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One woman's journey of recovery from mental illness—Hopes, back-up plans, rebuilding self and service support

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Abstract

Recovery from mental illness is a personal experience, unique to each individual. The purpose of this study was to explore the changing focus of one woman's continuing recovery from mental illness, exploring the domains of hope, self-identity, a meaningful life, and responsibility. A case study was conducted using semi-structured interviews with a woman during three separate admissions to a residential mental health unit, and analyzed using a theory-driven approach. Aspects of the service that were instrumental in the woman's recovery journey were analyzed, using a content analysis of the transcripts. The analysis demonstrated changes over time in the hopes the woman expressed; redefining self-identity was an ongoing objective; seeking a meaningful life involved overcoming addictions as a priority over pursuing hobbies and work; and there were indications she was taking more responsibility for her own recovery. Features of the residential service that were instrumental in her recovery progress were the therapeutic groups, tailored clinical support, support towards self-management, instrumental support, and social interaction. Repeat admissions to the residential unit assisted this woman to progress in her recovery. Her story demonstrates how personal responsibility can be increasingly achieved with the support of a recovery-oriented service.

Keywords

Mental health, psychosocial, substance abuse

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Introduction

Recovery from a mental illness is a uniquely personal experience, which for many people is viewed as a process or a journey. Anthony (1993) defines recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p. 13). According to Deegan (1988), one of the early proponents of recovery-base care, the recovery process has small beginnings and small steps forward, with people needing to be prepared to try, to fail, and to try again. Four key domains have been identified as salient in the recovery process: finding hope, redefining self-identity, finding meaning in life, and taking responsibility for recovery (Andresen et al., 2003).

First-hand accounts of recovery from serious mental illness indicate that while recovery is a personal experience, it also involves active participation from external sources. Three main themes of recovery have been identified in an integrative review of qualitative studies, recovery as an inner process, the contribution of others, and participation in meaningful and social activities (Salzmann-Erikson, 2013). The recovery process requires external support, with mental health workers who have a focus on good communication and the promotion of dignity (Kogstad et al., 2011). The alliance between people with mental illness and mental health care workers is an important factor in mental health recovery, with gains in recovery being both positively influenced by a stronger alliance and also facilitating a stronger alliance (Hicks et al., 2012).

Mental health services with supportive staff who are more focused on delivering recovery-oriented services tend to have a focus on hope, respect, and affection for the client (Grant, 2010). Recovery-oriented services have several recovery-focussed elements built into their program, including: collaborative strategies for management of the illness and medications; the development of relationships with staff and other people; peer support connections; support for clients to take responsibility for their recovery; and the creation of interventions that support positive factors such as self-esteem, self-efficacy, and well-being (Schrank et al., 2012).

Short-term, sub-acute, step-up step-down residential mental health services are increasingly being provided as part of the mental health care system in Australia and other countries, and offer a tailored support and therapy service for people with a mental illness, who are not currently in an acute phase. These services are typically for a limited time period, generally less than six months, and provide services and support for people with mental health problems that are not so severe as to be considered acute, but are problematic for the person in their daily functioning (Thomas and Rickwood, 2013). Step-up admissions refer to clients who enter the residential service directly from the community, with these clients experiencing an escalation in symptoms and problems with functioning, as an alternative to hospitalization. Step-down clients are those who enter the residential service as a transitional step between hospital and returning to living

in the community, as an opportunity to continue to access support and therapy in a less restrictive environment. These services range in the type of service they provide, level of staffing, number of beds, therapeutic interventions, and length of stay. Benefits of residential mental health services include tailoring the program to suit individual needs, providing individualized skill training, support in connecting with community resources and support services, and assisting clients to take responsibility for their recovery. Similar residential units, offering services to clients in an acute phase of their illness, have been found to provide clinical improvements equivalent to those gained by inpatient units, and qualitative studies indicate that many clients prefer them (Greenfield et al., 2008; Hawthorne et al., 2005; Howard et al., 2010; Lloyd-Evans et al., 2010).

