RECOVERY-ORIENTED SERVICES AND THE PROVIDER-CONSUMER RELATIONSHIP: INTERDISCIPLINARY PERSPECTIVES OF COMMUNITY MENTAL HEALTH CARE PROVIDERS IN VIRGINIA

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ABSTRACT

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Using a sample of 105 community mental health providers in seven agencies in Virginia, the present study examined the relative contribution participants’ individual characteristics, perceived job demands, and self-reported provider-consumer relationship variables in accounting for variation in providers reports of agency recovery-orientation, personal growth, and job satisfaction. Findings suggested no significant differences of providers’ reports of perceived agency recovery-orientation, personal growth, or reported job satisfaction as a function of the professional role of mental health providers or the mental health agency in which they worked. Findings in the present research study suggested that the provider-consumer relationship variables of working alliance and benevolent coercion techniques are the strongest predictors of perceived agency recovery-orientation, personal growth, and job satisfaction. Specifically, these effects emerged when controlling for providers’ individual demographic characteristics (e.g., age, gender) and perceived job demand characteristics (e.g., caseload size). Implications of study findings for research and clinical practice are discussed.
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INTRODUCTION

Prior to the 1980’s, schizophrenia and other types of serious mental illness were thought of as chronic debilitating disorders with a deteriorating course and little to no hope for sustained recovery (Shean, 2008). Moreover, the long duration of most individuals’ psychiatric hospital stays was believed to reflect the chronicity of mental illnesses in general, thus a belief that a patient could “recover” was simply not endorsed. Within the last twenty five years, however, advances in research, psychopharmacology, and increased advocacy on the part of adults with mental illness and their families have sparked the recovery movement in community mental health.

The recovery movement in mental health care is based on a vision of consumers in the community actively participating in their treatment with supportive mental health professionals whose role is to help promote wellness and recovery and not perpetuate illness and psychopathology. In short, the recovery movement is grounded in a belief that a person with a serious mental illness can strive to achieve life goals similar to people without a serious mental illness. A recovery-orientation is now the accepted and preferred method of service delivery for helping professionals (Davidson, Lawless, & Leary, 2005a; O’Connell, Tondor, Croog, & Evans, 2005; Peebles et al., 2009). At the national level, there is a push to transform the mental health system into a consumer focused recovery system (Harrow et al., 2005). To meet this mandate, many state hospitals and community mental health centers now purport to be recovery-oriented in their guiding paradigm of service delivery. It is unclear, however, whether agencies are creating new recovery-oriented treatment approaches and plans or merely relabeling existing medical model approaches as recovery-oriented (Borkman, 1998; Rodgers, Norell, Roll, & Dyck, 2007). Research on the implementation of recovery principles and the practices of mental health
professionals in the community mental health system is in its infancy (Davidson et al., 2009). Surprisingly little is known about recovery practices from the perspective of different disciplines of mental health professionals.

A central feature of recovery-oriented services, in stark contrast to the medical model, is the importance of the provider-consumer relationship, specifically, the therapeutic alliance. The therapeutic alliance is a central principle of the recovery movement (Oades et al., 2005; Green et al., 2008; Randal, 2009). Therapeutic alliance implies a good fit between clinician and client that involves a mutual trust that provides the client with some control over treatment and instills a sense of hope (Green et al., 2008). Working alliance is a departure from traditional assessment and treatment processes and is key to privileging the client’s voice and nurturing the alliance (Tilsen & Nylund, 2008). Cooper (2006) summarizes current literature suggesting that patients’ “trust in the clinician; perception of respectful treatment by the clinician; clinician familiarity, or ‘knowing’ of the patient; and affiliation and liking are all related to positive outcomes” (p.27).

Yet, Davidson, O’Connell, Tondora, Staeheli, and Evans (2005b) caution that the current enthusiasm in the recovery movement may increase social pressure on consumers to recover. Mental health professionals might prematurely encourage consumers to take on new challenges or goals for which they may not ready while operating under the guise of a recovery paradigm (Davidson et al., 2005b). A systematic understanding of helping professionals and consumers’ perceptions of recovery-oriented services is critical to an ongoing evaluation of the recovery movement (Kraus & Stein, 2012).

A therapeutic alliance may initially benefit the consumer; however, research suggests that mental health providers may additionally benefit from a close relationship with consumers. Stein and Craft (2007) found that case managers working with adults with serious mental illnesses
reported high perceptions of personal growth as a result of their work with consumers. Although a recovery paradigm is designed for the benefit of consumers, initial research suggests that higher perceptions of agency recovery-orientation among mental health providers was significantly positively related to providers’ reports of job satisfaction (Kraus & Stein, 2012). In the Kraus and Stein (2012) study, significant positive associations were found between case managers’ perceptions of recovery-oriented services at their agencies and their own sense of psychological well-being. Little is known, however, about mental health providers’ perceptions of their relationships with consumers, their views about agency recovery-orientation, and their reports of job satisfaction and individual well-being. Such research is needed to better integrate previous findings within a larger context of recovery-based activities between mental health care providers and individuals with serious mental illness with whom they work.

The present study examined the relationship between mental health professionals’ perceptions of agency recovery-oriented services, personal growth, and job satisfaction in community mental health and their views of the work they do with adult clients with serious mental illnesses. Specifically, the present research study examined the psychometric properties of a newly developed self-report measure of benevolent coercion techniques. The research examined views of recovery-oriented services, personal growth, and job satisfaction as a function of an individual’s professional role in the agency (staff psychologist, case manager, psychiatrist, social worker, nurse, occupational therapist, etc.) and as a function of community mental health agency (seven different community mental health centers in the Commonwealth of Virginia). The present research then examined the relative contribution of individual provider characteristics (e.g., gender, age), perceived job demands (e.g., caseload size, hours of direct service), and provider-consumer relationship characteristics (e.g., client working alliance,
benevolent coercion techniques, and reciprocity) in accounting for variation in providers’ reports of recovery-orientation, personal growth, and job satisfaction. Literature on the history of the recovery movement, definitions of recovery, recover implementation in the community, multidisciplinary community treatment team, the provider-consumer relationship, and finally, provider well-being and recovery are reviewed to provide a larger context in which to understand the present research.
LITERATURE REVIEW

Foundations of the Recovery Movement

What is popularly perceived as the modern recovery system is not an entirely new model for treating persons with mental illness. In the late 18\textsuperscript{th} and 19\textsuperscript{th} centuries, recovery principles were promoted to patients in asylums (psychiatric hospitals) in the form of moral treatment (see Pinel, 1806). From the turn of the 19\textsuperscript{th} century until the 1970’s and 1980’s the mental health system, however, was largely operated according to a medical model, which promoted the identification of symptoms, illnesses, and pathologies. During this time hospitals became warehouses where people remained for undetermined lengths of time with little expectation of returning to the community (Goffman, 1961). The medical model promoted the identification of signs and symptoms of mental illness that lead to a diagnosis. It was the diagnosis that guided treatment, not the client and clinician. Once acquired, most mental disorders were believed to be chronic over the lifespan (Shean, 2008). In the mid-1950s scientists developed the first generation of anti-psychotic medications, such as chlorpromazine (Thorazine) and haloperidol (Haldol) (Levinthal, 2005). Anti-psychotic drug treatment, combined with psychotherapy, psychiatric rehabilitation, and occupational rehabilitation helped support the notion that patients could indeed get better and leave the hospital. This resulted in a vast psychiatric consumer-survivor movement that shifted from the hospital to the community.

Beginning in the 1960’s, efforts to reform treatment and services received aid from a series of national and state legislative acts. The creation of the National Institute for Mental Health (NIMH, 1982) was only the first in a series of legislative acts to improve the quality and care of persons with mental illness. In 1963 the creation of the Community Mental Health Center Act (CMHCA) authorized the development of community mental health centers to replace state
institutions as the main source of treatment for people with serious mental illness (Swarbrick, 2009). After deinstitutionalization began, the Community Support Program (CSP) of the NIMH was developed to address the need for organized, community-based systems of care for adults living with mental illness (NIMH, 1982).

In the 1980’s additional legislation plead for increased services and resources for persons with serious and chronic mental illness. The bill, known as the State Comprehensive Mental Health Services Plan Act of 1986, provided block grants to states for the development of comprehensive mental health services (Marty & Chapin, 2000). Given the mandate for the court ordered creation of community care, however, there was a lack of community based programs which inhibited the treatment of individuals within the community (Marty & Chapin). In 1975, Dixon v. Weinberger provided a groundbreaking ruling in defining the state’s responsibility to develop a community based continuum of care (Rapson, 1981). Marty and Chapin (2000) write that the court ordered the government to develop a spectrum of community based programs and facilities that would allow the least restrictive principle to come to fruition.

Court rulings and legislative acts paved the way for a system of community mental health centers that were slowly created around the country. In effect, most hospitals that provided only regional care were decentralized to become a series of local mental health centers in multiple cities in each state. In theory, this helped to increase the ease of access to resources for consumers. Although legislative acts and court rulings provided a medium to improve and create community mental health resources across America, it was the former patients who largely established the recovery model in the community.

**Grassroots and Consumer Advocacy that Facilitated the Recovery Movement**
During the late 1990s, state mental health systems attempted to incorporate a recovery vision and promote recovery-oriented services (Anthony, 1993; Rodgers, Norell, Roll, & Dyck, 2007). As persons with mental illness were being discharged and becoming more prevalent in communities, family members and society gained a firsthand perception of the difficulties persons with serious mental illness faced. Family members of individuals diagnosed with mental illness organized and formed the National alliance for the Mentally Ill (NAMI) (Swarbrick, 2009). NAMI was a grassroots movement aimed at advocacy, education, prevention, and support for family members and persons with serious mental illness.

Additionally, the consumer-survivor movement gained strength. Swarbrick (2009) writes that consumer-survivors were often comprised of radical psychiatric survivors, who also refer to themselves as ex-patients and inmates, as well as a moderate mental health consumer group, now referred to as persons in recovery. The consumer-survivor movement helped create peer-support services for persons still institutionalized and those struggling in the community. The consumer survivor movement made tremendous strides in terms of reforming and transforming the mental health care delivery system to focus on the notion that mental health recovery is possible (Swarbrick, 2009). Personal experiences, testimonies, and strong advocacy by the consumer-survivor movement promoted the notion of recovery (Swarbrick, 2009). The consumer movement created a demand for recovery-oriented services in many areas of the country; this has often been critical in creating an impetus for system change (Sowers, 2005). Sowers writes that the transformation of systems from a paternalistic, illness oriented perspective to collaborative, autonomy enhancing approaches represents a major cultural shift in service delivery that required professional training to developed a workforce whose role was no longer a benign authority providing care for persons with severe, unremitting illnesses, unable to make rational decisions.
independently. Consumers took ownership of the recovery paradigm, a word that was largely adopted from the addiction self-help field (Davidson, Lawless, & Leary, 2005a). The self-advocacy, research, and peer and familial support led the 1990’s to be called the decade of recovery (Anthony, 1993).

The consumer-survivor movement made tremendous strides in terms of reforming and transforming the mental health care delivery system to focus on the notion that mental health recovery is possible (Swarbrick, 2009). As a result two distinctions of recovery began to emerge in the mental health field. Personal recovery recognizes that persons living with mental illness desire the same ideals that many people in the community desire: a sense of belonging, an adequate income, a decent place to live, to fulfill various life roles, contribute to their communities and regain physical, spiritual, mental, and emotional balance after encounters of illness, crisis, or trauma (Swarbrick, 2006). A recovery-orientation is a systemic approach to treatment, one that is embraced by clinicians, agencies, legislatures, and clients. A recovery-orientation necessitates a close relationship to empower clients toward goals of wellness and personal recovery beyond symptoms, illness, and pathology (Smith & Bartholomew, 2006). A recovery-orientation is the accepted and preferred method of service delivery for all helping professionals (Davidson, Lawless, & Leary, 2005a; O’Connell, Tondor, Croog, & Evans, 2005; Peebles et al., 2009).

What is Recovery?

Given the national mandate for recovery-oriented service delivery (Harrow et al., 2005), it is interesting to note that mental health practitioners and academicians have yet to agree on an operational definition of recovery and what constitutes “recovery-oriented” services. Recovery remains an elusive, vague, and poorly defined construct. In the literature, there is no consensus
about how to define recovery (Liberman & Kopelowicz, 2005; Roe, Rudnick, & Gill, 2007). Corrigan and Ralph (2005) write that there is currently no single definition of recovery. Furthermore, Davidson et al. (2005b) state that the word recovery has a variety of uses without having any meaningful implications. Jacobson and Curtis (2000) caution that the term recovery has become widely used in mental health policy and service delivery contexts and is in danger of losing specific meaning. Although no conclusive definition of recovery is currently endorsed, several themes have emerged in the literature which offer clarity and insight.

When defining recovery it is important to distinguish between personal recovery and a recovery-orientation or systemic recovery. Personal recovery largely refers to a consumer being “in recovery” and his or her subjective experiences, needs, and desires for wellness. A recovery-orientation refers to a systemic or agency paradigm model of treatment. One of the first definitions of personal recovery states, “A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles....development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993, p. 2). Swarbrick (2006) suggests that “recovery is a personal, unique process of (re)gaining physical, spiritual, mental, and emotional balance after one encounters illness, crisis, or trauma” (p.1). Sowers (2005) highlights the point that recovery is a highly personal process and may continue throughout a person’s life. Randal et al. (2009) write that recovery in mental health connotes achieving a meaningful life in the midst (or absence) of illness, and encompasses the notions of purpose, taking responsibility, having a renewed sense of hope, having meaningful relationships, and making decisions about one’s own treatment.

When referencing recovery-oriented service delivery, Jacobson and Curtis (2000) suggest that core elements of recovery programs include education about severe and persistent mental
illness, consumer and family involvement such as peer-support and self-help networks, support for consumer-operated services, emphasis on relapse prevention and management, incorporation of crisis planning and advance directives, innovations in contracting and financing mechanisms, definition and measure of outcomes, review and revision of policies, and stigma reduction initiatives. Farkus, Gagne, Anthony and Chamberlin (2005) write that recovery-oriented programs be person-centered and strengths-based by including the consumer in the design, plan, implementation, and evaluation of services; respecting the person’s rights to make his or her own decisions about treatment goals and services, and acknowledging the possibility of the person living a satisfying life beyond the disability.

