers, pets, and providers were seen as important. The results of the conjointly-run *RC Recovery Survey*, however, showed that connectedness promotion is not fully realized in the RC. Though the RC routinely sponsors various types of group activities, including educational classes, peer activities, and social events, relatively low rates of participation show that it is not simply the group experience that promotes connectedness. Hare-Duke et al., (2018) developed a conceptual framework (*CIVIC*) that delineates five dimensions of connectedness: closeness, shared identity, valuing the relationship, being socially involved, and feeling cared for and accepted. This showed through in the project photographs. As the RC plans future activities and services that recognize recovery as a social process (Topor et al., 2006; Schön et al., 2016; van Weeghel et al., 2019) and promote connectedness, this framework will be a useful advisory reference and aid in instilling relevance to those activities and services.

The Covid-19 pandemic arose between the first and second planned phases of the project. The second phase was intended to consist of in-person, semi-formal interviews and one to two focus groups that discussed how the RC could aid the recovery priorities and processes uncovered in the photo projects. However, before the interviews commenced, the RC initiated modified, primarily remote services for its members in response to the pandemic. Given the short time frame for the project, the increased work load of RC employees in providing continuing support, and the lack of availability of an evenly-accessible remote interviewing process (including a lack of needed technology/equipment) during social distancing, the project team chose to administer the brief, open-ended *Initial Social Distancing Survey* in its place, with the intent to pursue an enhanced follow-up survey or an interview process that plays off of the survey results at a later date. Burbidge (2020) states, "Thinking through the measures that we've all taken in response to Covid-19 in four categories—stopping activity, pausing activity, temporary measures, and new innovations—can help us focus on what's worked and what can last" (p. 1). This viewpoint proved useful not only for considering next steps mid-project, but also in evaluating the results of the survey undertaken and how those results apply to the RC moving forward.

The RC's *Initial Social Distancing Survey* indicated that members had maintained connectedness with the RC, peers, family, and other persons and entities during the pandemic. They were experiencing some difficulties, but were finding those issues to be mitigated through connectedness measures. Connectedness with/through the RC and others was being accomplished largely through telephone support and online meeting platforms, though other various methods also played a role. The survey showed that support and connectedness can be maintained and expanded through methods other than in-center support, and that these methods can play a role in the post-pandemic "new normal" of service provision. One gap in the data arose from the lack of feedback from persons with co-occurring mental health and substance use issues. Weiss (2015) discusses how addressing substance use as a connectedness-related issue can be key to successful support of persons with substance use issues, and points the RC in the same direction as did the photo project. In addition, accessibility to technologically-enabled remote methods of support, such as online peer support groups, was a concern. Economic, educational, and inclusivity determinants were at play (Compton & Shim, 2015; WHO, 2014). Overall, the results of the survey support a rethinking of the activities, services, and even the structure of the RC moving into the future, and paint an optimistic picture of how the center can become even more accessible and relevant to members.

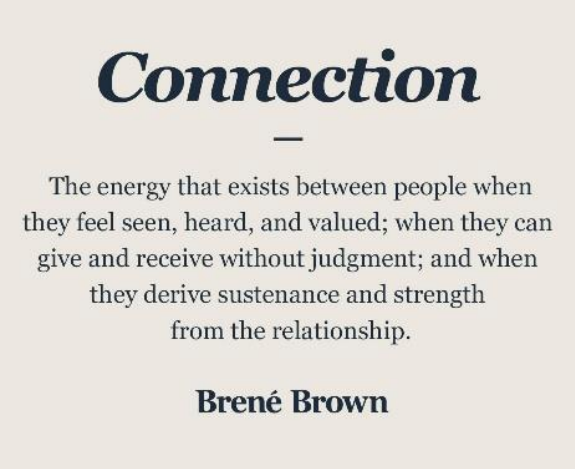
The RC project, as a whole, can be applied specifically only to this RC, though it presents implications for other RC's within the state's RC network and suggests methods by which they might evaluate their activities, services, and recovery focus. The small sample sizes in all aspects of the project limit generalizability. Recommendations for action in this RC include:

1. Continue and increase co-produced research and services/activities planning at the RC. Co-produce all program evaluations and assessments.
2. Periodically and on an ongoing basis reassess the recovery focus of the center and its activities.
3. Reassess post-pandemic activities and services of the RC with a positive change approach such as that outlined by Burbidge (2020).
4. Maintain a focus on connectedness in activities and services. Use the *CIVIC* conceptual framework (Hare-Duke et al., 2019) as a reference to evaluate whether essential aspects of connectedness are being promoted. Rethink group activities from this frame of reference.
5. Retain use of technology-based methods of support, such as peer support groups through video conferencing platforms and ongoing intensive telephone support. Blend these methods with in-person methods once the "new normal" of post-pandemic services is realized.

6. Seek funding for installing technology capabilities at the RC and assisting members with technology access. Provide technical assistance and education for RC members.
7. Follow up the *Initial Social Distancing Survey* with an extended post-social-distancing survey or interview series to evaluate the effectiveness of intermediary services and assess member needs moving forward.
8. Pursue a co-produced look into the existing gap in engagement for persons with dual concerns of mental health and substance use. When hiring is possible, add an employee-member who identifies as having lived experience with substance use issues.
9. Present findings of completed and pending research to the RC's managing and supervisory organizations and in testimony to the state's legislative body in 2021.

Items 1-6 and 9 are in process at the RC. Item 7 has been introduced to the project team and is in preliminary stages. Item 8 has been presented to the RC Director and is under early consideration.

The RC project was undertaken in order to, in simplest terms, make sure that the RC is doing the best it can for its members. Though we may speak of "recovery" or "inclusion" or "co-production", it all comes down to people, and to whether they are able to live full, contented lives of their own direction. The team entered the project with the idea that the RC must change *what* it does, and emerged with the realization that they must attend more to *how* they do what they do. Though the RC was open to and ripe for productive change at the outset of the project, the Covid-19 pandemic added both impetus and urgency to making true, life-affecting change. It appears that the path to that change runs through connection.



References

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal. 16*(4), 11-23. doi: 10.1037/h0095655.

Atterbury, K. & Rowe, M. (2017). Citizenship, community mental health, and the common good. *Behavioral Sciences and the Law, 35*(4), 273-87. doi: 10.1002/bsl.2293.

Austin, E., Ramakrishnan, A. & Hopper, K. (2014). Embodying recovery: a qualitative study of peer work in a consumer-run service setting. *Community Mental Health Journal, 50*(8), 879-85. doi: 10.1007/s10597-014-9693-z.

Beresford, P. (2019). Public participation in health and social care: Exploring the co-production of knowledge. *Frontiers in Sociology, 3,* 41:1-12. doi: 10.3389/fsoc.2018.00041.

Borg, M. & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health, 17*(2), 129-40. doi: 10.1080/09638230701498382.

Borkman, T., Munn-Giddings, C., Smith, L. & Karlsson, M. (2009). Social philosophy and funding in self-help: A UK-US comparison. *International Journal of Self Help & Self Care, 4*(3), 201-20. doi: 10.2190.SH.4.3.c.

Brown, L. D. (2009a). Making it sane: using narrative to explore theory in a mental health consumer-run organization. *Qualitative Health Research, 19*(2), 243-257. doi: 10.1177/1049732308328161.

Brown, L. D. (2009b). How people can benefit from mental health consumer-run organizations. *American Journal of Psychology, 43*(3-4), 177-188. doi: 10.1007/s10464-009-9233-0.