The process of recovery and unique experience of an individual can be illustrated through a case study that describes the personal nature of the recovery journey. The aim of reporting this current case study was to describe the ways in which a young woman's recovery was facilitated and supported by a recovery-oriented residential mental health service that she was involved with, along with her own growing self-determination.

Methodology

Participant

Tabitha (a pseudonym) is a woman in her early 30s, who has lived with mental illness and comorbid substance use disorder for most of her adult life. Her first admission into the mental health system was when she was 17, and was related to symptoms associated with alcohol and drug use. She was diagnosed with non-organic psychosis and major depressive disorder, and currently experiences psychotic symptoms, such as paranoia, and periods of severe depression. Tabitha's alcohol and drug use began in her teens with alcohol, and later cocaine and heroin; more recently, the use of cocaine, methamphetamines, marijuana, and alcohol. She has had over 50 admissions to a psychiatric inpatient unit, and has spent the majority of her adult life as a mental health patient either in hospital or under care in the community. Tabitha was offered the opportunity to access the residential unit as part of a continuum of care and alternative to hospitalization, by way of a strategy to break the cycle of continual hospitalizations.

This study received approval from the University of Canberra Committee for Ethics in Human Research and from the ACT Health Human Research Ethics Committee. The participant gave informed consent to participate in each of the interviews and provided additional consent for her responses to be presented in this case study. Tabitha was given the opportunity to discuss her involvement in the case study and to provide feedback in the drafting of this article, and did this with the assistance of a staff member of the service, who discussed with her in detail both the content of the article and its intended publication. The process of discussing the article with a staff member, rather than a member of the research team, was to

ensure that Tabitha could openly discuss her involvement in the case study without feeling coerced, and would be able to choose to not consent to be involved, if she preferred.

Setting

The recovery-oriented residential service operates as a five bed unit, with 24 h staffing. The service provides residential accommodation, clinical supervision, support, and psychoeducational groups, giving clients personal support and the opportunity to learn daily living skills and symptom management techniques, prior to returning home. Clients are provided with a private bedroom, shared bathroom, two shared lounge rooms and a shared kitchen. They are responsible for providing their own meals, with the exception of communal dinners two nights of the week, when all clients and staff prepare and eat a meal together. Maximum length of stay is usually limited to three months, with clients offered up to a month of outreach, after exiting the service (Thomas et al., 2015). Admission into the service is either directly from the community, with referral by a case manager (step-up admission), or transfer from an inpatient unit, when symptoms and medication are stable, as a transitional step before returning home (step-down admission).

Data collection

Clients of the residential mental health service were invited to be part of a larger study on the effectiveness of the service, conducted by independent researchers. The participant in this study consented to be involved in the evaluation of the program, and during the course of the evaluation period was admitted into the residential service on four occasions. On three of these occasions, as part of the evaluation study, Tabitha participated in in-depth, semi-structured interviews with the first author, and these interviews were digitally recorded. The interviews with Tabitha were during her first (duration 32 days), third (46 days), and fourth (22 days) admissions to the residential unit, with the third admission approximately 12 months after her first admission, and her fourth admission three months after this. On the first two occasions, Tabitha was admitted by her case manager due to an escalation in her psychotic symptoms and decreasing ability to function independently at home, as a strategy to avoid hospitalization (step-up admission). The third occasion was part of a transitional strategy as she prepared to return home after a hospital admission (step-down admission).

Analysis

An instrumental case study approach (Stake, 2008) was selected for the analysis of this data as this method allows for an issue of concern to be explored and illustrated in-depth by a particular case. In this study the process of recovery will be illustrated by an individual case of a recovery journey, allowing the unique

experience of the recovery process over time to be explored. As discussed by Creswell (2007), the case study is the exploration of a bounded system, over time, and is both a process of inquiry and the product of that inquiry. Using a theory-driven approach, the four key processes of recovery, identified by Andresen et al. (2003), were examined and illustrated by the reported experiences of one woman, over an 18 month period of her recovery journey.