With just a few definitions of recovery, common themes begin to emerge. A central theme is one of a unique and personal process that clients undergo, suggesting the individual nature of recovery for each client. Clients’ ownership of treatment is a prevalent theme in definitions that suggest peer-support, advanced directives, inclusion of the client in treatment decisions about goals and services, and relapse prevention. Lastly, the theme of a working relationship appears when recovery definitions reference peer supporters, family members, patient advocates, the therapeutic alliance, and treatment team members.

Two distinctions between definitions of recovery are noteworthy. Davidson, Lawless, and Leary, (2005a) suggest a distinction between clinical and rehabilitative recovery. Clinical recovery is observable diminution of signs and symptoms of disorder and the restoration of cognitive, social and occupational functioning, whereas rehabilitation recovery refers to the person’s efforts to live his or her life in a meaningful and gratifying way despite the limitations imposed by enduring disability (Davidson, Lawless, & Leary, 2005a). Arguably, clinical recovery most closely resembles a medical model approach at symptom monitoring and
reduction, disguised as a recovery orientation. Rodgers, Norell, Roll, and Dyck (2007) offer a review of operational definitions of recovery that are largely based on symptoms and psychopathology. Rehabilitative recovery then would appear to be focused on the personal biopsychosocial aspects of consumers’ recovery, such as attaining appropriate employment within their means, development of meaningful social relationships, ownership of their mental illness, and treatment versus passive acceptance of a prescribed treatment.

**Implementation of a Recovery-Orientation in Community Mental Health**

As the previously reviewed literature suggests, a recovery-orientation is the preferred agency orientation for service delivery for mental health consumers. Presently, however, it is unclear whether agencies create new treatment approaches and plans with a recovery orientation or merely re-label existing medical model approaches as recovery-oriented (Borkman, 1998; Rodgers, Norell, Roll, & Dyck, 2007). In effect, is the mental health system meeting the demand for a paradigm shift (Hardiman & Hodges, 2008)? Hardiman and Hodges (2008) found that while there was familiarity with recovery-based principles among providers, and high reported belief in the recovery model, actual utilization of recovery content in practice settings, however, remained mixed. In their study, O’Connell et al. (2005) found that “mental health professionals, persons in recovery, and family members generally agreed that their agencies were providing services that are consistent with a recovery orientation” (p. 383). The authors found that agencies were rated lowest on items regarding involvement of consumers in service design, and management (O’Connell et al., 2005), which are central components of a recovery paradigm. Rychener, Salyers, Labriola, and Little (2009) write that strong leadership, communication, feedback, and external partnerships help to facilitate recovery implementation. Tsai and Salyers (2008) highlight that treatment setting may influence the degree to which recovery practices are
utilized. The authors found that staff in state hospitals scored significantly lower than community mental health center staff on all measures of recovery-orientation after controlling for age, race, education, marital status, and length of time in current position and in the mental health field (Tsai & Salyers, 2008). To measure recovery-orientation, the authors used the Recovery Self-Assessment (RSA).

With the desire of a system to return to homeostasis, there are clear barriers to agency recovery implementation. Rychener et al. (2009) note that staff motivation, staff selection, staff openness to feedback and funding act as barriers to recovery implementation. Becker, Torrey, Toscano, Wyzik, and Fox (1998) write that both administrators and frontline practitioners must believe in the recovery model as well as implement recovery principles in practice for this model to work. Marsh et al. (1996) found that it was practitioners’ knowledge and attitudes of recovery principles that needed to improve, according to consumers. Despite the barriers to recovery implementation and shortage of results of such implementation efforts, several measures have proved successful in assessing an agency’s perceived recovery orientation. Much of the research indicates that it is often the clients and advocacy groups who desire recovery-oriented services rather than the helping professionals mandated to provide it.

Researchers found various forms of the Recovery Self-Assessment reliable and valid in assessing an agency’s recovery-orientation from the lens of both helping professional and patient (McLoughlin, & Fitzpatrick, 2008; O’Connell et al. 2005; Salyers, Tsai, & Stultz, 2007). Other measures such as the Recovery Enhancing Environment Measures (REE) and Recovery-oriented Systems Indicators Measure (ROSI) have been found efficacious in assessing agency recovery orientation. For a complete review (see Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005).

**Helping Professionals and the Multidisciplinary Treatment Team**
Recovery does not occur in isolation, but requires social bonds and supportive communities which are central to the process (Hardiman & Hodges, 2008). The recovery model offers a holistic way of addressing the personal and social consequences of psychiatric disability (Hardiman & Hodges, 2008). This holistic approach to personal recovery requires the services of a multidisciplinary treatment team. The community treatment team is a group of helping professionals, working in collaboration with each other and the client, to help the client achieve his or her treatment goals of wellness and recovery.

The treatment team usually consists of a psychiatrist, staff psychologist, occupational/rehabilitation therapist, nurse, social worker, masters level clinician, and case manager. The individual needs of clients will determine which helping professionals will be on “their” treatment team. The psychiatrist’s role is medication evaluation, prescription, and pharmacotherapy. The psychologist provides diagnostics, psychological testing, assessment, and psychotherapy. Occupational therapists help to teach and train clients to reintegrate into a vocation, if able. Nursing staff typically administer medications, take medical histories, and provide education for clients about their psychotropic medication. Social workers provide a link for clients to their families, peer-support specialists, and families; they assist in helping clients obtain social security resources, obtaining drivers licenses, and provide education for access to community resources. Masters level clinicians often provide individual, couples, or familial psychotherapy for clients and facilitate psychoeducation or psychotherapy groups. Lastly, case managers help clients day-to-day and week-to-week. Case managers are a key element in community mental health services for people experiencing serious mental illness (Stein & Craft, 2007), as they are often the professionals that have the most contact with clients and often provide a direct link to the treatment team.
In the past, case managers have been used extensively to measure different elements of recovery (see Kraus & Stein, 2012; O’Connell et al., 2005; Stein & Craft, 2007). It is possible for helping professionals other than case managers to identify recovery-oriented services. In their study (N=301), Hardiman and Hodges (2008) surveyed social workers, psychiatrists, and psychologists. The authors sought to learn about the helping professionals’ general views and attitudes of recovery and its implementation. The research questions were not geared directly toward participants’ own agency implementation of recovery-oriented service delivery. The authors found that there was familiarity with recovery-based principles among providers and high reported belief in the recovery model; however, actual utilization of recovery content in practice settings remains mixed (Hardiman & Hodges, 2008). The authors also found that psychologists in particular may be less familiar with the recovery model than social workers and psychiatrists (Hardiman & Hodges, 2008).

Because of the multidimensional requirements of recovery, different types of professionals are required to meet the needs of recovery-oriented services. Randal et al. (2009) articulate an elaborate theoretical model to the stages of recovery, similar to the Transtheoretical Model of Change (see Prochaska & DiClemente, 1983). The authors point out that at multiple stages of recovery, clients can experience crises, thus derailing them from their pathway of recovery. Since consumers work with many mental health professionals, it provides multiple avenues for helping professionals to identify thoughts or behaviors that may be indicative of relapse or crises.

The Provider-Consumer Relationship and Recovery

The relationship between mental health providers and consumers, specifically the therapeutic relationship, is of considerable interest to researchers and practitioners due to its
theoretical and empirical significance (Horvath & Symonds, 1991; Martin, Graske, & Davis, 2000). For example, Lambert and Barley (2002) write that the therapeutic alliance appears to be the single most important factor in psychotherapy regardless of technique or theoretical orientation. Carl Rogers, one of the most influential theorists of the therapeutic relationship, posited that empathy, unconditional positive regard, and congruence were the cornerstones of successful treatment (Horvath & Greenberg, 1989). In their hallmark research, Horvath and Greenberg (1989) found that at one month follow-up 30%-46% of the variance of conflict resolution in psychotherapy could be accounted for by the therapeutic alliance. That is, of all the multidimensional factors that contribute to conflict resolution or successful completion of a clients’ goal, 30%-46% may be explained by the therapeutic alliance. The authors defined conflict resolution as the client’s ability to resolve a personal conflict, which was a requirement for participation in the study, so clients “remained in treatment until their conflict was resolved or the program terminated” (Horvath & Greenberg, 1989, p. 228). The correlation coefficient for the target complaint measure used to assess the working alliance, that is reduction of the target complaint, was $r = .65 \ (p < .001)$. Horvath and Symonds (1991) found that the therapeutic relationship accounted for about 9% of the outcome variance, whereas others have noted 30% (Lambert, 1992).

A good “fit” between clinician and consumer is likely a prerequisite for producing the kind of working alliance needed to work on consumer’s recovery-oriented goals and wellness. In their mixed-methods study ($N=92$), Green et al. (2008) used in-depth interviews to assess mental health history as well as measures to assess quality of life and recovery-orientation. Analysis of the authors’ qualitative data indicated that trusting relationships with clinicians developed over time to aid recovery and when the "fit" with clinicians was good, long-term continuity of care
allowed for the development of close, collaborative relationships, fostered good illness and medication management, and supported patient-directed decisions (Green et al., 2008). Green et al. add that relationships purely focused on disease management, even when the clinician was perceived as competent, were not as valued by consumers or perceived as helpful. Further, at its inception, the provider must be aware of and acknowledge the power differential in order to foster trust in relationships with consumers (Randal et al., 2009), or a good fit may not be possible.

When providers establish a good fit with consumers with a serious mental illness, a working alliance may develop. In a working alliance under a recovery-oriented model, both clinician and client are in charge and there is a sharing of power between client and clinician for mutually agreed upon goals. In her qualitative study ($N=25$), Ásmundsdóttir (2009) identified supports and barriers to personal-recovery from the user’s perspective and then worked with professionals to create new ideas for service delivery for persons with mental illness. A grounded theory approach was used to code the qualitative data into meaningful themes, one of which was collaboration. Ásmundsdóttir (2009) writes that consumers being in charge of their life was fundamental to the recovery process, but was not easily achieved. The author argues that paternalistic approaches, such as those in a patriarchal therapeutic alliance, seem to correlate with mental health problems, as well as do lack of respect, stereotyping, labeling, and discrimination (Ásmundsdóttir, 2009). Thus, prescriptive service delivery or an approach of “clinician knows best” appears to cause more harm than good. Therefore, the function of the relationship between providers and consumers is that of a working *alliance*. Qualitative findings from Green et al. (2008) indicate that many of the participants’ discussions addressed how important it was for them to have knowledge about medications, support from clinicians in
controlling and making day-to-day medication adjustments, and clinicians responsive to requests for medication changes when symptoms worsened or side effects were problematic.

A strong working alliance between client and clinician is said to be an essential component of a recovery-oriented paradigm (Farkus, Gagne, Anthony, & Chamberlin, 2005; Green et al., 2008; Oades et al. 2005; Sowers, 2005). A working relationship occurs in the form of equal participation in the creation of treatment goals and decisions, such as placement, employment, illness education and management, and selection of psychotherapy homework (Green et al., 2008; Oades et al., 2005; Randal et al., 2009). Alverson et al. (2007) write that it is necessary to build an alliance between client and care providers in which treatment and recovery are based upon a mutual exchange of questions, concerns, knowledge, values, and goals. Decisions about medications, suicide plans, and possible in/voluntary decisions for inpatient treatment provide a great need for a strong relationship. Therefore, the provider-consumer relationship is not one-sided and requires an openness on the part of provider and consumer (Kraus & Stein, 2012). Finally, when providers work with consumers without a strong working alliance, providers may not have a clear understanding of consumers’ goals (Woltmann & Whitley, 2010).

In their qualitative study, Light and Tse (2006) used a series of focus groups (N = 16) to determine what constitutes a collaborative relationship. The authors found that using consumers’ language, expressing hope to clients, being open to new ideas, and asking consumers what they want increased the likelihood of a successful collaborative relationship. It should be noted, however, that the authors asked for perceptions of collaboration from the perspective of helping professionals and not clients. According to recovery principles, mental health care providers who deliver recovery-oriented services and maintain a strong working relationship are not supposed
to be manipulative or coercive. Although there are times when persons are not able to offer consent and or have insight because of the presence of symptoms, most persons with schizophrenia can achieve long and meaningful periods of recovery, optimistic outlook on life, and a sense of self-worth (Lysaker & Buck, 2008).

**Provider Well-Being and Recovery**

With a lack of adequate funding in community mental health, high caseload sizes, and paperwork and constant service demands provide challenges to the implementation of recovery-oriented services (Kraus & Stein, 2012). The outcome of these challenges often results in higher reports of professional burnout and lower job satisfaction among mental health professionals (Carney et al., 1993; Gitter, 2006). A review of the literature illustrates, however, that an agency recovery-orientation may affect not just consumers’ well-being, but may be associated with providers’ sense of job satisfaction and sense of well-being. Specifically, research suggests that providers’ perceptions of therapeutic alliance with clients are positively related to job satisfaction (Wilson & Crowe, 2008). Therapeutic alliance is one of several predictors, however. Priebe, Fakhoury, Hoffman, and Powell (2005) found in their community sample ($N = 189$) of psychiatrists, nurses, and social workers, that participants’ age ($p < .04$), type of profession ($p < .0001$), and job site ($p < .01$) significantly predicted higher scores on a measure of job satisfaction.

Recently, Kraus and Stein (2012) determined that providers’ perceptions of agency recovery-orientation significantly predicted their perceptions of job satisfaction. In their community sample of 114 case managers at multiple agencies in Ohio, the authors found that after controlling for age, education and income level, caseload size, and job tenure, case managers who perceived their agencies to offer higher levels of recovery-oriented services were
significantly more likely to report satisfaction in their job. Kraus and Stein (2012) found positive associations between case managers’ perceptions of recovery-oriented services at their agencies and their own sense of well-being. These findings suggest that while actual implementation of recovery-oriented services poses numerous challenges to an already overburdened community mental health system, when possible, providers’ perceptions of recovery-oriented services may relate to positive feelings such as increased job satisfaction and sense of well-being on the part of mental health providers who work with mental health consumers.