Brown, L. D. & Meissen, G. (2008). Organizational capacity needs of consumer-run organizations. *Administration and Policy in Mental Health, 35*(3), 212-19. doi: 10.1007/s10488-007-0162-7.

Brown, L. D., Shepherd, M. D., Merkle, E. C., Wituk, S. A. & Meissen, G. (2008). Understanding how participation in a consumer-run organization relates to recovery. *American Journal of Community Psychology, 42*(1-2), 167-78. doi: 10.1007/s10464-008-9184-x.

Brown, L. & Townley, G. (2015). Determinants of engagement in mental health consumer-run organizations. *Psychiatric Services, 66*(4), 411-417. doi: 10.1176/appi.ps.201400150.

Budig, K., Diez, J., Conde, P., Sastre, M., Hernan, M. & Franco, M. (2018). Photovoice and empowerment: Evaluating the transformative potential of a participatory action research project. *BMC Public Health, 18,* 432:1-9. doi: 10.1186/s12889-018-5335-7.

Burbidge, I. (2020). How to create real, lasting change after Covid-19. *RSA.* Retrieved June, 18, 2020 from https://www.thersa.org/discover/publications-and-articles/rsa-blogs/2020/04/change-covid19-response.

Cabassa, L. J., Nicasio, A. & Whitley, R. (2013). Picturing recovery: A Photovoice exploration of recovery dimensions among people with serious mental illness. *Psychiatric Services 64*(9), 837-42. doi: 10.1176/appi.ps.201200503.

Cahn, E. S. (2004). *No more throw away people: The co-production imperative (2nd ed.).* Washington, D.C.: Essential Books.

Carr, S. (2016). *Are mainstream mental health services ready to progress transformative co-production?* Bath, UK: National Development Team for Inclusion. Retrieved December, 26, 2019 from https://www.ndti.org.uk/uploads/files/MH_Coproduction_position_paper.pdf.

Castillo, H., Ramon, S. & Morant, N. (2013). A recovery journey for people with personality disorder. *International Journal of Social Psychiatry, 59*(3), 264-73. doi: 10.1177/0020764013481891.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: SAGE.

Charmaz, K. (2008). Constructionism and the grounded theory method. In J. S. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research.* (397-412). New York: The Guilford Press.

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.). London: SAGE.

Chinman, M., McCarthy, S., Bachrach, R. L., Mitchell-Miland, C., Schutt, R. K. & Ellison, M. (2018). Investigating the degree of reliable change among persons assigned to receive mental health peer specialist services. *Psychiatric Services, 69*(12), 1238-44. doi: 10.1176/appi.ps.201800118.

Clark, M. (2015). Co-production in mental health care. *Mental Health Review Journal, 20*(4), 213-19. doi: 10.1108/MHRJ-10-2015-0030.

Clarke, J., Waring, J. & Timmons, S. (2018). The challenge of inclusive coproduction: The importance of situated rituals and emotional inclusivity in the coproduction of health research projects. *Social Policy Administration, 53*(2), 233-48. doi: 10.1111/spol.12459.

Clements, K. (2012). Participatory action research and photovoice in a psychiatric nursing/clubhouse collaboration exploring recovery narrative. *Journal of Psychiatric and Mental Health Nursing, 19*(9), 785-91. doi: 10.1111/j.1365-2850.2011.01853.x.

Compton, M. T. & Shim, R. S. (2015). The social determinants of mental health. *Focus, 13*(4), 429-425. doi: 10.1176/appi.focus.21050017.

Corrigan, P. W. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services, 57*(10), 1493-96. doi: 10.1176/ps.2006.57.10.1493.

Creighton, G., Oliffe, J. L., Ferlatter, O., Bottorff, J., Broom, A. & Jenkins, E. K. (2018). Photovoice ethics: Critical reflections from men's mental health research. *Qualitative Health Research, 28*(3), 446-55. doi: 10.1177/1049732317729137.

Davidson, L., Borg, M. & Mann, I. (2005). Processes of recovery in serious mental illness: Findings from a multinational study. *Psychiatric Rehabilitation Skills, 8*(3), 177-201. doi: 10.1080/15487760500339360.

Deegan, P. E. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19. doi: 10.1037/h0099565.

Deegan, P. E. (1996). Recovery and the conspiracy of hope. *"There's a Person In Here": The Sixth Annual Mental Health Services Conference of Australia and New Zealand. Brisbane, Australia.* Retrieved September, 20, 2018 from www.patdeegan.com/sites/default/files/files/conspiracy_of_hope.pdf.

Denscombe, M. (2017). *The Good Research Guide* (6th ed.). London: Open University Press.

Doroud, N., Fossey, E. & Fortune, T. (2015). Recovery as an occupational journey: A scoping review exploring the links between occupational engagement and recovery for people with enduring mental health issues. *Australian Occupational Therapy, 62*(6), 378-92. doi: 10.1111/1440-1630.12238.

Eisenstadt, N. (2015). Evaluating co-production. *Know Your Bristol.* Retrieved February, 1, 2020 from https://knowyourbristol.org/on-the-move/exploring-co-production/.

Elliot, V. (2018). Thinking about the coding process in qualitative data analysis. *The Qualitative Report, 23*(11), 2850-61. Retrieved June, 22, 2020 from https://nsuworks.nova.edu/tqr/vol23/iss11/14/.

Fairey, T. (2018). Whose Photo? Whose voice? Who listens? 'Giving,' silencing and listening to voice in participatory visual projects. *Visual Studies, 33*(2), 111-26. doi: 10.1080/1472586X.2017.1389301.

Fisher, P. (2016). Co-production: what is it and where do we begin? *Journal of Psychiatric and Mental Health Nursing, 23*(6-7), 345-346. doi 10.1111/jpm. https://www.seemescotland.org/media/7287/co-production-self-assessment-framework.pdf12281.

Flanagan, E. H., Buck, T., Gamble, A., Hunter, C., Sewell, I. & Davidson, L. (2016). *Psychiatric Services, 67*(5), 566-69. doi: 10.1176/appi.ps.201500049.

Gilbert, D. (2020). *The patient revolution: How we can heal the health care system.* London: Jessica Kingsley Publishers.

Gheduzzi, E., Masella, C. & Segato, F. (2019). Implementing co-production in mental health organizations. *The Journal of Mental Health Training, Education and Practice, 14*(6), 480-92. doi: 10.1108/JMHTEP-01-2019-0008.

Happell, B. (2008). Determining the effectiveness of mental health services from a consumer perspective: Part I: Enhancing recovery. *International Journal of Mental Health Nursing, 17*(2), 116-22. doi: 10.1111/j.1447-0349.2008.00519.x.

Hardiman, E. R. (2016). Networks of caring: A qualitative study of social support in consumer-run mental health agencies. *Qualitative Social Work. 3*(4), 431-48. doi: 10.1177/1473325004048024.

Hare-Duke, L., Dening, T., de Oliveira, D., Milner, K. & Slade, M. (2018). Conceptual framework for social connectedness in mental disorders: Systematic review and narrative synthesis. *Journal of Affective Dirsorder, 245*, 188-99. doi: 10.1016/j.jad.2018.10.359.

Harmony Center. (2019). *Harmony Center Members Talk About Mental Health Recovery* [Video]. Retrieved May, 30, 2020 from https://www.facebook.com/HarmonyCenterMinot/videos/648987465906417/.