A theory-driven approach was adopted to explore Tabitha's responses over time in each of the recovery-related processes, as this provided a framework to shape engagement with the data (Gibson and Brown, 2009), providing a mechanism by which changes in her attitude and approach to recovery could be categorized and compared over time, and understood as part of an ongoing process. The interviews were transcribed and analyzed by the first author using NVivo 10 (QSR International, 2012). Source classifications were used to classify each transcript according to interview occasion, allowing comparisons to be made of changes in focus for each theme over time. Codes were developed for each of the four domains: finding hope, redefining self-identity, finding meaning in life, and taking responsibility for recovery. Transcripts were read and reread, and then coded line by line, with all responses pertaining to these domains coded under these nodes. Examining the longitudinal interview data for each domain revealed a progression of responses over time, with clear changes in focus for each of these domains being revealed. The progress of responses over time was then reviewed by the second author, with general agreement on the changes in focus over the three admissions.

To ascertain the elements of the residential program that Tabitha felt had supported her in her recovery, a content analysis of the transcripts was performed. The transcripts were reread, and the authors identified instances where Tabitha specifically mentioned how she had been supported by a particular aspect of the program. Similar aspects of the program were grouped together and, after discussion between the authors, consensus was reached on the key aspects of the program that Tabitha felt had been instrumental in her recovery.

Results

Over the 18 month period involving these three admissions to the residential service, there were distinct changes in Tabitha's outlook and the goals she was setting for herself. Each of the four key recovery processes: finding hope, redefining self-identity, finding meaning in life, and taking responsibility for recovery were discussed at each interview, with a slightly different focus at each time point.

Finding hope

There were notable changes in the hopes that Tabitha expressed during the three interviews. During the first interview, she expressed the highly optimistic

hope of having her case file closed soon and to be out of the mental health system.

> "I was talking yesterday to my case manager at ACT Mental Health and I'm doing all these things like rehab and study and all that, and maybe get a chance to get my file closed with Mental Health."

Tabitha's expressed hope at the second interview was more tempered, as she talked about feeling confidence and hope at not returning to the inpatient unit, and a determination that she would get through this difficult time.

> "I feel like I'm not going to end up in detox, I'm not going to end up in psych anytime soon, I'm going to get through this hard time, intact and well."

Unfortunately, Tabitha was readmitted to the inpatient unit after two months, and on discharge was admitted to the residential unit as a transitional step before returning home. Her expressed hope during the third interview was more grounded and realistic: she had hope that she could make it on her own at home, but now also had a back-up plan in place—if things started to go awry in two or three weeks, she would admit herself into the residential drug rehabilitation unit. She also emphasized the time she had spent 'bouncing ideas' off staff as a reality check, to ensure her goals were realistic and attainable.

> "Just to be supported and, you know, given encouragement to keep going, keep trying, realistically looking at things, sort of bouncing my head off people and stuff . . . like reality checks."

Redefining self-identity

On Tabitha's first admission she talked about how it was challenging to adapt to a living situation in the residential unit with more social interaction, after a long period of isolation and withdrawal from social situations. She slowly began to feel more confident and demonstrated this by being able to express her identity by sharing some of her cooking knowledge with other clients, a peer support role facilitated by staff.

> "They [staff] encourage us to, at least at the communal meal, to do the shopping, or to do the cooking or wash up and eat as a group. I live by myself, so I can do most of that stuff myself . . . another sort of view of it was that I was able to share my knowledge with other people here."

During the second interview, Tabitha also talked about not feeling as isolated and that her self-esteem was improving, and explained how staying at the residential

unit had allowed her to live in a community, which helped her to feel better about herself and her future.

> "The participants . . . they have a mental illness as well. You get to sit down and talk to each other and have coffee. You get to know them and make good friends, so they are very big, you know, in your recovery."

During the third interview, Tabitha talked about gaining confidence while transitioning from hospital to home, and, with the help of staff, was setting up social support systems for when she returned home so that she remained socially engaged.

> "I feel more confident to go home and get on with my life . . . like I'm able to be out in the world again, to look after myself, but with support as well. I probably might not be doing so well had I gone from hospital to straight home."