Although a recovery paradigm may directly affect consumers and indirectly affect providers, an established working alliance between provider and consumer may directly benefit both. For example, in their empirical study of 98 case managers who work with adults with mental illness, Stein and Craft (2007) found that helping professionals reported personal growth as a result of their work with consumers. Although case managers in their sample scored in the high range of professional burnout, the authors found that the age of participants and length of job tenure was significantly positively associated with overall reports of case manager personal growth ($r = .37; p < .001; r = .28; p < .05$, respectively) (Stein & Craft, 2007). Thus, older participants tended to report a greater sense of personal growth as a case manager than did younger case managers and less professional burnout. Qualitative analysis indicated that case managers reported that their work with consumers impacted their personal relationships and social consciousness and case managers felt they made a difference in their clients’ lives (Stein & Craft, 2007). Findings from this study suggest that providers and consumers may receive mutual benefits from an established working alliance; it is unclear at this time, however, what variables maintain a causal relationship with personal growth. Further analysis is necessary to understand a causal relationship with multidisciplinary helping professionals. It remains unclear
what the role of perceived agency recovery-orientation plays in the provider-consumer relationship and personal growth, though a relationship has been found (Kraus & Stein, 2012).

It is possible that a recovery-orientation may impact the provider–consumer relationship in unanticipated ways. For example, Davidson et al. (2005b) provides an interesting caution about the current enthusiasm in recovery-oriented services and the nature of a working alliance between provider and consumer. Specifically, Davidson and colleagues warn of the dangers of increased social pressure on consumers to recover and of the possibility of clinicians’ premature encouragement for clients to take on new challenges that they may not be ready for in the name of “recovery” (Davidson et al., 2005b). Davidson’s et al. (2005b) notion of increased social pressure from providers to have adults with mental illness “recover” without regard for their present circumstances or individual preferences and desires can be thought of as a form of “benevolent coercion” on the part of mental health providers. Operationally speaking, benevolent coercion techniques may be considered to be specific and purposeful behavioral actions in which mental health providers engage on behalf of consumers that are inconsistent with consumers’ desires. Typically, providers engage in these behaviors without malicious intentions, rather providers believe that they are acting with the best interests of consumers in mind. Based on Davidson’s observations and the present operational definition, it is expected that benevolent coercion techniques are in direct opposition to mental health recovery principles that called for shared participation in decision making between consumer and provider (Davidson et al., 2005b).

Interestingly, the concept of client coercion in the mental health field has a long history. For example, in their community sample \((N = 200)\), Monahan et al. (2005) found that between 44% and 59% of clients recruited from mental health centers from five sites in the United States
reported having experienced at least one form of “leverage” from mental health providers. The authors assessed four types of leverages derived from the social welfare system (e.g., money and housing) and the judicial system (e.g., criminal sanction and outpatient commitment). Sjöstrand and Helgesson (2008) write that coercion in treatment is acceptable when the client cannot make an autonomous decision about treatment and treatment is in client’s authentic interest. However, the authors go on to write that coercive treatment cannot be defended when the client “makes an autonomous decision against treatment or when treatment is not in the patient’s genuine interest” (p. 119). Benevolent coercion techniques as operationalized in the present study highlights the distinction between a consumer’s inability to make autonomous decisions and the provider’s desire to make decisions for a consumer because the provider feels that he or she knows “what’s best” for the consumer. For example, a mental health provider can seemingly be receptive to his or her clients’ autonomous wishes or desires about a specific treatment, but pressure or manipulate a client into seeking an outcome congruent with the provider’s own desires in the belief that the provider has expert knowledge that is more consistent with the client’s best interests than the client’s own preferences. Thus, the provider is engaging in coercion by denying autonomy. A simple provider response to a client in this situation might look like, “I hear what you are saying but I really think that it would be better if you…” or “That sounds really important to you, but I think that it makes more sense if…”

Coercion on the part of mental health providers towards consumers, even with good intentions, is still problematic. Research supports the notion that if clients perceive their provider as more coercive, consumers tend to report a poor working alliance. In their study of newly admitted inpatients ($N = 164$), Sheehan and Burns (2011) found that clients who perceived high levels of coercion tended to rate their admitting physician more poorly that those who
experienced low levels of coercion. These effects were found when controlling for voluntary and involuntary admission status of consumers. To decrease perceptions of coercion, the authors note that specifically, the modality for intervention lies in increasing the therapeutic relationship (Sheehan & Burns, 2011). When a strong working relationship is not present, the propensity for coercion is heightened. For example, consumers may be more likely to verbally acquiesce to providers and remain silent on their true desires. Specifically, Woltmann and Whitely (2010) conducted qualitative interviews with consumers ($N = 16$) to determine how they view shared decision making. One of the themes that emerged was the notion that consumers may be more likely to verbally agree with their case managers, however, not inform their case managers about their true desires or preferences.

**Summary**

Recovery-oriented service delivery is the preferred paradigm for community mental health. Yet, implementation of a recovery-oriented model of mental health care across settings is in its beginning stages. In order to help clients achieve their recovery goals, the recovery paradigm necessitates the involvement of multiple disciplines of helping professionals to aid them in their recovery. Research indicates that different disciplines can identify recovery-oriented services; however, there is no available research comparing helping professionals’ perceptions of recovery and the provider-consumer relationship across mental health agencies. There are, indeed, different definitions of the concept of recovery from serious mental illness, yet the provider-consumer relationship, specifically the therapeutic working alliance, consistently appears to be a central element of the process of recovery. Recovery-oriented service delivery, however, may inadvertently foster coercion between consumers and clinicians where providers prematurely encourage clients to take on new challenges or to take on tasks that are unrealistic in
light of the limitations imposed by their illness. Research suggests that recovery-oriented service
delivery benefits consumers and mental health providers as well. Specifically, providers who
report higher perceptions of agency recovery orientation also report greater job satisfaction and
and individual well-being. Further, there is some empirical evidence to suggest that providers
may benefit as well from the provider-consumer relationship and are more likely to report a
sense of personal growth as a result of their work with consumers. Research is needed to gain a
greater understanding of the role of perceived recovery-orientation, provider–consumer
relationship characteristics in mental health providers’ assessment of job satisfaction and
individual well-being.
PRESENT STUDY

The present research examined community mental health providers’ views of their work with adult clients who have a serious mental illness. The research investigated the role of individual characteristics, perceived job demands, and provider-consumer relationship factors as they related to providers’ views of the recovery-orientation of their agency and their sense of professional well-being. Specifically, the study examined the relative contribution of individual provider characteristics (e.g., gender, age), perceived job demands (e.g., caseload size, hours of direct service), and client relationship characteristics (e.g., client working alliance, benevolent coercion techniques, and reciprocity) in accounting for variation in providers’ reports of recovery-orientation, personal growth, and job satisfaction. The present study developed a self-report measure of benevolent coercion techniques to assess the extent to which providers intentionally seek to influence the decisions of their clients living with a serious mental illness. The psychometric properties of this new measure and the ability of the benevolent coercion construct to inform our understanding of providers’ experiences working with adults with mental illness will also be examined.

The present study addresses the following research questions:

1.) What are the basic psychometric properties of a newly developed self-report measure designed to assess the use of benevolent coercion techniques towards clients? It was expected that the measure would have acceptable internal consistency and scores on the measure would be uncorrelated with scores on a measure of social desirability. It was expected that greater perceived use of benevolent coercion techniques would be negatively related to scores on measures of perceived recovery-orientation, therapeutic working alliance, personal growth, and job satisfaction.
2.) Are there differences in providers’ reports of agency recovery-orientation, personal growth, and job satisfaction as a function of their professional role and their respective community mental health agency? Based on previous research (O’Connell et al., 2005; Salyers, Tsai, & Stultz, 2007), it was expected that scores of perceived agency recovery-orientation would not vary as a function of providers’ role or agency. Although personal growth (Stein & Craft, 2007) and job satisfaction (Kraus & Stein, 2012) have been studied exclusively among case managers, it is not expected that these individual well-being factors will vary by professional role or agency.

3.) Are there differences in providers’ reports of agency recovery-orientation, personal growth, and job satisfaction as a function of individual characteristics (e.g., age, gender, race, and professional role) and perceived job demands (e.g., caseload size and hours of direct contact with consumers)? Given previous research on agency recovery-orientation, it was expected that scores would not vary as a function of perceived job demands (Kraus & Stein, 2012), but may vary as a function of providers’ age (O’Connell et al., 2005; Salyers, Tsai, & Stultz, 2007). Based on previous research (Stein & Craft, 2007), it was expected that scores of perceived personal growth may vary as a function of age, such that older providers may be more likely to report personal growth because of the meaningful interactions with mental health consumers. It was also expected that personal growth scores would differ as a function of perceived job demand characteristics. Scores of perceived job satisfaction were expected to differ as a function of perceived job demand, with greater job satisfaction being related to smaller caseload sizes and a fewer number of hours per week of direct face-to-face time with consumers.

4.) What is the relative contribution of individual provider characteristics, perceived job demands characteristics, and client-provider relationship characteristics in accounting for
variation in providers’ perceptions of recovery-orientation, personal growth and job satisfaction? It was expected that perceived client-provider relationship characteristics would account for the majority of the variation in perceptions of recovery-orientation, personal growth and job satisfaction beyond that of job demand and individual characteristics.
METHOD

Procedure

To be eligible to participate in the study, participants needed to be at least 18 years old and work specifically with clients who have been diagnosed with a serious mental illness, as categorized by the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000). Professional disciplines of participants in the present sample included case managers, masters-level counselors, psychiatric nurses, social workers, occupational and rehabilitation therapists, psychologists, and psychiatrists.

The Human Subjects Review Board (HSRB) at Bowling Green State University approved the study for data collection. Community mental health centers were recruited via an agency recruitment text sent to a total of seventeen agencies in the Commonwealth of Virginia (see Appendix A). Data collection occurred via an Internet survey, hosted by SurveyGizmo. Mental health providers received an invitation to participate in the study by email (see Appendix B) sent by the principal investigator that notified potential participants of the purpose of the study, eligibility requirements, how much time they could expect to complete the survey, and about potentially winning an incentive (i.e., one of two $75 Visa gift cards). The email directed interested participants to an informed consent page (see Appendix C) where they could choose whether or not to take the survey.

Sample Characteristics

Participants in the present study consisted of a sample of 105 mental health professionals that work with consumers living with a serious mental illness. The sample was composed of mental health professionals across seven Community Mental Health Centers (CMHCs) in the
Commonwealth of Virginia. Of the 108 completed surveys, two surveys were removed because individuals did not meet inclusion criteria and one survey was removed due to substantial missing data. The sample of 105 mental health professionals (80 women, 22 men, 3 did not say) were employed in the professional roles of: Counseling/Psychological staff, \( n = 58.6\% \) (i.e., masters level counselor, substance abuse counselor, marriage and family therapist, rehabilitation therapist, occupational therapist, social work, staff psychologist), Medical staff, \( n = 10.3\% \) (i.e., nurse, RN, LPN, CN, CNA, and staff psychiatrist), and Direct Services staff, \( n = 21.6\% \) (i.e., direct care staff and case managers). Descriptive statistics about the sample are presented in Tables 1, 2, and 3.

A majority of the sample were Caucasian (63.8%), African-American (19%), or Other (6.9%), with an average age of 43.8 years (\( SD = 11.6 \)). Over one-third (41.4%) of adults in the sample identified as Protestant/Other Christian, and approximately one-half of the sample reported that they were currently married (51.7%). In regards to education, 20.7% of the sample holds a Bachelors degree, 53.4% a Masters degree, and 12.9% a Doctoral or M.D. degree. Fifty-one percent of the sample earned their highest degree in social work or psychology and 18.1% of the sample earns less than $39,999 annually, with 38.8% earning between $40,000 - $54,999, 15.5% earning between $55,000 - $64,999 and 16.3% earning more than $65,000.

The majority of the present sample reported working with adults with a serious mental illness (64%), and similar clientele such as substance abuse disorders (7.6%), and co-occurring disorders (7.6%). About one-third of the present sample (35.3%) indicated they follow a recovery model of mental health service delivery. In regards to their current caseload size, 32.8% reported carrying a caseload size of less than 14 clients, 11.2% reported that they carrying a caseload size between 15-19 clients, and 28.4% reported carrying a caseload size greater than 35
clients. The amount of direct contact per week participants reported engaging in appeared evenly distributed such that participants reported that they engaged in less than 5 hours per week (8.6%), 5-9 (4.3%), 10-14 (14.7%), 15-19 (13.8%), 20-24 (16.4%), 25-29 (12.1%), and greater than 30 hours (19.8%). A majority of participants (58.6%) reported that they participate in less than 9 hours per week of case collaboration with their fellow colleagues.

**Measures**

*Working Alliance Inventory (WAI).* The WAI (Horvath & Greenberg, 1986; see Appendix E) is a paper and pencil self-administered measure. The WAI is the most widely used assessment to measure the working alliance between therapist and consumer (Hatcher & Gillaspy, 2006). The measure comprises 36-items in three subscales, with 12 items each. The measure uses a seven-point Likert scale (1 = *Never* to 7 = *Always*). The subscales are goals (i.e., agreement about the goals of therapy), tasks (i.e., agreement about the tasks of the therapy), and bonds (i.e., the bond between client and therapist). The overall internal consistency for the WAI in the present study was excellent, with an internal consistency of .93. Subscale alpha coefficients ranged from .70 to .86 (Goal $\alpha=.82$, Task $\alpha=.85$, Bond $\alpha=.71$).

*The Recovery Self-Assessment-Revised (RSA-R).* The RSA-R (O’Connell et al. 2005; see Appendix F) is a 36-item self-administered measure assessing perceptions or practices that are considered to be consistent with a recovery service orientation. Essentially, the RSA-R measures the degree to which recovery services are being implemented in a given agency. The RSA-R offers a measure for helping professionals and clients, however, given the present research questions, only the helping professional version was used in the present study. The RSA-R has five factors that O’Connell et al. (2005) found, including: life goals, involvement, diversity of treatment options, choice, and individually-tailored services. The RSA-R utilizes a five-point
Likert scale ($1 = \textit{strongly disagree}$ to $5 = \textit{strongly agree}$). For the present study an overall reliability score was used with an internal consistency of .93.