Harmony Center. (2020). The Harmony Center needs your input! [Facebook post]. Retrieved May, 30, 2020 from https://www.facebook.com/notes/harmony-center/the-harmony-center-needs-your-input/2614870165415886/.

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies, 17*(1). doi: 10.1080/14725860220137345.

Holter, M. C., Mowbray, C. T., Bellamy, C. D., MacFarlane, P. & Dukarski, J. (2004). Critical ingredients of consumer run services: Results of a national survey. *Community Mental Health Journal, 40*(1), 47-63.

Honey, A., Berry, B., Hancock, N., Scanlan, J., Schweizer, R. & Waks, S. (2019). Using systematic collaborative reflection to enhance consumer-led mental health research. *British Journal of Occupational Therapy, 82*(110), 666-74. doi: 10.1177/0308022619862126.

Huesers, T. (2020). *The Recovery Photo Project* [Video]. Retrieved May, 11, 2020 from https://www.facebook.com/HarmonyCenterMinot/videos/558217328456026/.

Hui, A., Stickley, T., Stubley, M. & Baker, F. (2019). Project eARTh: Participatory arts and mental health recovery, a qualitative study. *Perspectives in Public Health, 139*(6), 296-302. doi: 10.1177/1757913918817575.

Human Services Research Institute. (2018). North Dakota behavioral health system study: final report. *HRSI.* Retrieved October, 31, 2018 from https://www.hsri.org/publication/north-dakota-behavioral-health-system-study-final-report.

INVOLVE. (2019). *Guidance on Co-producing a Research Project.* NHS. Retrieved February, 1, 2020 from https://www.invo.org.uk/wp-content/uploads/2019/04/Copro_Guidance_F.eb19.pdf.

Janzen, R., Nelson, G., Hausfather, N. & Ochocka, J. (2007). Capturing system level activities and impacts of mental health consumer-run organizations. *American Journal of Community Psychology, 39*(3-4), 287-99. doi: 10.1007/s10464-007-9107-2.

Kirkegaard, S. & Andersen, D. (2018). Co-production in community mental health services: blurred boundaries or a game of pretend? *Sociology of Health & Illness, 40*(5), 828-42. doi: 10.1111/1467-9566.12722.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*(2), 445-452. doi: 10.1192/bjp.bp.110.083733.

Lozano-Casal, P. & Tyler-Grieg, R. (2017). *Evidencing genuine co-production in the third sector*. TSRF. Retrieved June, 20, 2020 from http://www.evaluationsupportscotland.org.uk/media/uploads/tsrf/evidencing_successful_co-production_in_the_third_sector_-_final.pdf.

Lotfi, M. S. (2018). Interview in grounded theory: Charmaz approach. *Slideshare.net.* Retrieved January, 21, 2020 from https://www.slideshare.net/sajjadlotfi/interview-in-grounded-theory-charmaz-approach.

Lorenz, L. S. & Kolb, B. (2009). Involving the public through participatory visual research methods. *Health Expectations, 12*(3), 262-74. doi: 10.1111/j.1369-7625.2009.00560.x.

Marcinowicz, L., Chlabicz, S. & Grebowski, R. (2007). Open-ended questions in surveys of patients' satisfaction with family doctors. *Journal of Health Services Research and Policy, 12*(2), 86-89. doi: 10.1258/135581907780279639.

Markkanen, S. & Burgess, G. (2016). *Introduction to co-production in research: Summary report*. Cambridge: Cambridge Centre for Housing and Planning Research. doi: 10.13140/RG.2.1.1753.5123.

Mead, S. & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal, 36*(3), 315-28. doi: 10.1023/A:1001917516869.

Mental Health Foundation. (2020). Pets and mental health. *MHF.* Retrieved June, 13, 2020 from https://www.mentalhealth.org.uk/a-to-z/p/pets-and-mental-health.

Mowbray, C. T., Woodward, A. T., Holter, M. C., MacFarlane, P. & Bybee, D. (2008). Characteristics of users of consumer-run drop-in centers versus clubhouses. *Journal of Behavioral Health Services & Research, 36*(3), 361-71. doi: 10.1007/s11414-008-9112-8.

Mowbray, C. T., Holter, M. C., Stark, L., Pfeffer, C. & Bybee, D. (2005). A fidelity rating instrument for consumer-run drop-in centers (FRI-CRDI). *Research on Social Work Practice*, *15*(4), 278-90. doi: 10.1177/1049731505275060.

Nelson, G., Janzen, R., Trainor, J. & Ochocka, J. (2008). Putting values into practice: Public policy and the future of mental health consumer-run organizations. *American Journal of Community Psychology, 42*(1-2), 192-201. doi: 10.1007/s10464-008-9191-y.

Nelson, G. & Lomotey, J. (2009). Quantity and quality of participation and outcomes of participation in mental health consumer-run organizations. *Journal of Mental Health, 15*(1), 63-74. doi: 10.1080/09638230500512524.

Nelson, G., Ochocka, J., Janzen, R., Trainor, J. & Lauzon, S. (2004). A comprehensive evaluation framework for mental health consumer/survivor organizations: Values, conceptualization, design, and action. *Psychology Faculty Publications, (11),* 28-53. Retrieved February, 6, 2020 from https://scholars.wlu.ca/cgi/viewcontent.cgi?article=1010&context=psyc_faculty.

Ness, O., Borg, M., Semb, R. & Karlsson, B. (2014). "Walking alongside:" Collaborative practices in mental health and substance use care. *International Journal of Mental Health Systems, 8*(1):55, 1-8. doi: 10.1186/1752-4458-8-55.

North Dakota Department of Health. (2017). *Institutional Review Board (IRB) Documentation and Guidance.* NDDOH. Retrieved January, 31, 2020 from https://www.ndhealth.gov/IRB/Documents/NDDoH_IRB_Documentation_and_Guidance.pdf.

North Dakota Department of Human Services. (2014). *Behavioral Health: Vision for an Effective Behavioral Health System.* NDDHS. Retrieved June, 13, 2020 from https://www.behavioralhealth.nd.gov/sites/www/files/images/Behavioral%20Health%20Overview.pdf.

Ochocka, J., Nelson, G., Janzen, R. & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: part 3—a qualitative study of impacts of participation on new members. *Journal of Community Psychology, 34*(3), 273-83. doi: 10.1002/jcop.20099.

O'Leary, K., Bhattacharya, A., Munson, S. A., Wobbrock, J. O. & Pratt, W. (2017). Design opportunities for mental health peer support technologies. In Lee, C. P. & Poltrock, S. (Gen. Chairs), *CSCW '17: Computer Supported Cooperative Work and Social Computing*. (pp. 1470-84). New York: Association for Computing Machinery. doi: 10.1145/2998181.2998349.

Oliver, K., Kothari, A. & Mays, N. (2019). The dark side of coproduction: Do the costs outweigh the benefits for health research? *Health Research Policy and Systems, 17*, 33:1-10. doi: 10.1186/s12961-019-0432-3.

Ostrom, E. (1996). Crossing the great divide: Coproduction, synergy, and development. *World Development, 24*(6), 1073-87. doi: 10.1016/0305-750X(96)00023-X.

Ostrow, L. & Hayes, S. L. (2015). Leadership and characteristics of nonprofit mental health peer-run organizations nationwide. *Psychiatric Services, 66*(4), 421-25. doi: 10.1176/appi.ps.201400080.