Finding meaning in life

During Tabitha's first admission, making vocational changes was a key aim and, with the help of staff, she was actively making plans to pursue tertiary study options in a social welfare course. She had started attending art classes, a hobby that brings her a feeling of peace and also a purpose in life, and as she prepared to exit she was keen to become more actively involved in activities that would help give her life more meaning.

> "One of the staff here took me to an information evening to get a scholarship to work toward a statement of attainment in community welfare, next year".

During the second interview, Tabitha was more focussed on her immediate health and well-being; she made no references to pursuing activities that helped her find meaning in life—the immediacy of the need to have ongoing assistance to overcome her drug and alcohol problems was her primary aim at this stage of her recovery.

> "I'm getting help with things, my GP appointments, like my physical health, my mental health, my drug and alcohol stuff."

In the third interview, Tabitha's focus was on symptom management and avoidance of drugs and alcohol, as she had realized that other meaningful activities were predicated on her sobriety.

> "I want to try and do it, you know, at home by myself for a couple of weeks. I've given myself two or three weeks . . . If things start getting messy in that time, with my drug use or my mental health, then I know now that there are options."

During this admission, staff worked to maintain the positive improvements that she had made in her life, in particular her part-time job, by ensuring she could continue to work her scheduled shifts, and provided advocacy for her with her employer when she needed it.

> "They've [staff] supported me by giving me cab vouchers or dropping me off at work and picking me up after work . . . support after work, you know sit down, 'how was work?'"

Taking responsibility for recovery

During her first admission at the residential unit, Tabitha worked through a drug and alcohol module with her support worker and agreed to staff booking her into a drug rehabilitation center; she was excited about the possibility that she would finally get on top of her addictions. Tabitha did attend the rehabilitation center, although after one week she discharged herself and returned home; her drug use continued and her mental health deteriorated. In the second interview, Tabitha discussed how she was more involved in becoming well and in making decisions for herself, a situation quite different to her previous years of treatment in the mental health system.

> "It's more involved here, more involved in being well . . . making decisions, and in the activities like the groups."

In the third interview, Tabitha's approach to self-management of her recovery had changed slightly, with relapse prevention a key aim. She had discussed with her case worker the need for her to have early feedback on changes to her mental health, to allow her to make decisions sooner about how to respond to a possible relapse. She also expressed a stronger resolve to put into practice all the strategies that she had learned over the years to maintain her mental health—"it is a case of me sticking to it".

> "I've been doing pretty well with that, I've only had a couple of really small lapses."

Aspects of the program that facilitated recovery

Five distinct aspects of the residential program that had supported and facilitated Tabitha's recovery emerged in the data: therapeutic groups, support tailored to her personal circumstances, support for self-management, instrumental support, and social interaction.

Therapeutic groups. On several occasions Tabitha talked about the usefulness of the bi-weekly Optimal Health course, where she was taught illness management

strategies and signs of early relapse. She appreciated having a greater understanding of her illness and knew that her long-term health depended on her putting the things she had learned into action.

> "The Optimal Health stuff, I usually left those groups feeling pretty good about things, especially in my drug and alcohol stuff, and just in myself in general, just feeling OK, you know, and just feeling good."

Psychosocial groups were a peer support aspect of the program that Tabitha looked forward to each week.

> "I like the psychosocial group, we did that a couple of days ago, with these cards. There's six different cards, each go round in the circle, pick one each, everyone answers the questions, and it's nice to get to know the people that I'm living with."

Tailored support. Tabitha was aware of the support she received that was tailored to her individual circumstances. Some of the specific aspects she mentioned were the drug and alcohol module that her key worker went through with her and the opportunity to go home each day to maintain connections with the things that were important to her in her life.

> "I have been doing one-on-one drug and alcohol sessions with my key worker."

> "They took me every day to my place, which isn't far from here, to feed my dog. I could spend a few hours and occasionally spend the night at my place."

> "Often a couple of the staff members here have been, if I was having a rough day, which I have had a few, 'Come on Tabitha, let's go and shoot some hoops outside, play some basketball or kick the footy on the oval'. That's been really helpful too."