\textit{Case Manager Personal Growth Scale (CMPG).} The CMPG (Stein & Craft, 2007; see Appendix G) is a 16-item self-administered measure that assesses case managers’ sense of personal growth as a result of their work with consumers. The measure uses a five-point Likert scale ($1 = \textit{strongly disagree}$ to $5 = \textit{strongly agree}$). In the present study the internal consistency of the CMPG scale was good with an alpha coefficient of .91.

\textit{Marlowe-Crowne Social Desirability Scale – Short Form (MCSD).} The MCSD (Strahan & Gerbasi, 1972; see Appendix H) is a 10-item self-administered measure that assesses how likely a person is to respond in a socially acceptable manner or in a manner that would be viewed favorably by others. Questions include “I’m always willing to admit it when I make a mistake” and “There have been occasions when I took advantage of someone.” Responses are scored as either true or false ($true = 1$ and $false = 0$). Five questions are reversed scored ($true = 0$ and $false = 1$). The alpha coefficient for the present study was moderate ($\alpha = .67$).

\textit{Benevolent Coercion Techniques (BCT).} Benevolent Coercion Techniques is a newly developed measure to detect specific and purposeful behavioral actions that mental health providers engage in, without a malicious intention, that are inconsistent with consumers’ desires. The construct of benevolent coercion techniques is based on Davidson’s et al. (2005b) caution of coercive practices by providers. Specifically, items were generated based on various domains of behaviors in which providers engage in with consumers, such as increasing community supports, relationships, or employment. The principal investigator invited several mental health practitioners in the community to provide direct feedback to aid in item refinement. Sample items on the benevolent coercion techniques measure included: “I have encouraged my clients to
take control of their finances, even if they tell me they are not ready” and “When I feel my clients are not capable of collaborating, I determine treatment goals for them.” The measure contains 12 items, with a five-point Likert scale (1 = strongly disagree to 5 = strongly agree).

Job Satisfaction Survey (JSS). The JSS (Spector, 1985; see Appendix J) provides an overall job satisfaction score based on nine facets (i.e., pay, promotion, supervision, fringe benefits, contingent rewards, operating conditions, coworkers, nature of work, and communication). Respondents were asked to rate nine statements using a six-point scale (0 = disagree very much to 6 = agree very much). Four items are reversed scored. Sample items consist of “My supervisor is quite competent in doing his/her job” and “I like the people I work with.” Respondents with higher total job satisfaction score are more satisfied with their jobs than are individuals with lower scores. The reliability of the JSS in the present study was low (α = .64).

Specific Reciprocity Measure (SRM). The SRM (Van Horn, Schaufeli, & Taris, 2001; see Appendix K) assesses the therapeutic investments of providers and their perceived outcomes (i.e., satisfaction) from three different exchange relationships: investments/outcomes with clients, investments/outcomes with colleagues, and finally, investments/outcomes to ones agency of employment. The measure contains 23-items rated on a five-point Likert scale (1 = very little to 5 = very much). The SRM has been applied to similar populations such as direct care staff working with adults in residential settings (Rose et al., 2010). The present study utilized the subscale related to the provider-consumer relationship. Scores on the SRM are calculated via a ratio score where total investments are divided by total outcomes. Scores of more than one indicate a non-reciprocal relationship where more is invested than received, and a ratio score of less than one indicates a nonreciprocal relationship where more is received than invested (Rose
Thus, the greater the SRM score, the less reciprocal the relationship. In the present study in the mean ratio score was 1.12, indicating a non-reciprocal, unbalanced relationship. The internal consistency of the SRM scale was moderate ($\alpha = .77$).

*Demographic Questionnaire.* Demographic data (see Appendix L) such as age, gender, ethnicity, education level, marital status, etc. were collected on all participants. Additionally, demographic data collected included participants’ employment history, education history, case collaboration, and direct contact per week with clients.
RESULTS

Preliminary Analyses

_Benevolent Coercion Techniques_. Participants’ responses on the Benevolent Coercion Techniques measure items were used to conduct an exploratory analysis to determine the factor structure of the proposed measure. In order to determine if the current sample size of multidisciplinary mental health professionals ($N = 105$) was adequate for a principal components factor analysis with 14-items, the Kaiser-Meyer-Olkin (KMO) test of sampling adequacy was used. It is recommended that a sample is adequate if the KMO is above .60. In the present study, KMO = .70, indicated that there was an adequate sample size for principal component analysis. To further test the appropriateness of the present samples’ data for principal component analysis, Bartlett’s test of sphericity was calculated. This tests the null hypothesis that the correlation matrix is an identity matrix whereby all of the diagonal elements are 1 and all off diagonal elements are 0. In the present sample, $X^2 (91) = 291.23, p < .000$, indicating to reject the null hypothesis. Taken together, results suggested that the data in the present sample was appropriate for principal components analysis.

Responses of the 14-item measure were entered into a principal components factor analysis and a four-factor solution was selected using Kaiser Normalization criteria and was subjected to Varimax rotation. The four factor solution accounted for 60.5% of the total variance in the present sample. Based on recommendations by Floyd and Widaman (1995) and Clark and Watson (1995) about item elimination in principal components analysis, items with factor loadings below .50 (items 4 and 6) on the benevolent coercion measure were removed, resulting in a 12-item measure of benevolent coercion techniques. The overall alpha coefficient for the measure was modest ($\alpha = .68$). A mean score for the measure was calculated for the present
sample and fell in the moderate range ($M = 2.80, SD = 1.67$), which suggested that participants that are more likely to agree or strongly agree with the statements, are more likely to be coercive in their practices and procedures with consumers. It is important to note that the Benevolent Coercion Techniques measure was not significantly correlated with a measure of social desirability (MCSD) ($r = -.01$). Table 6 contains the final items and the factor loading of each item onto the components.

The first factor, *Primary Treatment*, consisted of four items and reflected specific, purposeful, treatment decisions that practitioners make for consumers, such as generating treatment goals, assigning homework, and alternative therapies (i.e., occupational or vocational therapy), without consumer input. This factor accounted for 17.6% of the variance in the present sample. In the present sample the internal reliability coefficient for this factor was .68.

The second factor, *Social Empowerment*, consisted of three items and reflected the idea that providers may intentionally initiate social engagements for consumers they work with, such as starting romantic relationships or maintaining ongoing contact with their families, when this is inconsistent with consumers’ prerogatives. This factor accounted for 16.7% of the variance in the present sample. In the present sample the internal reliability coefficient for this factor was .67.

The third factor, *Community Support*, consisted of three items and reflected the theme that mental health professionals purposefully initiate supportive service goals in the community, such as facilitating securing housing, expanding friendships, or medication support goals, that are inconsistent with their clients’ desires. This factor accounted for 14.2% of the variance in the present sample. In the present sample the internal reliability coefficient for this factor was .55.

The fourth factor, *Community Engagement*, consisted of three items and reflected the idea that providers may deliberately encourage engaging in services in the community, such as
seeking employment or unfamiliar transportation methods, when these goals are inconsistent
with consumers’ desires. This factor accounted for 10.6% of the variance in the present sample.
In the present sample the internal reliability coefficient for this factor was .50.

Table 4 contains the zero-order correlation matrix for present study variables. It was
observed that the components of the Benevolent Coercion Techniques measure significantly
correlated with each other, the first component, and/or the total mean score for the measure. It
appears that the construct of Benevolent Coercion Techniques is best explained by the sum of its
parts, therefore a total mean score was used in all subsequent analysis.

**Descriptive Statistics.** Means and standard deviations for all study measures of interest
are presented in Table 4. The mean scores for perceived recovery-orientation (RSA-R) fell in the
moderate range \( (M = 4.08, SD = .66) \), indicating that participants in the present sample perceived
their respective community mental health agency’s as recovery focused in service delivery. The
RSA-R mean score in the present study was significantly higher than the mean score of 3.87 \( (SD
= .62) \) reported in the O’Connell et al. (2005) study of Connecticut mental health professionals,
\( t(104) = 3.38, p = .01 \). This suggested that the present sample of community mental health
professionals perceived their agencies as more recovery-oriented in service delivery than the
Connecticut sample.

In the present study, mean scores for the perceived working alliance (WAI) fell in the
moderate range \( (M = 5.53, SD = .52) \), indicating that participants in the present sample believed
they had a relatively strong therapeutic alliance with their clients. The WAI mean score in the
present sample is not significantly different from Busseri and Tyler (2003) mean score of 5.51
\( (SD = .64) \) derived from a university counseling center population, \( t(104) = .434, p < .67 \).
In regards to the views of the relationship the present sample of mental health professionals has with their clients, overall present study participants reported experiencing relatively high levels of personal growth as a result of their experiences working with adults with a serious mental illness. The mean scores for perceived personal growth (CMPG) were high ($M = 3.89$, $SD = .60$). The CMPG mean score was significantly different from Stein and Craft’s (2007) mean score of 3.7 ($SD = .50$) who tested a community sample of case managers ($N = 98$), $t(104) = 3.26, p < .001$.

In regards to the perceived reciprocal nature of the provider-consumer relationship (Specific Reciprocity Measure), participants reported a SRM mean ratio score of 1.12 ($SD = .19$). Scores greater than one indicates a non-reciprocal relationship where more is invested by the provider than received (Rose et al., 2010). Therefore, participants in the present sample perceived themselves as investing more in their work with his or her clients and receiving less in return. The SRM mean score was significantly different from Thomas and Rose’s (2010) mean score of 1.38 ($SD = .46$), who tested a community sample of direct service workers ($N = 95$) that work with adults with intellectual difficulties, $t(104) = -13.55, p < .000$. While the participants in the present sample perceived themselves as under-benefited, they did so to a significantly lesser degree than staff members performing similar duties.

Mean scores of participants’ perceived job satisfaction (JSS) fell in the moderate range, with a mean of 3.83 ($SD = .70$), suggesting that the sample was relatively satisfied with their current jobs. The JSS mean score was significantly different from Spector’s (1985) mean score of 3.69, who tested a large sample of human service providers ($N = 3,067$), $t(104) = 2.13, p < .05$. Thus, participants in the present sample appeared to report higher levels of perceived job satisfaction compared to similar samples. The short form of the Marlowe-Crowne Social
Desirability Scale (MCSD) was used to assess how likely a person is to respond in a socially acceptable manner. Participants obtained a mean score of .46 ($SD = .22$), suggesting that participants had relatively low levels of socially desirable responding. The MCSD mean score for the present sample was not significantly different from Stein and Craft’s (2007) mean score for mental health professionals of .47 ($SD = .22$), $t(104) = -.495, p < .62$.

Multiple Analysis of Dependent and Independent Variable. A one-way multiple analysis of variance (MANOVA) examined the present study’s dependent variables of perceived agency recovery-orientation, personal growth, and job satisfaction as a function of professional role (i.e., counseling/psychology staff, medical staff, and direct services staff) and community mental health agency. Specifically, in the MANOVA analysis, scores on the Recovery Self-Assessment – Revised, Case Manager Personal Growth Scale, and Job Satisfaction Scale served as the dependent measures and helping professionals’ role and agency served as the independent or fixed variables. Findings indicated that there were no statistically significant differences in scores on dependent measures of recovery-orientation, personal growth, or job satisfaction as a function of participants’ agency and/or professional role, $F(27,105) = 1.12; p = .25$; Wilk’s $\lambda = .704$, partial $\epsilon^2 = .111$. Taken together, the present findings suggested that the three main study dependent variables generally do not differ as a function of participants’ agency or professional role; therefore these were not used in subsequent analysis.

Dependent Variable Differences for Individual Characteristics. A series of one-way analyses of variance (ANOVA) examined whether scores on the dependent measures of recovery, personal growth, job satisfaction, working alliance, and benevolent coercion techniques differed as a function of demographic characteristics (i.e., gender, age, ethnicity) and perceived job demands (i.e., caseload size, hours of direct contact with consumers per week, and
case collaboration with colleagues per week). Age was collapsed and dummy coded into
categorical variables. Ethnicity was also collapsed and dummy coded into: African American,
Caucasian, and Other. Finally, the perceived job demand variables were already in categorical
form.

Findings indicated no significant differences for scores of the recovery-oriented services
measure (RSA-R) as a function of gender, $F(1,102) = .29; p = .59$, race, $F(2,104) = 1.92; p = .15,$
caseload size, $F(6,103) = .32; p = .93$, or hours direct contact with consumers per week, $F(7,104) =
1.24; p = .29$. Statistically significant differences in scores on the RSA-R were found as a
function of participant’ age, $F(4,101) = 2.75; p = .03$, such that older participants were more
likely to report high scores on the RSA-R measure, indicating they perceive their agency’s as
more recovery-oriented than younger participants [$M = 3.82 (SD = .60)$ for 25 – 34 year olds and
$M = 4.55 (SD = .58)$ for 55 – 65+ year olds].

On a measure of personal growth (CMPG) there were no statistically significant
differences found as a function of age ($p = ns$), race ($p = ns$), caseload size ($p = ns$), hours of
direct contact with consumers per week ($p = ns$) or professional role ($p = ns$). Significant
differences in scores on the CMPG scale were found as a function of gender, $F(1,101) = 4.49; p
< .04$, such that women were more likely to report higher perceptions of personal growth than
men [$M = 3.97 (SD = .62)$ for females, $M = 3.67 (SD = .46)$ for males].

On a measure of participants’ job satisfaction (JSS), no significant differences were
found as a function of age ($p = ns$), gender ($p = ns$), race ($p = ns$), caseload size ($p = ns$), or hours
of direct contact with consumers per week ($p = ns$). When examining mean different scores on a
measure of working alliance (WAI), no significant differences were found as a function of age ($p
= ns$), race ($p = ns$), caseload size ($p = ns$), or hours of direct contact with consumers per week ($p
Significant differences on scores of the WAI were found as a function of gender, $F(1, 101) = 4.95; p < .05$, suggesting that women were more likely to report higher scores on the WAI than men [$M = 5.58 (SD = .52)$ for females, $M = 5.31 (SD = .60)$ for males].

Lastly, on a measure of benevolent coercion techniques, there were no statistically significant differences found as a function of age ($p = ns$), gender ($p = ns$), race ($p = ns$), caseload size ($p = ns$), or hours of direct contact with consumers per week ($p = ns$).