Ostrow, L. & Leaf, P. J. (2014). Improving capacity to monitor and support sustainability of mental health peer-run organizations. *Psychiatric Services, 65*(2), 239-231. doi: 10.1176/appi.ps.201300187.

Padgett, D. K., Smith, B. T., Derejko, K., Henwood, B. F. & Tiderington, E. (2013). A picture is worth. . . ? Photo elicitation interviewing with formerly homeless adults. *Qualitative Health Research, 23*(11), 1435-44. doi: 10.1177/1049732313507752.

Piat, M., Seida, K. & Sabetti, J. (2017). Understanding everyday life and mental health recovery through CHIME. *Mental Health and Social Inclusion, 21*(5), 271-79. doi: 10.1108/MHSI-08-2017-0034.

Pinfold, V., Szymczynska, P., Hamilton, S., Peacocke, R., Dean, S., Clewett. N., . . . Larsen, J. (2015). Co-production in mental health research: Reflections from the People Study. *Mental Health Review Journal,* 20(4), 220-31. doi: 10.1108/MHRJ-09-2015-0028.

Ramon, S., Shera, W., Healy, B., Lachman, M. & Renouf, N. (2009). The rediscovered concept of recovery in mental illness: A multicountry comparison of policy and practice. *International Journal of Mental Health, 38*(2), 106-26. doi: 10.2753/IMH0020-7411380205.

Recoveryplace. (2017). The CHIME framework for personal recovery. *Recoveryplace*. Retrieved June, 7, 2020 from https://www.therecoveryplace.co.uk/chime-framework/.

Reinhart, C., Meissen, G., Wituk, S. & Shepherd, M. (2005). Setting level characteristics in consumer-run organizations that enhance member outcomes. *International Journal of Self Help & Self Care, 4*(1), 1-20. doi: 10.2190/SH.4.1-2.j.

Rich, J., Handley, T., Inder, K. & Perkins, D. (2018). An experiment in using open-text comments from the Australian Rural Mental Health Study on health service priorities. *Rural and Remote Health, 18*(1):4208. doi: 10.22605/RRH4208.

Riiskjær, E., Ammentorp, J. & Kofoed, P. (2012). The value of open-ended questions in surveys on patient experience: Number of comments and perceived usefulness from a hospital perspective. *International Journal for Quality in Health Care, 24*(5), 509-16. doi: 10.1093/intqhc/mzs039.

Scholz, B., Gordon, S. & Happell, B. (2016). Consumers in mental health service leadership: A systematic review. *International Journal of Mental Health Nursing, 26*(1), 20-31. doi: 10.1111/inm.12266.

Schön, U., Denhov, A. & Topor, A. (2009). Social relationships as a decisive factor in recovering from severe mental illness. *International Journal of Social Psychiatry, 55*(4), 336-47. doi: 10.1177/0020764008093686.

Sederer, L. I. (2016). The social determinants of mental health. *Psychiatric Services,* 62(7), 234-235. doi: 10.1176/appi.ps.201500232.

Seale, C. (1999). *The Quality of Qualitative Research.* London: SAGE.

Segal, S. P., Sliverman, C. J. & Temkin, T. L. (2011). Self-help and community mental health agency outcomes: A recovery-focused randomized controlled trial. *Psychiatric Services, 62*(9), 905-910. doi: 10.1176/appi.ps.61.9.905.

Shagott, T., Vu, C., Reinhart, C., Wituk, S. & Meissen, G. (2013). Member characteristics of consumer run organizations and service utilization patterns. Online Publication: *Yumpu.* Retrieved on March, 27, 2019 from https://www.yumpu.com/en/document/read/6792534/consumer-run-organizations-and-service-utilization-patterns.

Slade, M. (2009). *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals.* Cambridge: University Press.

Slade, M., Williams, J., Bird, V., Leamy, M. & Le Boutillier, C. (2012). Recovery grows up. *Journal of Mental Health, 21*(2), 99-103. doi: 10.3109/09638237.2012.670888.

Stickley, T., Wright, N. & Slade, M. The art of recovery: Outcomes from participatory arts activities for people using mental health services. *Journal of Mental Health, 27*(4), 367-73. doi: 10.1080/09638237.2018.1437609.

Stuart, S. R., Tansey, L. & Quayle, E. (2017). What we talk about when we talk about recovery: A systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health, 26*(3), 291-304. doi: 10.1080/09638237.2016.1222056.

Tanenbaum, S. J. (2011). Characteristics associated with organizational independence in consumer-operated service organizations. *Psychiatric Rehabilitation Journal, 34*(3), 248-51. doi: 10.2975/34.3.2011.248.251.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work, 42*(3), 443-60. doi: 10.1093/bjsw/bcr076.

Thomas, E. C & Salzer, M. S. (2017). Associations between the peer support relationship, service satisfaction and recovery-oriented outcomes: A correlational study. *Journal of Mental Health, 27*(4), 352-58. doi: 10.1080/09638237.2017.1417554.

Thompson, N. C., Hunter, E. E., Murray, L., Ninci, L., Rolfs, E. M. & Pallikkathayilm L. (2008). The experience of living with chronic mental illness: A Photovoice study. *Perspectives in Psychiatric Care, 44*(1), 14-24. doi: 10.1111/j.1744-6163.2008.00143.x.

Tie, Y. C., Birks, M. & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine, 7*(1), 1-8. doi: 10.1177/2050312118822927.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I. & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation, 9*(1), 17-37. doi: 10.1080/15487760500339410.

Townley, G. & Terry, R. (2018). Highlighting the way forward: A review of community mental health research and practice published in AJCP and JCP. *American Journal of Community Psychology, 61*(1-2), 10-21. doi: 10.1002/ajcp.12210.

Travis, J., Roeder, K., Walters, H., Piette, J., Heisler, M., Ganoczy, D., . . . Pfeiffer, P. (2010). Telephone-based mutual peer support for depression: A pilot study. *Chronic Illness, 6*(3), 183-91. doi: 10.1177/1742395310369570.

Tritter, J. & McCallum, A. (2006). The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy, 76*(2), 156-68. doi: 10.1016/j.healthpol.2005.05.008.

van Weeghel, J., van Zelst, C., Boertien, D. & Hasson-Ohayon, I. (2019). Conceptualization, assessments, and implications of personal recovery in mental illness: A scoping review of systematic reviews and meta-analyses. *Psychiatric Rehabilitation Journal, 42*(2), 169-81. doi: 10.1037/prj0000356.

Wallcraft, J. (2013). Consumer models of recovery: Can they survive operationalism? *World Psychiatry, 11*(3), 166-67. doi: 10.1002/j.2051-5545.2012.tb00122.x.

Wang, C. C., Yi, W. K., Tao, Z. W. & Corovano, K. (1998). Photovoice as a participatory health promotion strategy. *Health Promotion International, 13*(1), 75-86. doi: 10.1093/heapro/13.1.75.

Ward, K., Hoare, K. J. & Gott, M. (2015). Evolving from a positivist to constructionist epistemology while using grounded theory: Reflections of a novice researcher. *Journal of Research Nursing, 20*(6), 449-462. doi: 10.1177/1744987115597731.

Webber, M., Reidy, H., Ansari, D., Stevens, M. & Morris, D. (2015). Enhancing social networks: A qualitative study of health and social care practice in UK mental health services. *Health and Social Care, 23*(2), 180-89. doi: 10.1111/hsc.12135.