> "I think they tailor the program, I've had a lot of support and encouragement to stay off drugs or to minimize the harm."

Support for self-management. The concept of being able to take more responsibility for her health and well-being was refreshing for Tabitha. She appreciated the opportunity to explore new ideas and to make decisions for herself, while knowing that she had the support of staff who would help her to make good choices.

> "Obviously when I leave I'm sort of on my own, so encouraging me to be active, to do things for myself."

> "The staff member sat with me during the session. I've got some forms after that information session [tertiary scholarship] and I've filled them out and posted them."

> "They don't want to overmedicate you; they're not here to hold you down, just make the most of your time here, because it's a good service."

> "By [staff] giving me a bit of a push to do things, like being proactive, encouraged to also do things for myself as well, not be babied too much."

Instrumental support. Practical, instrumental support was an aspect of the residential program that was highly valued by Tabitha at each of her admissions. This support included assistance with transport and applying for courses and programs.

> "Giving me a lot of support to get to rehab, and just in lining stuff up if that didn't work out, and also supporting me in the things like [doing a tertiary course] for next year."

> 'They've got me involved with [employment agency], to start looking for work or training."

Social interaction. One of the highlights of Tabitha's admissions to the residential unit was the many opportunities to socialize with other people in an environment where she felt welcome and accepted. Some opportunities for social interaction were built into the program, such as social outings on Fridays and communal meals on Wednesday and Sunday nights. Casual social interaction also occurred when clients and staff used the shared facilities.

> "I just felt like I was living with a bunch of people who had their struggles but were helping themselves out and being helped as well."

> "I like the communal meals, everyone gets together and cooks a feed, we eat it together, we clean up together and we do the shopping together. It really brings the house together, the residents."

Discussion

Several admissions to a sub-acute residential mental health service allowed Tabitha to progress in her recovery, building on skills and knowledge gained from previous admissions. Examining this 18 month period of Tabitha's recovery journey shows that her recovery is a deeply personal experience, and an individual journey with her adapting and responding in her thoughts and plans, depending on where she

was at with her symptoms and her drug and alcohol use. Her experience illustrates the recovery processes of finding hope, redefining self-identity, creating a meaningful life and taking responsibility for recovery (Andresen et al., 2003), and her changing focus within these domains as she pursued her recovery goals.

Tabitha's shifting focus in her recovery plans and efforts during her admissions at the residential unit show growth in her personal understanding of what recovery means for her. Progression in understanding of recovery has been included in several models of recovery, such as Davidson and Strauss' (1992) four stage model, involving awareness of a more active self, taking stock of self, putting self into action and appealing to the self. Andresen et al. (2003) identified a five stage model of recovery, involving the initial stage of moratorium, moving to a stage of awareness of the possibility of recovery, then a preparation stage, a rebuilding stage and finally a stage of growth. The progression of Tabitha's recovery indicates that she is working within the latter recovery stages; she is actively working on plans for her recovery and rebuilding her life as she recovers from both mental illness and drug and alcohol addiction.

The striving toward manageable goals that are personally meaningful is an important component of taking responsibility for recovery from mental illness (Clarke et al., 2006). Tabitha's hopes and goals at her first admission were worthwhile ambitions, leading to a life with more meaning and greater community connections. However, over the following admissions to the residential unit there was a 'down-grading' of her stated hopes and goals, as Tabitha grappled with more short-term goals of 'staying clean' and putting into practice the techniques she had learned to maintain her mental health and respond to early relapse signs. Tabitha developed greater insight into the building blocks of recovery, and identified that she needed to focus on these as primary issues, and the higher goals of having her case file closed and being engaged in learning and community work would come later.

Over the course of the three interviews, Tabitha showed a growing understanding of who she was, with her self-identity developing as she had more confidence to participate in a community. The residential unit provided a micro-community for her to practice developing relationships with other people, both staff and other residents, and learning to be involved in community activities. Through these experiences, Tabitha grew in confidence and felt that she had something to contribute to the people around her. The development of sense of self and self-efficacy has been identified as a central feature that has contributed to people's recovery from mental illness (Mancini, 2007).