Taken together, the present findings suggested that the dependent variables generally do not differ as a function of individual factors such as demographic variables or perceived job demands. Although the dependent variables did not significantly vary as a function of caseload size, case collaboration, and hours of direct contact per week with consumers, they are included in subsequent statistical analysis based on theoretical predictions regarding job demand characteristics. More specifically, caseload size and hours of direct contact with consumers per week are refined indices of providers’ direct engagement with consumers beyond providers’ professional role or agency. It is therefore necessary to understand the extent to which time spent with consumers is related to perceptions of agency recovery-orientation, personal growth, and job satisfaction.

_Bivariate Pearson Correlations for Independent and Dependent Variables._ A series of bivariate Pearson product-movement correlations among four variables of the provider-consumer relationship (personal growth, reciprocity, benevolent coercion, and working alliance), individual (age and gender) and perceived job demands (caseload size, case collaboration, and direct hours of contact with consumers per week), and agency recovery-orientation, personal growth, and job satisfaction were calculated (see Table 4 for additional details). In general, correlations ranged from low to moderate ($rs$ ranged from -.10 to .66). Scores on personal growth were positively
related to participants’ perceptions of agency recovery-orientation ($r = .31, p < .01$), working alliance ($r = .30, p < .01$), benevolent coercion techniques ($r = .24, p < .05$), gender ($r = .21, p < .05$), and job satisfaction ($r = .19, p < .05$).

Scores on the perceived working alliance were modestly positively correlated with perceptions of agency recovery-orientation ($r = .21, p < .05$), gender ($r = .21, p < .05$), and job satisfaction ($r = .27, p < .01$). Conversely, scores on working alliance were negatively correlated with perceived reciprocity ($r = -.37, p < .01$), benevolent coercion techniques ($r = -.28 p < .01$), and social desirability ($r = -.28, p < .01$). This suggested that lower scores of working alliance are associated with high scores of benevolent coercion and reciprocity. Additionally, perceptions of agency recovery-orientation were positively correlated with benevolent coercion techniques ($r = .21, p < .05$) and job satisfaction ($r = .31, p < .01$).

Participant age was positively correlated with personal growth ($r = .24, p < .05$) and scores on perceived agency recovery-orientation ($r = .26, p < .01$). This suggested that older mental health professionals were more likely to report greater experiences of personal growth and perceived recovery-oriented services at their respective agency.

Participants’ caseload size was positively correlated with hours spent in direct contact with clients ($r = .29, p < .01$). The numbers of hours participants reported spending in case collaboration was positively correlated with hours spent in direct contact with clients ($r = .22, p < .05$). As case collaboration did not significantly correlate with any of the study dependent variables and is not indicative of direct engagement with consumers, it was removed from all subsequent analysis.
Hierarchical Regression Analysis

A series of three hierarchical multiple regression analyses were conducted to examine the relative contribution of participants’ individual characteristics, perceived job demands, and self-reported provider-consumer relationship variables in accounting for variation in scores of 1) perceived recovery-orientation, 2) personal growth, and 3) job satisfaction. Regression results are presented in Table 7.

In the first regression analysis, the criterion variable was participants’ mean score on the Recovery Self-Assessment-Revised (RSA-R). Step 1 consisted of demographic variables (e.g., age and gender), Step 2 consisted of perceived job demands (e.g., current caseload size and the hours spent per week in direct contact with consumers), and Step 3 consisted of perceived relationship variables (e.g., self-report scores on working alliance, benevolent coercion techniques, and reciprocity with consumers). In the second regression analysis, the criterion variable was participants’ mean score on the Case Manager Personal Growth Scale (CMPG). Step 1 consisted of demographic variables (e.g., age and gender), Step 2 consisted of perceived job demands (e.g., current caseload size and the hours spent per week in direct contact with consumers), Step 3 consisted of perceived agency recovery-orientation, and finally, Step 4 consisted of perceived relationship variables (e.g., self-report scores on working alliance, benevolent coercion techniques, and reciprocity with consumers). In the third and final regression model, the criterion variable was participants’ mean score on the Job Satisfaction Scale (JSS). Step 1 consisted of demographic variables (e.g., age and gender), Step 2 consisted of perceived job demands (e.g., current caseload size and the hours spent per week in direct contact with consumers), Step 3 consisted of perceived agency recovery-orientation, and finally,
Step 4 consisted of perceived relationship variables (e.g., self-report scores on working alliance, benevolent coercion techniques, and reciprocity with consumers).

Recovery-orientation. When using agency recovery-orientation as the criterion measure, the overall regression model was significant, $F(7, 94) = 3.18, p < .01$ (see Table 7) and explained 20% of the total variance in perceived agency recovery-orientation. In Step 1, age ($\beta = .17, p < .01$), but not gender, accounted for 8% of the variance in perceptions of recovery-orientation such that older participants were more likely to perceive a higher level of agency recovery-orientation. In Step 2, the addition of caseload size and direct contact time did not add any additional statistically significant predictions of recovery-orientation, age remained significant ($\beta = .16, p < .05$). Step 2 explained 1.4% of the variance in perceptions of recovery-orientation. In Step 3, the inclusion of working alliance ($\beta = .40, p < .01$) and benevolent coercion ($\beta = .37, p < .01$), but not reciprocity, accounted for 11% of the variance in the prediction of perceived recovery-orientation. These findings suggested that after accounting for individual variables and perceived job demands such as caseload size and hours direct contact per week, participants with a perceived stronger relationship with their clients were more likely to report higher perceptions of agency recovery-orientation.

Personal Growth. When using personal growth as the criterion measure, the overall regression model was significant, $F(8,94) = 4.26, p < .001$ (see Table 7) and explained 28% of the total variance in personal growth. In Step 1, age ($\beta = .14, p < .05$), but not gender, accounted for 9% of the variance in reported personal growth as a result of the work participants do with consumers. In Step 2, the addition of caseload size and direct contact time per week did not add any significant variance in predicting personal growth and accounted for .1% of the variance. In Step 3, the addition of perceived recovery-orientation ($\beta = .22, p < .05$) accounted for 5% of the
variance in the prediction of perceived personal growth. Finally, in Step 4 the addition of working alliance ($\beta = .47, p < .01$) and benevolent coercion techniques ($\beta = .36, p < .01$), but not reciprocity or recovery-orientation, accounted for 14% of the variance in reports of personal growth. This suggested that after accounting for individual variables, perceived job demands, and perceptions of agency recovery-orientation, participants with high perceived provider-consumer relationship variables were more likely to report personal growth as a result of the work that they do with consumers.

*Job Satisfaction.* When using job satisfaction as the criterion measure, the overall regression model was significant, $F(8,94) = 3.05, p < .01$ (see Table 7) and explained 22% of the total variance in job satisfaction (see Table 7). In Step 1, age and gender did not significantly predict job satisfaction. Step 1 accounted for .7% of the variance. In Step 2, hours of direct contact with consumers per week ($\beta = -.08, p < .05$) but not caseload size, accounted for 5% of the variance in reports of job satisfaction. In Step 3, direct contact with consumers per week remained significant ($\beta = -.09, p < .01$) as did the addition of perceptions of agency recovery-orientation ($\beta = .34, p < .01$). Step 3 accounted for 10% of the variance. Finally, in Step 4 direct contact with consumers per week ($\beta = -.08, p < .05$), recover-orientation ($\beta = .28, p < .05$), and working alliance ($\beta = .32, p < .05$), but not benevolent coercion techniques or reciprocity, accounted for 6% of the variance in reports of current job satisfaction. These findings suggested that after accounting for individual variables and perceived job demands, participants with a perceived stronger working alliance with consumers, more direct contact per week, and higher perceptions of agency recovery-orientation were more likely to report more job satisfaction in their current professional role.
DISCUSSION

Using a sample of 105 mental health providers in the Commonwealth of Virginia, the present research investigated the role of individual characteristics, perceived job demands, and provider-consumer relationship factors as they related to providers’ views of the recovery-orientation of their agency and their sense of professional well-being. Consistent with study expectations and previous research (O’Connell et al., 2005; Salyers, Tsai, & Stultz, 2007), present findings indicated that mental health provider perceptions of recovery-orientation, personal growth, and job satisfaction did not vary significantly as a function of providers’ role (i.e., counseling/psychology staff, medical staff, and direct services staff) or by respective agency. However, contrary to expectations, mental health providers’ scores on the newly developed measure of benevolent coercion techniques were positively correlated with their scores on measures of recovery-orientation, personal growth, and job satisfaction.

In terms of individual characteristics, results indicated that older mental health professionals in the present sample generally perceived higher amounts of agency recovery-orientation. This finding is consistent with existing research that found a relationship between older aged providers and higher scores on agency recovery orientation (McLoughlin & Fitzpatrick, 2008). In the present study, women were more likely to report higher levels of personal growth as a result of working with consumers than were men. In contrast to previous research findings that showed no gender differences in reports of personal growth as a result of working with consumers (Stein & Craft, 2007), gender differences in reports of personal growth may reflect the predominantly female sample in the present study and should be interpreted with caution.

Present findings highlighted the role of consumer–provider relationship factors in accounting for variation in providers’ reports of agency recovery-orientation and individual well-
being. Specifically, regardless of provider demographic characteristics and perceived job demands, providers’ reports of a stronger working alliance with consumers and a greater use of benevolent coercion techniques accounted for a significant proportion of variation in providers’ reports of agency recovery-orientation and personal growth as a result of working with consumers. Providers’ reports of a stronger working alliance with consumers statistically predicted higher job satisfaction scores, regardless of provider demographics and perceived job demands. Greater working alliance significantly predicted higher reports of job satisfaction.

When looking specifically at consumer–provider relationship factors, results further suggested that providers’ views of working alliance and benevolent coercion techniques were more powerful predictors of their reports of perceived agency recovery-orientation and personal growth than are providers’ reports of relationship reciprocity with consumers.

**Provider-Consumer Relationship Characteristics**

Results from the present study suggested that the provider-consumer relationship variables consistently accounted for the most variance when statistically predicting the criterion variables of recovery-orientation, personal growth, and job satisfaction. These effects emerged when controlling individual characteristics of providers and their perceived job demands, and depending on the regression model, providers’ perceptions of agency recovery-orientation. More specifically, working alliance and benevolent coercion techniques appear to significantly contribute to the prediction of recovery-orientation and personal growth, while working alliance appears to significantly contribute to job satisfaction. Reciprocity was not a significant predictor across all regression models and therefore does not appear to be a salient component to the provider-consumer relationship. At the bivariate level reciprocity was only negatively correlated with working alliance.
Findings in the present study in regards to working alliance are noteworthy. A strong working alliance is thought to be essential in a recovery paradigm (Farkus et al., 2005; Green et al., 2008; Oades et al. 2005; Sowers, 2005) and findings in the present suggested that working alliance is a strong predictor of providers’ views of agency recovery-orientation. Contributions of the therapeutic alliance have been traditionally studied to explain outcome variance in treatment (Horvath & Greenberg, 1989; Horvath & Symonds, 1991; Lambert, 1992). They are often studied as a bidirectional relationship, where a clinician gives empathy, understanding, or concern, whereby the client obtains trust and guidance. Findings in the present study suggested that provider-consumer relationship variables help explain predictions of personal growth, in that those providers with higher perceptions of working alliance reported greater perceptions of personal growth as a result of their work with consumers. These findings appear consistent with the literature. The vast majority of psychotherapists acknowledge experiencing emotional growth as a direct result of their professional work (Guy, Poelstra, & Stark, 1989). Norcross and Guy (2007) write that practitioners feel enriched, nourished, and privileged in conducting psychotherapy and the work brings relief, joy, meaning, and growth for both clients and practitioners. Stated simply and concisely, Norcross and Guy (2007) write, “the work changes us” (p. 25). The present research articulated the specific contributions to feelings of personal growth, such as age and working alliance. These effects emerged when controlling for perceptions of agency-recovery-orientation.

Perceived job demands (e.g., caseload size and hours of direct contact with consumers per week), were not significant in the first two regression models. In the regression model predicting job satisfaction, however, perceived job demands, specifically, hours of direct contact with consumers per week, significantly contributed to the prediction of job satisfaction. These
findings appear unique to the present study. Onyett, Pillinger, and Muijen (1997) similarly found that caseload size and hours of case collaboration with colleagues per week were not significant predictors of job satisfaction whereas others (Kraus & Stein, 2012; Priebe, Fakhoury, Hoffman, & Powell, 2005) found age to be a significant predictor of job satisfaction. Thus, hours of direct contact appears to be unique and worthy of future study.

The present research also found similar provider-consumer relationship variables and perceptions of agency recovery-orientation to contribute to the prediction of job satisfaction. Specifically, Kraus and Stein (2012) and Wilson and Crowe (2008), also found perceptions of agency recovery-orientation and working alliance to significantly predict job satisfaction, respectively. This suggested that those mental health providers who work in a recovery paradigm, establish a strong therapeutic relationship, and see clients frequently, may be more satisfied with their jobs as mental health professionals.

In the present research, it appears as though, regardless of providers’ age and caseload size, that the perception of a strong working alliance and perceived agency recovery-orientation are the best predictors of explaining job satisfaction. This is an important finding to understand, as currently, there is minimal literature that considers the contributions of relationship variables between providers and consumers in explaining and predicting community mental health providers’ overall satisfaction with their job. Further, it begs the question about the relationship between perceived agency recovery-orientation and job satisfaction. At the bivariate level they maintained a moderate correlation, but longitudinal research is necessary to understand a causal relationship.
Benevolent Coercion Techniques

A number of authors have noted that recovery-oriented programs be person centered and strengths based by including consumers in the design, plan, implementation, and evaluation of services (Farkus, Gagne, Anthony, & Chamberlin, 2005). Thus, part of the necessary and meaningful relationships is with mental health providers, who establish a strong working alliance. A meaningful therapeutic alliance is necessary in a recovery paradigm. Accordingly, the results that working alliance significantly contributed to perceptions of recovery-orientation is understandable and consistent with theory and research on mental health recovery.