Weiss, R. (2015). The opposite of addiction is connection. *Psychology Today.* Retrieved June, 18, 2020 from https://www.psychologytoday.com/us/blog/love-and-sex-in-the-digital-age/201509/the-opposite-addiction-is-connection.

Werremeyer, A., Skoy, E. & Kelly, G. A. (2017). Use of Photovoice to understand the experience of taking psychotropic medications. *Qualitative Health Research, 27*(3), 1959-69. doi: 10.1177/1049732317693221.

Wituk, S., Vu, C. C., Brown, L., Shepherd, M. & Meissen, G. (2008). Organizational capacity needs of consumer-run organizations. *Administration and Policy in Mental Health and Mental Health Services, 35*(3), 212-219. doi: 10.1007/s10488-007-0162-7.

World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social Determinants of Mental Health.* Geneva: WHO.

Yates, I., Holmes, G. & Priest, H. (2011). Recovery, place and community mental health services. *Journal of Mental Health, 21*(2), 104-13. doi: 10.3109/09638237.2011.613957.

Yuen, W., Tse, S., Murray, G. & Davidson, L. (2019). 'From my point of view, my wife has recovered': A qualitative investigation of caregivers' perceptions of recovery and peer support services for people with bipolar disorder in a Chinese community. *International Journal of Social Psychiatry, 65*(4), 305-12. doi: 10.1177/0020764019842287.

What Is Mental Health Recovery to You?

The Recovery Photo Project

For some of us, mental health issues are an ever-present, ebbing and flowing part of life. This, however, doesn't mean that our lives are forever stunted or at an end. It is possible—in fact, necessary—to move beyond our illnesses and create full, satisfying lives.

Mental health recovery is the personal way that an individual strives for this type of full, contented life. Recovery is about *creating a life*, not about *fixing* the person or waiting for a cure. Recovery happens *now*, but is also an ongoing process.

Mental health recovery is about putting the pieces of life together that help a person live well. These pieces might include having a safe and comfortable home, taking needed medications, exercising, pursuing a meaningful hobby or work, taking part in counseling, caring for others or for pets, and so many more things. The pieces of recovery are those things that:

-help us feel ***connected*** to others.
-give us ***hope and optimism.***
-support us in developing a positive ***identity.***
-help us find ***meaning*** in life.
-***empower*** us: in other words, make us feel like we have control and a say in our own lives.

The Recovery Photo Project

The Harmony Center is looking for your photos of the things that help you in your mental health recovery. Just snap photos, like those shown on this page, of things that help you to be mentally healthy and live a good life, then share them with us. The photos will be gathered into a photo display, to be exhibited at the Harmony Center in early 2020. The project will also be the first stage in a broader research project that will be done through the Harmony Center. The photos will help show what is important to people in their recovery journeys, and help the Harmony Center find out how to make their programs and service reflect those values.

If you would like to contribute to the photo project, just take photos on your own camera or phone, or ask about using a loaner camera from the Harmony Center. Photos can be downloaded in person at the Harmony Center, or sent by email or messaging ap. Contact Tamra at 852-3263 or at thuesersresearch@gmail.com for more information. The more people that contribute photos, the more we'll learn!

Harmony Center, 212 East Central Ave, Minot, ND 701-852-3263., harmonycenterminot@gmail.com.

The Recovery Photo Project
Kick-off Party

Join Us
For a celebration to kick off the
Harmony Center's

Recovery Photo Project

Tuesday, December 3rd
1:00 pm

- Enjoy pizza and other treats
- Learn about the photo project and how you can have a part in it.
- Win door prizes.
- All Harmony Center members are welcome!

(Not yet a Harmony Center member? Just ask staff how you can become one.)

Harmony Center, 212 East Central Ave, Minot, ND 701-852-3263., harmonycenterminot@gmail.com.

What Is Mental Health Recovery to You?

The Recovery Photo Project – Photo Instructions (updated)

Submitting Photos

What helps you in your mental health recovery? We are looking for photos from Harmony Center members of things that represent the pieces that make up the good life you are building for yourself and that help you live well despite experiencing mental health issues. These can be photos of places, things, activities, people, or anything that you find instrumental to your mental health recovery. We would ideally like to have four to five photos from each person, but that is just a guideline. Later, you will be asked to provide a few brief phrases that describe your photos.

If you take photos on your own phone or digital camera, you can provide them to Tamra either by direct download at the center, flash drive, email, or messaging ap through the Harmony Center Facebook page. Send photos to:
- thuesersresearch@gmail.com *or*
- Facebook @HarmonyCenterMinot, using Facebook Messenger

If you do not have a smart phone or camera, you may borrow a camera from the Harmony Center for the project. See below for how to borrow a camera. You must be an enrolled member to borrow.

Photo consent is required. We know that relationships and the people in our lives can be important factors in our mental health recovery. If you take photos of people, make sure that you let them know that their photos may be included—without identifying them--in a photo exhibit at the Harmony Center. As a confidentiality consideration, we do have to have written permission from photographed persons (or their parent or guardian, as appropriate) in order to use the photo in the planned exhibit. Consent forms are available at the Harmony Center.

Using a Loaner Camera

If you do not have a camera or smart phone, you may borrow a digital camera from the Harmony Center for use for this project only. You may borrow the camera for up to five days and must return it after that time for other people to use for the same purpose. Please see Tamra in order to use one of these cameras. You will be required to sign a borrowing agreement in order to use a loaner camera.

Commenting on Photos

Once you provide your photos, you will be asked for two to three phrases that describe each photo. Tamra will guide you through this process, which will just take a few minutes. Think about a few words that tell how the thing in the photo is helpful to you.

Harmony Center, 212 East Central Ave, Minot, ND 701-852-3263., harmonycenterminot@gmail.com.

Join the RECOVERY PHOTO PROJECT

(There's still time! Contribute photos until Jan. 20th.)

The Harmony Center is doing research! We are asking members, "What things are important to you and help you in your mental health recovery?"

Our research will start with The Recovery Photo Project, during which members can take pictures of their recovery helps. The photos will become part of an exhibit to be shown at the Harmony Center in early 2020. The photos will also be used to develop themes for later phases of research, and to evaluate program needs for the center .

If you're interested, look for the flyers shown below at the center for detailed information, and talk with Tamra about taking part.

Recovery Photo Project Consent Form

The Recovery Photo Project is a project of the Harmony Center that will focus attention on the things that members find instrumental in their mental health recovery. The photos from the project will be organized into an exhibit to be displayed at the Harmony Center. In addition, the recovery themes gathered through the project will be used as a first step in a larger research project that seeks the views of members regarding how the Harmony Center's programs and services should evolve as we move into the future. The project is led by Tamra Huesers, who is utilizing the research in her master's dissertation as she seeks a master's degree in Mental Health Recovery and Social Inclusion through the University of Hertfordshire. Members of the Harmony Center will serve as co-researchers for the project.

In submitting photos for the Recovery Photo Project, contributors become part of the research project and give a visual "voice" to planning at the Harmony Center. Contributors, therefore, must give their consent for the use of their photographs in the exhibition and research. To protect the privacy of contributors, all photographs will be held in secure digital storage by the researcher in accompaniment to the research summary. Photos will be attached to the contributor's name in storage only and will be accessed only by the lead researcher. Photos will be presented anonymously with the use of an alias in both the exhibition and any written reports.