Changes in Tabitha's focus on the development of a meaningful life indicate that she is aware that the life that she wants is only attainable if she is able to control her drug and alcohol use and focus on her continued mental health. She is seeking to live a full and meaningful life, however, at this time in her life her recovery efforts were still consuming much of her time, energy, and emotion, limiting her capacity to pursue other meaningful goals and activities. The role of mental health services in assisting clients to develop meaningful lives is discussed by Peterson et al. (2014)

who found that mental health services that are based on shared management, with a person-centered focus and encourage self-direction allow clients to build meaningful and hopeful lives.

Tabitha was aware over subsequent admissions that she needed to take more responsibility if she wanted her recovery to progress. Over time, Tabitha was showing that she was developing resilience to be able to withstand setbacks, knowing that she had support systems in place to help her to refocus on her recovery goals. Tabitha's understanding of the need to take more personal responsibility is consistent with research demonstrating that people recovering from mental illness take on increasing responsibility as they progress through the stages of recovery (Copic et al., 2011).

Elements of the program that facilitated recovery

Five specific aspects of the residential program were instrumental in assisting Tabitha with her recovery journey: the therapeutic groups offered, support tailored to her personal circumstances, support for self-management of her health and her future, instrumental support, and social interaction.

Two types of therapeutic groups were offered in the residential service, a structured course (Optimal Health Program) and a peer support (psychosocial) group. The Optimal Health Program is a nine-session course facilitated by a staff member, with topics covered including perceptions of health, understanding stress, positive and negative stressors, developing health plans, collaborative strategies, problem solving techniques, and coping and relapse prevention strategies (Gilbert et al., 2012). The program adopts a person-centred approach and, although the course is a generic program not specific to a particular diagnosis, participants are encouraged to define health in their own terms and personalize the program through their responses in a workbook. The aim of the Optimal Health Program is to improve self-efficacy by assisting clients to build their personal skill set, so that they can effectively manage their illness, navigating through the support systems available to them and work towards staying well (Castle, 2013). Self-efficacy appears to be an important factor in recovery from serious mental illness (Mancini, 2007) and, particularly relevant to Tabitha's current situation, higher self-efficacy has been found to be associated with less alcohol and cocaine use (Warren et al., 2007).

The peer support group is also facilitated by a staff member, although participants are actively encouraged to contribute to discussions and to share their experiences with others. There was no set program for these weekly group times; the topic would be chosen that morning by clients and staff would prepare some resources to share with the group to get the session started. At times the psychosocial group had a social focus, assisting new clients in the house to get to know other clients and staff, and other times there was a therapeutic focus, with mindfulness or relaxation skills taught, or discussions on sleep, medications, or other issues that were concerning clients. Clients were encouraged to contribute to these groups times, sharing their own knowledge and experiences as a way of supporting and encouraging their peers.

Peer support has been widely accepted as an important aspect of recovery from serious mental illness, and can take a range of formats, depending on the skills of the facilitator and the group members. Loumpa (2012) suggests three approaches to peer support that can be used by social work clinicians: allowing the members to be experts; creating a forum where the expertise of group members combines with the professional expertise of the facilitator, as this creates an environment of mutual support and learning; and maintaining a state of curiosity within the group, where meaning is sought within discussions, rather than a focus on facts alone.

Tabitha was very aware that staff personalized the program to work specifically with her and her needs as they were on each occasion. In particular, staff worked individually with her on a drug and alcohol educational module and actively connected her with other drug and alcohol support services. Comorbidity of drug and alcohol abuse and mental illness is common. For example, the rate of substance use by people with first-episode psychosis has been estimated at double that of the broader population (Barnett et al., 2007), with an estimate of between 64% and 71% of people being treated for drug or alcohol abuse also having a mental disorder (Mortlock et al., 2011). The treatment of people with comorbidity is complex, with both disorders needing to be addressed; mental health services need to consider comorbidity when treating clients and when necessary, incorporate drug and alcohol abuse treatment into their program. People recovering from co-occurring substance abuse and mental illness have additional areas of difficulty when working on their own recovery, such as dealing with feelings and inner conflict, socioeconomic problems, and ongoing challenges with decisions regarding drug or alcohol use, all of which negatively impact their recovery (Laudet et al., 2000).