Perhaps the most intriguing result of the present study concerns benevolent coercion techniques. Overall, the present research suggested that the measure of benevolent coercion appeared to have acceptable psychometric properties. Mental health providers’ use of benevolent coercion techniques with consumers was thought to be antithetical to consumers’ personal and systemic recovery. The measure of benevolent coercion techniques was negatively correlated with a measure of working alliance, providing evidence for its construct validity. What is striking, however, is that scores on benevolent coercion techniques were significantly positively correlated with scores on measures of perceived agency recovery-orientation and personal growth as a result of working with consumers. That is, higher scores on benevolent coercion techniques combined with higher scores on working alliance significantly predicted providers’ views of greater agency recovery-orientation and higher levels of personal growth as a result of working with consumers. In terms of accounting for variance in regression equations, the working alliance and benevolent coercion techniques measures nearly equally contributed to accounting for variance in scores on agency recovery-orientation and perceptions of personal growth, after controlling for individual characteristics and perceived job demands.
Although these findings appear counterintuitive at first glance, benevolent coercion techniques may indeed be a salient component of strengthening perceptions of the provider-consumer relationship. Some authors have argued against coercive practices (Sjöstrand & Helgesson, 2008). However, there are a number of possible arguments in favor of using mild forms of coercion in healthcare settings as it can be argued that mild forms of coercive treatment may be justified when it protects central values and interests of the patient. In elucidating procedural justice situations, Galon and Wineman (2010) write that the behavior of legal professionals, clinical staff, and significant others, especially in commitment hearings is evaluated by the client for genuine interest, respect, and benevolence. The authors write that the elements of fairness and transparency contained in procedural justice can be equated with the ethical principle of justice, beneficence, and nonmaleficence. Clinicians’ justification of coercive practices by means of ethical decision making could decrease his or her potential cognitive dissonance. The integral benevolence in procedural justice is clearly related to the principle of beneficence, referring to the direct assistance, consideration, and respect accorded to the client by clinician (Galon & Wineman, 2010).

Although clinicians may at times limit autonomy of their clients (Galon & Wineman, 2010; Monahan et al., 2005; Sheehan & Burns, 2011; Sjöstrand & Helgesson, 2008), research suggests that clinicians do so under the auspices of ethical decision making and beneficence and not overt coercion (Galon & Wineman, 2010; Sjöstrand & Helgesson, 2008). When mental health providers “coerce” consumers, they intentionally do so to act congruently and avoid harm, such as in situations of medication refusal, elopement, or involuntary hospitalization. This may explain why in the present study, providers reported a strong therapeutic alliance in addition to benevolent coercion techniques. It is likely that those with a strong alliance, who may
benevolently coerce consumers, do so in a transparent nature to minimize harm, and in effect, continue to practice recovery principles. It is possible providers engage in benevolent coercion techniques because they perceive a strong alliance and might not do so otherwise. Further, mental health providers may believe that benevolent coercion techniques are part of what makes them responsible and compassionate providers, adding to feelings of personal growth. In the present study, it appeared as though benevolent coercion techniques represented a positive construct in the remaining unexplained variance beyond what therapeutic alliance explained, allowing for directedness on the part of the provider.

Findings from this study suggested that having a therapeutic relationship with persons with a serious mental illness provides multiple benefits outside of the provider-consumer relationship. It appears that when providers viewed their agencies as more recovery-orientated, they tended to have greater job satisfaction and they were likely to report feelings of personal growth. Thus, once providers establish a therapeutic alliance with consumers, the provider-consumer relationship may impact providers’ perceptions of agency recovery-orientation, job satisfaction, and personal growth.

**Study Limitations**

The present research study contributed in a number of important ways to the literature, but is limited in a number of respects. Specifically, the research used a convenient sample of seven out of forty community mental health agencies. The overall sample size is relatively small, comprised of primarily female, Caucasian mental health providers, and just under two-thirds (64%) indicated that they worked with consumers living with serious mental illness. Taken together, it is important to not apply the present findings to all community mental health agencies.
in the state, people from diverse ethnic and cultural backgrounds, or those providers not working directly with consumers with a serious mental illness.

The cross-sectional nature of the study did not allow for examination of the causative direction of associations between the independent and dependent variables. Although the present study did not find differences as a function of agency or providers’ professional role, it is possible that too few providers were sampled within each role. In addition, the present sample of mental health providers may reflect a highly motivated subset of mental health providers within the agencies sampled, possibly inflating scores on the dependent and independent measures. Future research should strive to randomly sample agencies, adhere to stricter inclusion criteria, and strive for a larger, more diverse sample size, obtained from each agency.

**Implications for Future Community Research and Practice**

A recovery-orientated service delivery paradigm is now the preferred method of service delivery for helping professionals (Davidson, Lawless, & Leary, 2005a; O’Connell, Tondor, Croog, & Evans, 2005; Peebles et al., 2009) and encouraged at the national level (Harrow et al., 2005). Over the last decade, it has become unclear whether “recovery” was simply rhetoric or competent clinical practice. Further, it remains unclear whether agencies are creating new recovery-oriented treatment approaches and plans or merely relabeling existing medical model approaches as recovery-oriented (Borkman, 1998; Rodgers, Norell, Roll, & Dyck, 2007). A central principle of the recovery movement is the therapeutic alliance between mental health provider and consumer (Oades et al., 2005; Green et al., 2008; Randal, 2009).

The present research provides a number of interesting findings salient to academicians and community mental health providers. Although previous research has noted the importance of the therapeutic alliance (Horvath & Greenberg, 1989; Horvath & Symonds, 1991), the present
research demonstrated the importance of the provider-consumer relationship from the perspective of providers working with adults who have a serious mental illness. More specifically, the present research demonstrated the benefits of the provider-consumer relationship in that mental health providers are likely to experience increased perceptions of agency recovery-orientation, feelings of personal growth, and report higher feelings of job satisfaction. This discovery provides an interesting avenue for research. Most of the previously reviewed literature related to adults with serious mental illness notes the necessity of working under a broad recovery model with the importance of establishing a working alliance with consumers subsumed under one of several recovery goals. Findings in the present study suggest that measuring or assessing the provider-consumer relationship first may provide a more direct path to understanding perceptions of agency recovery-orientation. It is likely that applying further recovery-oriented techniques and practices, without a foundational provider-consumer relationship, is superfluous. Further, the present research highlights the notion that consumers are not the only ones benefited from a close working alliance. More research is needed to understand the outcomes of working under a recovery paradigm. It is likely when recovery-orientated programs were implemented for consumers’ benefit; it created a culture of care, indirectly providing mental health providers with a sense of well-being. It is believed that this sense of well-being may directly impact consumers’ outcome and recovery, however, more empirical research is needed to understand this notion.

The present research suggested that practitioners may consider directing a substantial portion of their time and effort to establishing and maintaining a strong working relationship with their clients who have a serious mental illness. Investing the time and energy into the provider-consumer relationship is likely to benefit mental health providers, however, more
Another important contribution of the present research is the newly created, Benevolent Coercion Techniques measure. Provided that therapeutic alliance is an important concept in recovery-oriented service delivery, it would seem coercion is the antithesis. Thus, coercive practices were believed to be negatively associated with recovery. The present research suggested that benevolent coercion techniques may be a significant variable to predict perceptions of recovery-orientation and is likely a necessary action for consumers with a serious mental illness. It is important to note again that in the present research, benevolent coercion techniques were negatively associated with a measure of social desirability. The present research also noted high scores on measures of therapeutic alliance. Therefore, expansion of the theory of what services and behaviors encompassing a recovery-orientated definition and practice may be broadened. Although the word “coercion” maintains a negative connotation, it is difficult to articulate a different description for the construct of benevolent coercion techniques at this point.

It is possible that providers justify their coercive decisions by reframing their actions as making ethical decisions (Galon & Wineman, 2010) as well as making all coercive actions as transparent and open as possible with their clients. Based on the findings in the present research study and implications for future research, the definition of the construct underlying the Benevolent Coercion Techniques measure is best described as follows: the measure detects specific and purposeful behavioral actions that mental health providers engage in, without a malicious intention, that are inconsistent with consumers’ desires. It is further possible that the conceptual construct of benevolent coercion techniques exists outside of a recovery paradigm.
Future research is needed to compare responses of the present sample of multidisciplinary mental health providers on the benevolent coercion techniques measure with that of their consumers. From consumers’ perspective, other researchers have found that higher perceived coercion was associated with a poor rating of therapeutic relationship (Sheehan & Burns, 2011). It is important to ascertain whether consumers with a serious mental illness perceive their respective community mental health agencies as recovery-oriented and whether or not they endorse items on the Benevolent Coercion Techniques measure, suggesting that a certain amount of intentional directedness may be necessary for those with a serious mental illness. Clearly, future research is needed to better understand the concept of benevolent coercion techniques and the meanings that clinicians ascribe to these types of behaviors.

Previous research found that case managers reported feelings of personal growth as a result of the work that they do with consumers (Stein & Craft, 2007). The present research expanded their findings to include multiple community mental health centers and multidisciplinary helping professionals, finding no differences as function of professional role or agency. The present research additionally identified predictors of personal growth while controlling for perceptions of agency recovery-orientation, such as working alliance, benevolent coercion techniques, and age. This suggested that direct interventions may focus on younger or newer staff, regardless of professional role, aimed at increasing skills to foster or strengthen a working alliance and collaboration. Additionally, it is important to note that when staff feels that they are making “correct” decisions for their clients (i.e., benevolent coercion techniques), they are more likely to report feelings of personal growth as a result of working with consumers. This is an important finding noteworthy of future research. It is critical to understand the role of coercion in predicting personal growth. It is suspected that providers may report an ethical
decision making argument in explaining their behavior, but this is not well understood at this time.

The present research found that working alliance was a significant predictor of job satisfaction in a recovery paradigm. The present research appears to be the first research to include both provider-consumer relationship variables, individual characteristics, and perceived job demands to predict job satisfaction. Previous research has found differences in individual and perceived job demands and multidisciplinary helping professionals (Priebe, Fakhoury, Hoffman, & Powell, 2005). Through qualitative analysis, other researchers have noted the contributions of working alliance in explaining job satisfaction (Wilson & Crowe, 2008). However, given the inconsistent findings, more research is necessary.

Contrary to previous research, the present research did not support the belief that reciprocity was a necessary component of the provider-consumer relationship. Reciprocity was not significant in any of the regression models in predicting any of the dependent variables. It is possible that reciprocity is not an appropriate variable to the provider-consumer relationship construct; however, it is important to note that it was not correlated with recovery-orientation, personal growth, or job satisfaction. Future research may identify a better variable to illustrate the notion of a give-and-take component in the provider-consumer relationship.

Taken together, these findings elucidate a number of interesting policy implications for community mental health. Most notable is that administrators may benefit from providing trainings and in-services targeted at fostering relationship skills for all new and/or younger mental health professionals, regardless of their professional discipline. It appears that by increasing working alliance and acts of benevolent coercion techniques, administrators may observe increases in his or her staff’s perceived agency recovery-orientation, personal growth,
and job satisfaction. With a shortage of time and money in community mental health, focusing on fostering specific skills to increase working alliance appears to be the most fruitful use of resources. In looking at the bigger picture, the present research reinforces previous research that establishing a working alliance is critical for all mental health providers, regardless of agency or discipline, in working with adults with a serious mental illness. There is no doubt that community mental health settings are typically demanding settings in which mental health providers work. However, as suggested by the present study, it may ultimately be professional relationships between provider and consumer that relate to providers’ feelings of job satisfaction and personal well-being.
REFERENCES


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Table 1

Sample Demographic Characteristics

<table>
<thead>
<tr>
<th>N = 105</th>
<th>Number (%)</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender *</td>
<td>Field of Highest Degree</td>
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</tr>
<tr>
<td>Male</td>
<td>22 (19)</td>
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<td>3 (2.6)</td>
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<tr>
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<td>$80,000+</td>
<td>12 (10.3)</td>
<td>30 to 34</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35+</td>
</tr>
<tr>
<td>Highest Education</td>
<td>Population Primarily Work With</td>
<td></td>
</tr>
<tr>
<td>High School Diploma</td>
<td>0 (0)</td>
<td>Adults with SMI</td>
</tr>
<tr>
<td>Some College</td>
<td>1 (9)</td>
<td>Adults with a DD</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>2 (1.7)</td>
<td>Adults with SA/SU</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>24 (20.7)</td>
<td></td>
</tr>
<tr>
<td>Masters Degree</td>
<td>62 (53.4)</td>
<td></td>
</tr>
<tr>
<td>Doctoral Degree/MD</td>
<td>15 (12.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child/Adols. with emotional problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child/Adols. with DD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

Note. * Indicates missing data for two or more individuals.
Table 2

*Combined Provider Roles*

<table>
<thead>
<tr>
<th>Role</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Psychological Staff</td>
<td>68 (58.6)</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>12 (10.3)</td>
</tr>
<tr>
<td>Direct Services Staff</td>
<td>25 (21.6)</td>
</tr>
</tbody>
</table>

Table 3

*Breakdown of Provider Roles*

<table>
<thead>
<tr>
<th>Role</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Psychological Staff</td>
<td></td>
</tr>
<tr>
<td>Masters Counselor</td>
<td>35 (33.3)</td>
</tr>
<tr>
<td>Substance Abuse Counselor</td>
<td>17 (16.2)</td>
</tr>
<tr>
<td>Marriage and family Therapist</td>
<td>3 (2.8)</td>
</tr>
<tr>
<td>Rehab. Therapist</td>
<td>1 (.9)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>3 (2.8)</td>
</tr>
<tr>
<td>Staff Psychologist</td>
<td>9 (8.6)</td>
</tr>
<tr>
<td>Medical Staff</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2 (1.9)</td>
</tr>
<tr>
<td>Nurse/RN/LPN/CN/CNA</td>
<td>10 (9.5)</td>
</tr>
<tr>
<td>Direct Services Staff</td>
<td></td>
</tr>
<tr>
<td>Direct Service/Case Manager</td>
<td>25 (23.8)</td>
</tr>
</tbody>
</table>