As a contributor to the Recovery Photo Project, please provide the following consents by initialing beside each item and signing below:

____ 1. I consent to the anonymous use of any photographs I contribute in the Recovery Photo Project and the research that will build on the project's findings.

____ 2. I understand that my photographs will be used in an organized display, to be exhibited at the Harmony Center for viewing by members of the center and any members of the public who attend activities at the center. I understand that the center may be opened to the public for a designated showing of the exhibit. This may involve parts of the exhibit being used in a promotional manner, including in social and commercial media.

____ 3. I also understand that my photographs may be included in written reports of the project, which may be viewed in academic and public settings.

____ 4. I consent to the preservation of my photographs in secure digital storage for the duration of their usefulness to the conduct of any associated research and during the writing, evaluation, and dissemination of any associated summaries or reports.

____ 5. I will select a first name alias that may be used to reference my photographs in display or written report. The alias I choose is:

_____.

I understand the above information and give my permission for the use of my photographs as outlined.

_____ _____

(signature) (date)

Recovery Photo Project Consent Form:
For Persons Appearing in Photos or Videos

The Recovery Photo Project is a project of the Harmony Center that will focus attention on the things that members find instrumental in their mental health recovery. The photos from the project will be organized into an exhibit to be displayed at the Harmony Center. In addition, the recovery themes gathered through the project will be used as a first step in a larger research project that seeks the views of members regarding how the Harmony Center's programs and services should evolve as we move into the future. The project is led by Tamra Huesers, who is utilizing the research in her master's dissertation as she seeks a master's degree in Mental Health Recovery and Social Inclusion through the University of Hertfordshire. Members of the Harmony Center will serve as co-researchers for the project. In submitting photos for the Recovery Photo Project, contributors become part of the research project and give a visual "voice" to planning at the Harmony Center.

To protect individual privacy and to assure consent from persons who may appear in photos or video clips, we are asking for written confirmation of consent. As a photographed individual, please read the accompanying information and sign below to allow your image to appear in the photo display or in reports regarding this project and subsequent research. All photographs or videos will be held in secure digital storage by the researcher in accompaniment to the research summary. Photos/videos will be attached to the contributor's name in storage only, which will be accessed only by the lead researcher. Photos/videos will be presented anonymously in both the exhibition and any written reports.

Please provide the following consents by initialing beside each item and signing below:

____ 1. I consent to the anonymous use of any photographs or brief videos I appear in for the Recovery Photo Project and the research that will build on the project's findings.

____ 2. I understand that my photographs/videos may be used in an organized display, to be exhibited at the Harmony Center for viewing by members of the center and any members of the public who attend activities at the center. I understand that the center may be opened to the public for a designated showing of the exhibit. This may involve parts of the exhibit being used in a promotional manner, including in social and commercial media. *If I do not initial this box, I am consenting to use of the photos in the research but not in the photo display.*

____ 3. I also understand that photographs/videos that include me may become part of written reports of the project, which may be viewed in academic and public settings.

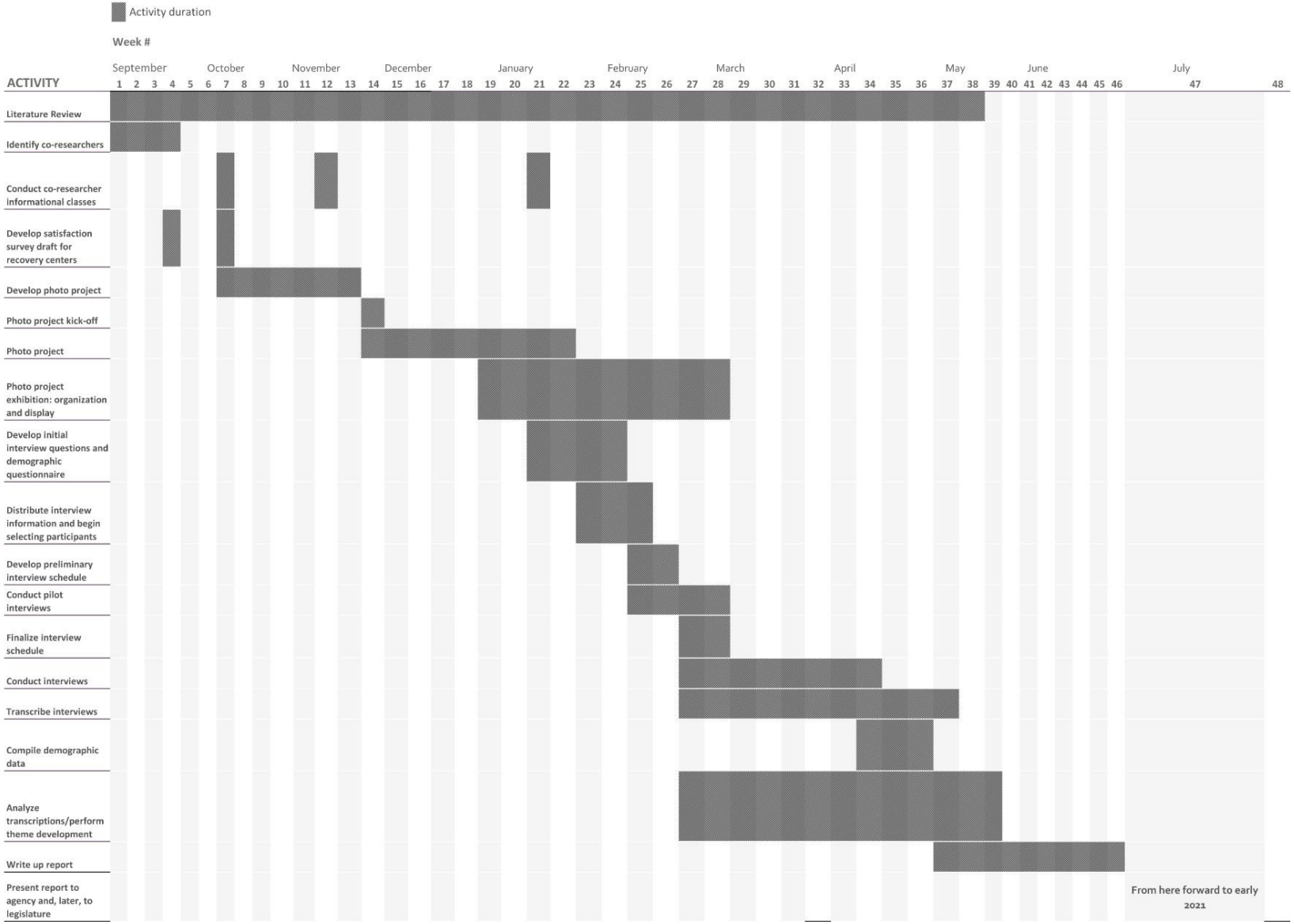
____ 4. I consent to the preservation of my photographs/videos in secure digital storage for the duration of their usefulness to the conduct of any associated research and during the writing, evaluation, and dissemination of any associated summaries or reports.

I understand the above information and give my permission for the use of my photographs as outlined.