The individualized support provided by staff was also conducive to a positive therapeutic relationship. Positive outcomes from therapy are strongly related to the therapeutic alliance between patient and therapist (Martin et al., 2000), with a need for trust (Farrelly and Lester, 2014; Fonagy and Allison, 2014), mutual respect, and shared decision-making (Farrelly and Lester, 2014) as key features of the relationship. The therapeutic relationship has been described as a form of therapy on its own (Priebe and McCabe, 2008), and is essential for clinicians wanting to focus on person-centred care (Doherty and Thompson, 2014).

Support towards self-management of health and well-being was a powerful feature of the program, as Tabitha had not previously experienced this level of help to take some responsibility for her life and her health, nor the opportunity to actively participate in shared decision-making. Tabitha had been in and out of inpatient services the majority of her adult life, and was accustomed to being part of the mental health system and having decisions made on her behalf. The purpose of her admissions to the residential mental health service was to intervene in the 'revolving door' cycle of inpatient admission, home, inpatient admission, home, etc. For Tabitha, this opportunity was a lifeline, and from her first admission she experienced improvements in her self-determination and personal growth. During each subsequent admission she built on these personal skills, along with a growing understanding of what it meant for her to manage her own health and to take

responsibility for her recovery. Service providers are well placed to positively contribute to people's recovery, through facilitating the gradual increase of personal responsibility in the managing and directing their lives (Noordsy et al., 2002).

The instrumental support Tabitha received was tangible; it was clear to her that the staff genuinely cared for her and wanted her to be able to practically work towards the goals she had for her life. Although instrumental support is of a practical nature, research has demonstrated that a client perceives this support to also be emotional support from the counsellors, and it is a way that counsellors can communicate to their clients that they do care for them (Semmer et al., 2008).

Social interaction was an aspect of the residential program that Tabitha particularly enjoyed. There appeared to be two aspects of socializing that were most valuable; firstly, that she was in what appeared to be a typical home environment where she was accepted for who she was, and was able to be herself around other people who also had had similar experiences. Secondly, she was aware of being socially isolated prior to her step-up admissions, and had appreciated the opportunity to make new friends and interact with people and to be able to make plans to continue to interact with people, such as through art classes or through work or training courses. Similar themes have been reported by other people recovering from serious mental illness, with social support, meaningful activities, and lifestyle modification seen as facilitators of recovery (Windell and Norman, 2012). An advantage for clients of non-hospital mental health services is that they have greater opportunity to begin social activities that they can continue after discharge, compared to the opportunities provided for them in inpatient services (Fenton and Mosher, 2000).

Limitations

A case study design has several limitations, primarily around the generalizability of the study to other people and situations. This study described one woman's experiences, over 18 months of her life, in one mental health service, and as such cannot provide a comprehensive insight into the experiences of other people recovering from mental health problems. Secondly, the longitudinal design of the study allowed for some verification of how the client progressed in following her recovery goals, although there were no regularly scheduled follow-up interviews or assessments of her progress, after each admission. A more rigorous design would have allowed for a deeper understanding of the recovery processes; however, the intention of the interviews with this client was not to measure or assess her recovery, or check on her progress in reaching her stated goals, but rather to allow her to discuss how she felt about her current recovery experiences, and explore how these changed over time.

Conclusion

This case study demonstrates the progress a person with a comorbid mental illness and substance use disorder can make with personalized support in a residential

setting. Interestingly, her gains in understanding of her recovery developed over several admissions into the residential service, indicating that the staff at the residential unit met her where she was at and tailored the support they offered according to her current state. This study demonstrates that clients with long term, serious mental health problems can benefit from periodic admissions to recovery-focused services, so that they can build on their experiences from previous admissions. Admission to a community-based recovery-focused service can be a positive experience, building the recovery scaffolding—in contrast to the historically negative and often damaging experiences of inpatient admissions.

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