*Note.* Due to rounding, percent’s may not add up to 100%.
Table 4

Zero-Order Correlation Matrix for Research Measures and Demographic Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
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</thead>
<tbody>
<tr>
<td>CMPG</td>
<td>3.89</td>
<td>.60</td>
<td>--</td>
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<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>SRM</td>
<td>1.12</td>
<td>.20</td>
<td>-.08</td>
<td>--</td>
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<td></td>
<td></td>
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<tr>
<td>BCT</td>
<td>2.80</td>
<td>.49</td>
<td>.24*</td>
<td>.131</td>
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<tr>
<td>WAI</td>
<td>5.53</td>
<td>.52</td>
<td>.30**</td>
<td>-.57**</td>
<td>-.28**</td>
<td>--</td>
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<tr>
<td>JSS</td>
<td>3.83</td>
<td>.71</td>
<td>.19*</td>
<td>-.14</td>
<td>.06</td>
<td>.27**</td>
<td>--</td>
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<td></td>
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<tr>
<td>RSAR</td>
<td>4.09</td>
<td>.67</td>
<td>.31**</td>
<td>-.06</td>
<td>.21*</td>
<td>.21*</td>
<td>.31**</td>
<td>--</td>
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<tr>
<td>MCSD</td>
<td>.46</td>
<td>.22</td>
<td>-.13</td>
<td>.11</td>
<td>-.01</td>
<td>-.28**</td>
<td>-.07</td>
<td>-.16</td>
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<tr>
<td>Caseload</td>
<td>3.98</td>
<td>2.46</td>
<td>-.05</td>
<td>-.11</td>
<td>-.09</td>
<td>.01</td>
<td>.01</td>
<td>.03</td>
<td>.02</td>
<td>--</td>
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<td></td>
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<tr>
<td>Direct Contact</td>
<td>4.72</td>
<td>2.13</td>
<td>.00</td>
<td>.04</td>
<td>.18</td>
<td>-.13</td>
<td>-.06</td>
<td>.18</td>
<td>-.01</td>
<td>-.04</td>
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<tr>
<td>Case Collab.</td>
<td>2.42</td>
<td>1.55</td>
<td>.02</td>
<td>-.04</td>
<td>-.02</td>
<td>-.09</td>
<td>-.13</td>
<td>.18</td>
<td>-.11</td>
<td>.29**</td>
<td>.22*</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>43.48</td>
<td>11.65</td>
<td>.24*</td>
<td>-.13</td>
<td>.06</td>
<td>.15</td>
<td>.11</td>
<td>.26*</td>
<td>-.23*</td>
<td>-.11</td>
<td>.15</td>
<td>.08</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BC PrimTx</td>
<td>2.95</td>
<td>.80</td>
<td>.29*</td>
<td>.05</td>
<td>.76*</td>
<td>-.28**</td>
<td>-.13</td>
<td>.14</td>
<td>.09</td>
<td>-.09</td>
<td>.18</td>
<td>.02</td>
<td>-.02</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BC SocEmp</td>
<td>2.38</td>
<td>.76</td>
<td>.11</td>
<td>.20*</td>
<td>.66**</td>
<td>-.16</td>
<td>.09</td>
<td>.17</td>
<td>-.10</td>
<td>-.14</td>
<td>.00</td>
<td>.00</td>
<td>.11</td>
<td>.28**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BC CommSup</td>
<td>2.80</td>
<td>.78</td>
<td>.20*</td>
<td>.10</td>
<td>.71*</td>
<td>-.19</td>
<td>.18</td>
<td>.14</td>
<td>.03</td>
<td>.01</td>
<td>.06</td>
<td>-.02</td>
<td>.01</td>
<td>.37**</td>
<td>.29**</td>
<td>--</td>
<td></td>
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</tr>
<tr>
<td>BC CommEng</td>
<td>3.15</td>
<td>.81</td>
<td>-.17</td>
<td>-.05</td>
<td>.21*</td>
<td>.03</td>
<td>.08</td>
<td>.04</td>
<td>-.13</td>
<td>.05</td>
<td>.22*</td>
<td>.00</td>
<td>.11</td>
<td>-.15</td>
<td>.03</td>
<td>.01</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.21</td>
<td>-.19</td>
<td>-.10</td>
<td>.22*</td>
<td>-.03</td>
<td>.05</td>
<td>.19</td>
<td>.05</td>
<td>.15</td>
<td>-.05</td>
<td>-.022</td>
<td>-.08</td>
<td>-.11</td>
<td>-.02</td>
<td>-.03</td>
<td>--</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05. **p < .01.; CMPG = Helping Professional Personal Growth, SRM = Specific Reciprocity Measure, BCT = Benevolent Coercion Techniques Measure, WAI = Working Alliance Inventory, JSS = Job Satisfaction Scale, RSAR = Recovery Self-Assessment-Revised, MCSD = Marlow-Crowne Social Desirability, Caseload = Number of clients providers are currently responsible for, Direct Contact = Hours of direct contact with consumers per week, Case Collaboration = Hours per week providers spend in case collaboration with colleagues, Age = Participants’ current age, BC PrimTx = Benevolent Coercion Techniques Measure Primary Treatment Subscale, BC SocEmp = Benevolent Coercion Techniques Measure Social Empowerment Subscale, BC CommSup = Benevolent Coercion Techniques Measure Community Support Subscale, BC CommEng = Benevolent Coercion Techniques Measure Community Engagement Subscale, Gender = Male or Female.
Table 5

**Benevolent Coercion Techniques Measure Principal Components Factor Analysis with Varimax Rotation**

<table>
<thead>
<tr>
<th>Items</th>
<th>Component Matrix</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have encouraged clients to have ongoing contact and interaction</td>
<td>1. <strong>.255</strong></td>
<td>2. <strong>.710</strong></td>
<td>3. <strong>.031</strong></td>
<td>4. <strong>.085</strong></td>
</tr>
<tr>
<td>2. I have encouraged my clients to take control of their finances,</td>
<td>1. <strong>.130</strong></td>
<td>2. <strong>.806</strong></td>
<td>3. <strong>-.038</strong></td>
<td>4. <strong>.015</strong></td>
</tr>
<tr>
<td>3. Regardless of my clients’ expressed objections, I have advised</td>
<td><strong>.074</strong></td>
<td>2. <strong>.721</strong></td>
<td>3. <strong>.300</strong></td>
<td>4. <strong>-.058</strong></td>
</tr>
<tr>
<td>4. I have spoken to other professionals on behalf of my clients when</td>
<td>1. <strong>.240</strong></td>
<td>2. <strong>.183</strong></td>
<td>3. <strong>.477</strong></td>
<td>4. <strong>-.027</strong></td>
</tr>
<tr>
<td>5. I have urged my clients’ to remain on medication(s) despite their</td>
<td>1. <strong>.132</strong></td>
<td>2. <strong>-.059</strong></td>
<td>3. <strong>.631</strong></td>
<td>4. <strong>-.092</strong></td>
</tr>
<tr>
<td>6. If my clients expressed concerns, I generally did not recommend</td>
<td>1. <strong>.456</strong></td>
<td>2. <strong>-.215</strong></td>
<td>3. <strong>-.076</strong></td>
<td>4. <strong>.441</strong></td>
</tr>
<tr>
<td>7. I have facilitated securing housing for clients (i.e., group home,</td>
<td><strong>-.057</strong></td>
<td>2. <strong>.054</strong></td>
<td>3. <strong>.821</strong></td>
<td>4. <strong>.015</strong></td>
</tr>
<tr>
<td>8. I have helped my clients pursue the goal of improving or expanding</td>
<td>1. <strong>.262</strong></td>
<td>2. <strong>.384</strong></td>
<td>3. <strong>.512</strong></td>
<td>4. <strong>.195</strong></td>
</tr>
<tr>
<td>9. Despite their objections, I have helped clients get involved in</td>
<td>1. <strong>.651</strong></td>
<td>2. <strong>.170</strong></td>
<td>3. <strong>.448</strong></td>
<td>4. <strong>-.040</strong></td>
</tr>
<tr>
<td>10. Even with expressed concerns from clients, I have encouraged my</td>
<td>1. <strong>.765</strong></td>
<td>2. <strong>.245</strong></td>
<td>3. <strong>.092</strong></td>
<td>4. <strong>-.033</strong></td>
</tr>
<tr>
<td>11. I have not encouraged clients to use methods of transportation</td>
<td><strong>-.032</strong></td>
<td>2. <strong>.072</strong></td>
<td>3. <strong>-.143</strong></td>
<td>4. <strong>.710</strong></td>
</tr>
<tr>
<td>12. I do not facilitate the pursuit of employment goals or</td>
<td><strong>-.182</strong></td>
<td>2. <strong>.023</strong></td>
<td>3. <strong>.179</strong></td>
<td>4. <strong>.786</strong></td>
</tr>
<tr>
<td>13. When I feel my clients are not capable of collaborating, I</td>
<td>1. <strong>.554</strong></td>
<td>2. <strong>-.149</strong></td>
<td>3. <strong>.159</strong></td>
<td>4. <strong>-.325</strong></td>
</tr>
<tr>
<td>14. I have assigned therapeutic “homework assignments,” even though</td>
<td>1. <strong>.578</strong></td>
<td>2. <strong>.203</strong></td>
<td>3. <strong>.070</strong></td>
<td>4. <strong>-.021</strong></td>
</tr>
</tbody>
</table>

**Note.** Component Loadings ≥ .40 are bolded

- Component eigenvalue = 3.3; Percent of variance = 15.2%
- Component eigenvalue = 1.7; Percent of variance = 14.7%
- Component eigenvalue = 1.3; Percent of variance = 13.9%
- Component eigenvalue = 1.3; Percent of variance = 10.6%
*Item Removed from Final Measure.*
Table 6

*Benevolent Coercion Techniques Measure Principal Components Factor Analysis with Varimax Rotation - Final*

<table>
<thead>
<tr>
<th>Items</th>
<th>Component Matrix</th>
<th>1&lt;sup&gt;a&lt;/sup&gt;</th>
<th>2&lt;sup&gt;b&lt;/sup&gt;</th>
<th>3&lt;sup&gt;c&lt;/sup&gt;</th>
<th>4&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have encouraged clients to have ongoing contact and interaction</td>
<td></td>
<td>.176</td>
<td>.775</td>
<td>.033</td>
<td>-.010</td>
</tr>
<tr>
<td>with family members, even if clients at times express concerns about</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>doing so.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I have encouraged my clients to take control of their finances,</td>
<td></td>
<td>.151</td>
<td>.799</td>
<td>-.074</td>
<td>.039</td>
</tr>
<tr>
<td>even if they tell me they are not ready.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Regardless of my clients’ expressed objections, I have advised</td>
<td>-.012</td>
<td>.712</td>
<td>.304</td>
<td>-.003</td>
<td></td>
</tr>
<tr>
<td>them to start romantic relationships (e.g., dating) if I think they</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are ready.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I have urged my clients’ to remain on medication(s) despite their</td>
<td>.149</td>
<td>-.017</td>
<td>.614</td>
<td>-.121</td>
<td></td>
</tr>
<tr>
<td>concerns about side effects.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. I have facilitated securing housing for clients (i.e., group</td>
<td>-.023</td>
<td>.096</td>
<td>.840</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>home, independent living, residential setting, etc.) when necessary,</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>even if clients did not want to be involved in the process.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. I have helped my clients pursue the goal of improving or</td>
<td>.348</td>
<td>.357</td>
<td>.541</td>
<td>.235</td>
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</tr>
<tr>
<td>expanding their friendships with others, even if they were not ready.</td>
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</tr>
<tr>
<td>7. Despite their objections, I have helped clients get involved in</td>
<td>.734</td>
<td>.132</td>
<td>.374</td>
<td>-.002</td>
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<td>additional treatment programs if I feel that it would help them (e.g.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>club house, group therapy, AA or other support programs, etc.).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Even with expressed concerns from clients, I have encouraged my</td>
<td>.777</td>
<td>.229</td>
<td>.009</td>
<td>-.050</td>
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</tr>
<tr>
<td>clients to seek additional types of treatment (i.e., occupational</td>
<td></td>
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<tr>
<td>therapy, medication management, vocational rehabilitation, etc.).</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I have not encouraged clients to use methods of transportation</td>
<td>-.008</td>
<td>.028</td>
<td>-.180</td>
<td>.736</td>
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<tr>
<td>that are unfamiliar to them (e.g., carpool, bus, airplane) if they</td>
<td></td>
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<tr>
<td>expressed any discomfort about trying new ways to get from place to</td>
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<tr>
<td>place.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>10. I do not facilitate the pursuit of employment goals or</td>
<td>-.090</td>
<td>.029</td>
<td>.153</td>
<td>.847</td>
<td></td>
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<tr>
<td>opportunities for clients if they sometimes told me that they are not</td>
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</tr>
<tr>
<td>ready.</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>11. When I feel my clients are not capable of collaborating, I</td>
<td>.559</td>
<td>-.162</td>
<td>.175</td>
<td>-.336</td>
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<tr>
<td>determine treatment goals for them.</td>
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<td>12. I have assigned therapeutic “homework assignments,” even though</td>
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<td>clients said that they did not want to complete them.</td>
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</table>

*Note. Component Loadings ≥ .40 are bolded*

*Component eigenvalue = 3.1; Percent of variance = 17.6%*

*Component eigenvalue = 1.7; Percent of variance = 16.7%*

*Component eigenvalue = 1.3; Percent of variance = 14.2%*

*Component eigenvalue = 1.2; Percent of variance = 12.1%*
### Hierarchical Regression Analysis

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</table>

Note. * $p < .05$. ** $p < .01$. 
Dear X,

My name is Andrew Osborn. I am doctoral student in Clinical Psychology at Bowling Green State University. I am writing to describe a research study that may be of interest to you and the Agency.

As you know, the recovery model is now described as the preferred model of service delivery in community mental health. Much has been written about the importance of recovery principles, but more systematic study is needed to better understand the advantages and limitations of recovery-oriented service delivery. I am currently conducting a study that examines helping professionals’ perceptions of mental health recovery and their views about collaboration with clients coping with serious mental illness. Specifically, I am interested in views of recovery from the perspective of different types of helping professionals (clinicians, social workers, case managers, occupational and rehabilitation counselors, etc.) and their views about working with their clients.

I would like to talk with you more about inviting helping professionals in Agency to participate in this study by completing a brief on-line survey. Participation in the study is completely voluntary, and the survey takes no more than 20 minutes to complete. No names or identifying information will be directly associated with participants’ responses to protect their anonymity. The research has been approved by the Human Subjects Review Board at Bowling Green State University (No., H11T286GE7).