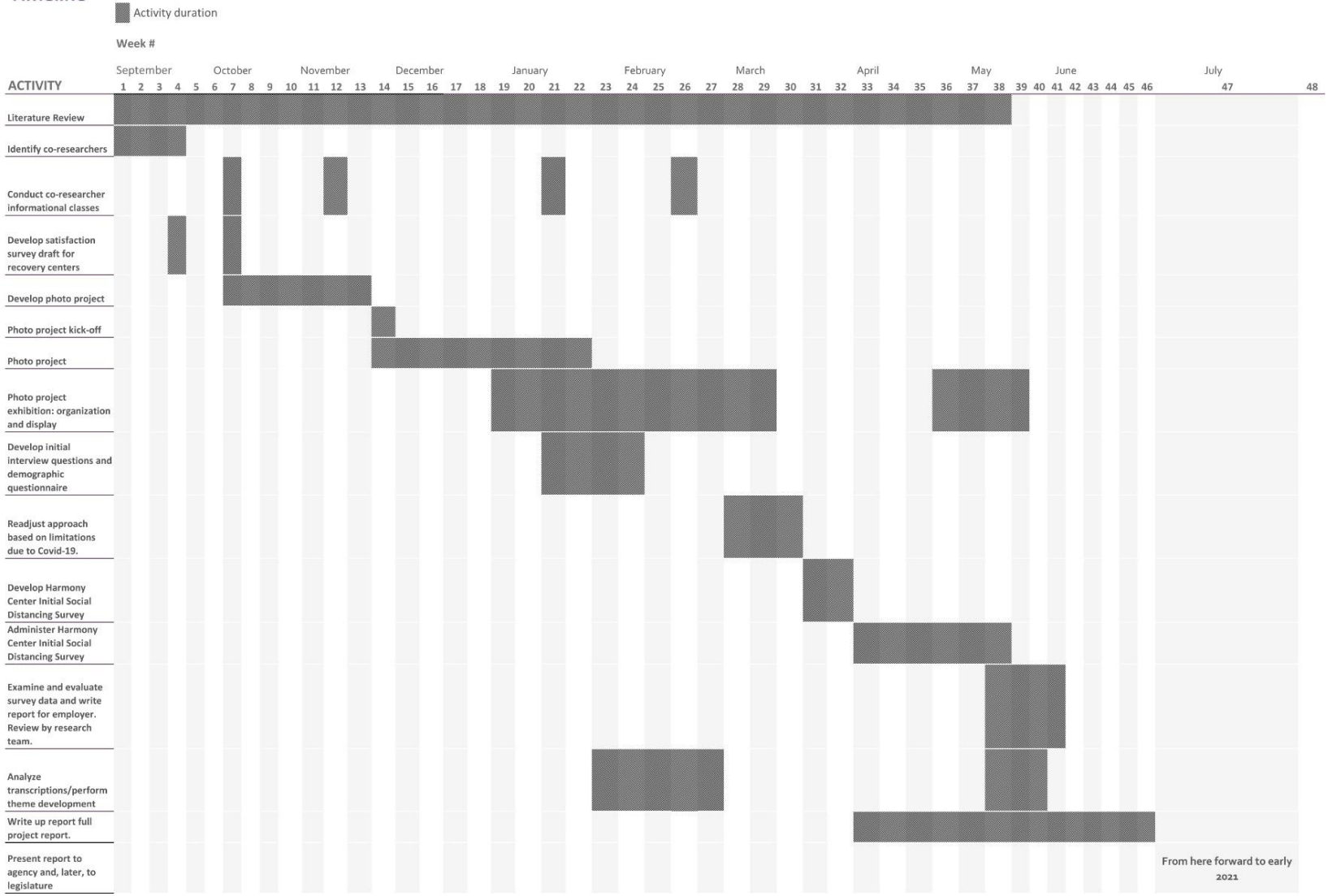
_____ _____

(signature) (date)

Research Timeline



Amended Research Timeline



Harmony Center Initial Social Distancing Survey

About this survey:

As you are likely aware, the spread of the Covid-19 virus has caused many businesses and agencies to take precautions to prevent the spread of the virus and to institute social distancing practices. The Harmony Center modified its services to include only remote-type contacts in mid March, and this will continue through April and possibly beyond. However, the staff of the Harmony Center are still available to provide support to members through several means, such as phone and video contact, social media, newsletters, and more. We'd like to know whether you've been able to keep in touch with us, whether the support we've provided has been helpful, and what more we can do to provide support during this time. It would be very valuable to us if you would answer just a few questions and make suggestions about how we can help you more.

Earlier this year the Harmony Center completed its *Photo Research Project,* which showed us that one of the things most valuable to members in their mental health recovery is connectedness. This includes feeling connected with family, friends, people in your community, and even your pets. It is very important that, though we may not be able to be physically close to others at this time, we stay socially and emotionally close to them. Many of the following questions deal with this need to stay connected and how the Harmony Center can support that process.

Please answer as many of the questions below as fully as you can. If a question doesn't apply to you, skip to the next question. The information collected here may be used anonymously in Harmony Center program development or for research purposes. Your personal information will remain confidential.

1. Have you been able to stay in touch with Harmony Center staff since services were modified due to the Covid-19 Virus?

___ Yes ___ No

2. If you said yes in #1, how have you been in touch, and how has this helped you?

3. If you said no to #1, do you want to be in contact? How, when, and how often would you like to be in contact? (For example: by phone call or text, once a week, in the afternoon.) How would this help you?

4. In what ways has the Harmony Center supported you during the time of social distancing so far?

5. What other things could the Harmony Center do to support you? (Be creative in your suggestions. No suggestions are bad.)

6. Have you been able to stay connected to other people--such as family, friends, counselors, clergy, and so on--in some way during social distancing?

___ Yes ___ No

7. If you said yes to #6, how? Tell us about the support you're receiving.

8. If you said no to #6, why? How might the Harmony Center be able to help you with this?

9. Do you have other needs that are not being met during social distancing, for which the Harmony Center could provide assistance or help you find other resources? If so, what?

10. If you would like, please provide us with your contact information so that we can get back to you about needs you've expressed. Your contact information will always be kept confidential.

Name:

Phone number:

Address:

Email:

- - - - - - - - - - - - -

Interviewer use only:

Date_____

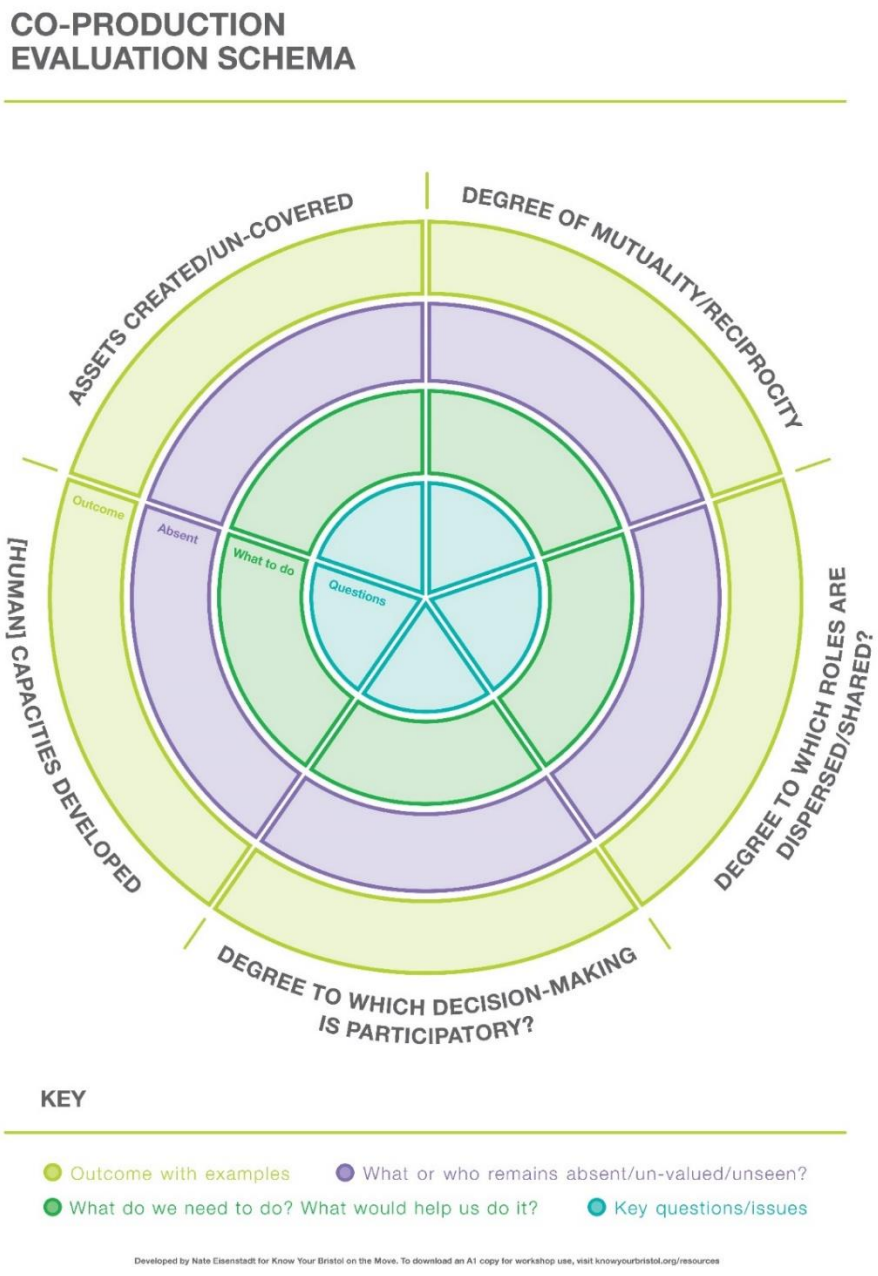
Mode of interview: ____ phone ____video ____ mailed in ____ other _____

Interviewer notes:

Co-Production Evaluation Schema
Reviewing Harmony Center Research Project 2019-2020

Harmony Center Research Team
Team Members Present: T. Huesers, D. Olson, W. Monson, M. Johnson
June 18, 2020

Please refer to the following image when reviewing evaluation responses:



1. Degree of Mutuality/Reciprocity:

Outcome: The team felt that mutuality and reciprocity were attended to well during this project. They identify that, because the project was conducted partially as an assignment in the primary investigator's educational course, it was necessary that she take the lead in planning, implementation, and certain aspects of decision-making. However, they felt that they were given a voice and afforded the power to influence and alter the project along the way. Members indicate that they felt respected and listened to.

Absent: Once the pandemic and social distancing measures hit, the ability of the full team to be closely involved was impaired. The primary investigator communicated less with team members about project matters. One team member withdrew from interaction with the group for personal reasons. In some ways, dealing with tightened resources and diminished in-person interaction created a situation that did not necessarily impair interaction, but that put the team in a different action mode more similar to leader + followers rather than participants on a level playing field.

What to do: Attend specifically to mutuality during times of stress or limited resources. Recognize that mutuality and reciprocity require time and attention. It may be "easier" and more expedient to assume leader-follower roles, but it does not lead to truly co-produced projects.

Questions: Do recovery center members realize that they deserve reciprocity and mutuality? Would it be helpful to address this in peer support and educational groups?

2. Degree to Which Roles are Dispersed/Shared?

Outcome: Team members were asked to participate in portions of the project with which they were comfortable. The principal investigator/author did most of the writing related to the project, subject to review and input by team members. Assuming new roles was uncomfortable for some team members, especially where it meant reviewing qualitative data submitted by people they know and interact with. One team member expressed that the data coding process that was done by the team was fun and informative. Interested team members chose to appear in an informational video about recovery.

Absent: Some team members had been looking forward to progressing with an interview process in the later phase of the project, which was altered due to the pandemic. This was a disappointment. In addition, though the team had input, they did not get to initiate or ultimately design many parts of the project due to its nature as also being an educational assignment.

What to do: The team suggested improving remote access (phone, video chat, etc.) for all persons involved in the project, and for collecting qualitative data such as interviews. This would aid persons to stay involved. Also, in future projects we must identify and embrace the initial effort it takes to disperse and share roles in order to reap the benefits in the long run.

Questions: How do we better support persons in new and sometimes uncomfortable roles?

3. Degree to Which Decision-Making is Participatory?

Outcomes: Initial decisions about the nature of the project and about the design of certain aspects of the project were primarily given to the principal investigator, again, due to the project being educational assignment-related. The principal investigator is also the only employee of the recovery center on the team, so she had more influence on logistical and supervisory matters. Team members were afforded oversight and/or review of some project design plans and of all video and written products of the project.

Absent: Equal distribution of power was not present. There was agreement expressed on most matters throughout the project. It is difficult to evaluate what power structures would dominate if there had

been an intense disagreement about any part of the project. There were no formal conflict management protocols in place for this project. With this, members don't seem to readily express alternate opinions very often.

What to do: Evaluate what it is that keeps persons from expressing opinions often. Also, consider organized input methods that encourage participation. Consider a conflict resolution plan in next project.

Questions: Why don't people often express their opinions on things such as the research project? Are they happy with how things proceeded? Are they unaccustomed to having control and having their suggestions listened to? Are they uncomfortable speaking up or do they have other barriers to doing so?

4. Human Capacities Developed.

Outcomes: A heightened bond among team members was observed. Team members expressed that they felt empowered within the process of this project. They got to express views on project matters, learned new skills, and developed new viewpoints. One member stated, "I never thought in a million years that I'd be doing research." Participants learned what parts of such projects they like to do, and which ones they do not. All team members present for the review expressed that they would like to continue to do research and services planning for the recovery center.

Absent: Sufficient resources and education for members who want to participate in co-produced projects. This includes pay for time spent and outside learning opportunities to develop co-research skills.

What to do: Pursue projects with a wider range of participatory avenues. Work toward some type of compensation for persons who give their time and energies. Investigate learning and educational opportunities. Make use of online platforms that provide educational videos and resources.

Questions: What would peer co-research participants like to get out of projects such as the one we just completed?

5. Assets Created/Uncovered.

Outcomes: The team created two surveys, one that has been accepted for state-wide recovery center use. They also created two informational videos that can be used for recovery education and other purposes on an ongoing basis. They formed a co-research team that would like to continue to do other projects. The team developed personal skills and improved relationships among the group. The project found that connectedness is of primary importance to the recovery center members but that this is not necessarily optimally facilitated by past activities and services. It was made apparent that "group activities" do not automatically translate into connectedness.

Absent: Immediate opportunities for co-productive activities, largely due to the continued closure of the recovery center's physical structure because of the pandemic. We are also missing the technology to keep us optimally connected during distancing.

What to do: Continue to work toward a physical display of project photos for the recovery center when the building opens again. Begin work on the follow-up survey or interview process regarding activities and services of the center post-pandemic and moving forward. Build on the research just completed, and focus on *connectedness* and not just group activity in program planning.

Questions: What promotes connectedness? What is the recovery center's role in promoting connectedness?