Helping professionals who complete the survey have the opportunity to reflect upon their views and beliefs about recovery which can benefit them personally. Agency will receive summary information about views of recovery from your staff that can be beneficial in agency planning. Ultimately, findings from the research will serve to inform administrators, researchers, and helping professionals about recovery-oriented care in Virginia.

I will be contacting you by telephone or email in the coming week to talk with you further about this opportunity. I know the outstanding reputation of Agency, and I hope that helping professionals here will consider playing a critical role in research that has direct implications for clients and mental health care.
Thank you in advance for your consideration. I look forward to speaking.

Sincerely,

Andrew Osborn, M.Ed.
Hello,

My name is Andrew Osborn. I am a doctoral student in Clinical Psychology at Bowling Green State University. For my Masters thesis, I am completing a research project to assess the perceptions of recovery-oriented services offered at a number of Community Services Boards across Virginia, including yours. In addition, I am interested in measuring the presence of different variables regarding the relationship you have with the clients you work with at the CSB that have a serious mental illness. The Human Subjects Review Board at Bowling Green State University approved this research study (Human Subjects Review Board approval, No., H11T286GE7). No individual consumer/client information will be collected in this study and your responses will be anonymous. That is, you will not be identified in the thesis report nor will your identity be made known to your CSB. Finally, no CSB will be identified in the research paper or in any publication.

Participation in this study involves completing an online questionnaire at a computer of your convenience. I estimate that it will take you about 20 minutes to complete this survey. The anticipated risks to you as a result of participation in this study are no greater than those normally encountered in daily life. Additionally, for your participation, you will have the opportunity to be entered into a random raffle should you choose to (i.e., win one of two $75 Visa gift cards).

Please click here to participate: [LINK]

Thank you for your time.

Sincerely,

Andrew Osborn, M.Ed.
Doctoral Student in Clinical Psychology
Department of Psychology
Bowling Green State University
Bowling Green, OH 43403
losborn@bgsu.edu
APPENDIX C.

Informed Consent

Department of Psychology
Bowling Green State University
Bowling Green, OH 43403

Purpose
You are invited to be in a study that focuses on measuring the presence of recovery-oriented mental health services provided to individuals with serious mental illness. In addition, I am interested in measuring the presence of different variables regarding the relationship you have with your clients.

Eligibility Requirements
You are eligible to participate in this study if you are at least 18 years old, currently employed at this CSB, and currently provide direct mental health services (i.e., case management, nursing services, occupational therapy, rehabilitation therapy, psychotherapy/counseling, psychological services such as assessment and diagnostics, and psychiatric services) to individuals with serious mental illness.

Procedure
Your participation will involve completing a questionnaire on the Internet. I estimate that your total participation will take about 20 minutes or less to complete. The information that you will provide is anonymous.

Risks
The anticipated risks to you are no greater than those normally encountered in daily life.

Benefits
By participating in this study, you may have the opportunity to reflect upon the types of services you provide for clients with serious mental illness and the degree of therapeutic relationship you have with them. You also have opportunity to learn about how psychologists conduct research on this kind of topic. Additionally, for your participation in this study, you have the opportunity to be entered into a random raffle should you choose to (i.e., win one of two $75 Visa gift cards).

Confidentiality
Your responses to the questionnaire used in this study are anonymous. You will not be asked to provide your name anywhere in the study. The principal investigator will only access your responses to the questionnaires and any other information you provide. Your participation in this study is voluntary and you can refrain from answering any or all questions without penalty or explanation. Additionally, all data will be published in aggregate form.

Those participants choosing to enter the random raffle will be redirected to a separate page to enter their name and email address. This information will be stored separately from all survey data and destroyed upon completion of the study.

Online Survey Participation
Because the Internet is not 100% secure in terms of privacy, please do not leave the partially completed survey open or unattended if completing it on a public computer. You may want to clear the browser page history and cache when finished with the survey and should completely close the browser window upon completion of the survey.
Your Rights as a Participant
You are free to withdraw consent and to discontinue participation in the project at any time. You may click on the “X” at the top right hand corner of your computer window to exit the survey. Your responses will not be saved until you click the “Submit” button at the end of the survey.

Should you choose to withdraw or not participate in this research study; it will not impact your employment standing/relationship with your respective agency or Bowling Green State University.

As a participant, you have the right to have all questions concerned with the study answered by the researcher, and you may request a summary or copy of the results of the study after its completion. You may request a copy of this consent document.

- If you have any questions or comments about this study, you can contact the Principal Investigator, Andrew Osborn, M.Ed., at (419) 372-4567, losborn@bgsu.edu or the Project Supervisor, Dr. Catherine Stein, at (419) 372-2301, cstein@bgsu.edu

- If you have any questions or concerns about your rights as a research participant please contact the Chair of BGSU’s Human Subjects Review Board, 309A University Hall, at (419) 372-7716, hsrb@bgsu.edu

Your completion of this online survey indicates your voluntary consent to participate in this research investigation. You may refuse to participate in this investigation or withdraw your consent and discontinue participation in this study at any time. If you are eligible to participate and wish to give your consent and continue, please select the option below and click on the “Next” button.

I have been presented with and have read the statement of risks and benefits of participating in this project and I agree to participate. I certify that I meet the eligibility requirements for this study.
APPENDIX D.

Debriefing Sheet

Thank you for participating in this study!

In this study, you completed a few short surveys, on topics ranging from recovery, personal growth, therapeutic alliance, and job stress. Since the mid 1970s, the Recovery Model has become increasingly important in community mental health practice and research. Recovery is understood within the model as a personal journey that may involve developing a sense of hope, a secure base and sense of self, fostering supportive relationships, empowerment, social inclusion, coping skills, collaboration, and meaning-making.

The purpose of this study was to examine different helping professionals’ views of the Recovery Model and its perceived relevance in their work with their clients. Moreover, this study investigated perceived agency recovery-orientation and the role of collaboration with clients. Specifically, this study measured providers’ reports of their employment history, job satisfaction, views of personal growth, therapeutic alliance, and benevolent coercion in relation to their views about the Recovery Model. In completing this study, I hope to contribute to the literature with empirical data in the form of a publication and/or conference presentation.

If you are interested in learning the results of this study when they are available, please contact:

Andrew Osborn, M.Ed.
Department of Psychology
Bowling Green State University
Psychology Building, Room 119,
Bowling Green, OH 43403
Office: 419-372-4597, Email: losborn@bgsu.edu

Here are some readings to consider if interested on this topic:


APPENDIX E.

Working Alliance Inventory

Form T Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her clients. As you read the sentences mentally insert the name of your clients in place of ____________ in the text.

Below each statement inside there is a seven point scale:

1  2  3  4  5  6  7
Never Rarely Occasionally Sometimes Often Very Often Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your client nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see. (PLEASE DON’T FORGET TO RESPOND TO EVERY ITEM.)

1. I feel uncomfortable with ______________.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

2. ______________ and I agree about the steps to be taken to improve his/her situation.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

3. I have some concerns about the outcome of these sessions.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

4. My client and I both feel confident about the usefulness of our current activity in therapy.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

5. I feel I really understand ______________.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

6. ______________ and I have a common perception of her/his goals.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

7. ______________ finds what we are doing in therapy confusing.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

8. I believe ______________ likes me.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

9. I sense a need to clarify the purpose of our session(s) for ______________.
   
   Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always
10. I have some disagreements with _____________ about the goals of these sessions.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

11. I believe the time _____________ and I are spending together is not spent efficiently.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

12. I have doubts about what we are trying to accomplish in therapy.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

13. I am clear and explicit about what _____________'s responsibilities are in therapy.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

14. The current goals of these sessions are important for _____________.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

15. I find what _____________ and I are doing in therapy is unrelated to her/his current concerns.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

16. I feel confident that the things we do in therapy will help _____________ to accomplish the changes that he/she desires.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

17. I am genuinely concerned for _____________'s welfare.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

18. I am clear as to what I expect _____________ to do in these sessions.
   1  2  3  4  5  6  7
   Never  Rarely Occasionally Sometimes Often Very Often Always

19. _____________ and I respect each other.
20. I feel that I am not totally honest about my feelings toward ________.

Never Rarely Occasionally Sometimes Often Very Often Always

21. I am confident in my ability to help ________.

Never Rarely Occasionally Sometimes Often Very Often Always

22. We are working towards mutually agreed upon goals.

Never Rarely Occasionally Sometimes Often Very Often Always

23. I appreciate ________ as a person.

Never Rarely Occasionally Sometimes Often Very Often Always

24. We agree on what is important for ________ to work on.

Never Rarely Occasionally Sometimes Often Very Often Always

25. As a result of these sessions ________ is clearer as to how she/he might be able to change.

Never Rarely Occasionally Sometimes Often Very Often Always

26. ________ and I have built a mutual trust.

Never Rarely Occasionally Sometimes Often Very Often Always

27. ________ and I have different ideas on what his/her real problems are.

Never Rarely Occasionally Sometimes Often Very Often Always

28. Our relationship is important to ________.

Never Rarely Occasionally Sometimes Often Very Often Always
29. _______________ has some fears that if she/he says or does the wrong things, I will stop working with him/her.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

30. _______________ and I have collaborated in setting goals for these session(s).

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

31. _______________ is frustrated by what I am asking her/him to do in therapy.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

32. We have established a good understanding between us of the kind of changes that would be good for _______________.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

33. The things that we are doing in therapy don't make much sense to _______________.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

34. _______________ doesn't know what to expect as the result of therapy.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

35. _______________ believes the way we are working with her/his problem is correct.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

36. I respect _______________ even when he/she does things that I do not approve of.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always
### APPENDIX F.

**Recovery Self-Assessment – Revised Provider Version**

*Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program.*

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 N/A D/K</td>
<td></td>
</tr>
</tbody>
</table>

N/A = Not Applicable
D/K = Don’t Know

1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.

2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).

3. Staff encourage program participants to have hope and high expectations for their recovery.

4. Program participants can change their clinician or case manager if they wish.

5. Program participants can easily access their treatment records if they wish.

6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.

7. Staff believe in the ability of program participants to recover.

8. Staff believe that program participants have the ability to manage their own symptoms.

9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.

10. Staff listen to and respect the decisions that program participants make about their treatment and care.

11. Staff regularly ask program participants about their interests and the things they would like to do in the community.

12. Staff encourage program participants to take risks and try new things.

13. This program offers specific services that fit each participant’s unique culture and life experiences.

14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.

15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.

16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).

17. Staff routinely assist program participants with getting jobs.

18. Staff actively help program participants to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.

19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).

20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.

21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.

22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.

24. People in recovery are encouraged to be involved in the evaluation of this agency’s programs, services, and service providers.

25. People in recovery are encouraged to attend agency advisory boards and management meetings.

26. Staff talk with program participants about what it takes to complete or exit the program.

27. Progress made towards an individual’s own personal goals is tracked regularly.

28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.

29. Persons in recovery are involved with facilitating staff trainings and education at this program.

30. Staff at this program regularly attend trainings on cultural competency.

31. Staff are knowledgeable about special interest groups and activities in the community.

32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.
APPENDIX G.

Case Manager Personal Growth Scale
CMPG

Below is a set of statements that describe how some helping professionals may feel as a result of working with consumers that experience a chronic mental illness. Please indicate how true each statement is for you at this time in your career. Please respond to the statements using the rating scale below:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

1. I have made positive changes in my life as a result of my work with consumers.
2. I often think about the lives of some consumers when I encounter setbacks in my own life.
3. Working with consumers has led me to focus on strengthening my personal relationships.
4. Working as a case manager has caused a sense of spiritual growth for me.
5. I feel I have more to offer my family and friends as a result of my experience being a case manager.
6. I feel being a case manager has led to personal growth in several areas of my life.
7. I often hear profound “stories” from consumers that cause me to reflect on my own life.
8. I have found that working with consumers has caused me to try harder when I encounter personal problems.
9. The longer I work with consumers, the more I realize our lives are not that different.
10. I am more willing to “stand up” for others that experience stigma and discrimination since working with consumers.
11. I have found that I am more willing to help others in need since working as a case manager.
12. Working with consumers has led me to have a stronger religious faith.
13. I have become more aware of the importance of my family since working as a case manager.
14. I have found I can learn a lot about myself from working with consumers.
15. Seeing the struggles of consumers has made me more willing to take on challenges in my own life.
16. I am more open to help and support from family and friends since working as a case manager.
APPENDIX H.

Marlowe-Crowne Social Desirability Scale – Form X1
MCSD

The following questions are True/False. Please circle the correct answer that best fits how you feel about yourself:

1. I'm always willing to admit it when I make a mistake. (True)
   True  False

2. I always try to practice what I preach. (True)
   True  False

3. I never resent being asked to return a favor. (True)
   True  False

4. I have never been irked when people expressed ideas very different from my own. (True)
   True  False

5. I have never deliberately said something that hurt someone's feelings. (True)
   True  False

6. I like to gossip at times. (False)
   True  False

7. There have been occasions when I took advantage of someone. (False)
   True  False

8. I sometimes try to get even rather than forgive and forget. (False)
   True  False

9. At times I have really insisted on having things my own way. (False)
   True  False

10. There have been occasions when I felt like smashing things. (False)
    True  False
APPENDIX I.

Benevolent Coercion Techniques Measure
BCTM

Directions
Working to help consumers achieve their goals is a complex process. Mental health professionals tell us that sometimes their clients are uncertain about what they want or need or are reluctant to make necessary changes in their lives.
We are interested in understanding ways that you work with consumers. Please think about the adults with serious mental illness with whom you currently work when responding to the items below. Please circle the degree to which each statement generally describes what you do in working with clients/consumers.

Questions
1. I have encouraged clients to have ongoing contact and interaction with family members, even if clients at times express concerns about doing so.
   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

2. I have encouraged my clients to take control of their finances, even if they tell me they are not ready.
   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

3. Regardless of my clients’ expressed objections, I have advised them to start romantic relationships (e.g., dating) if I think they are ready.
   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

4. I have spoken to other professionals on behalf of my clients when I have felt they lacked the ability to do it for themselves.
   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

5. I have urged my clients’ to remain on medication(s) despite their concerns about side effects.
   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree

6. If my clients expressed concerns, I generally did not recommend that they pursue goals for obtaining basic education (i.e., finishing a GED, skill or trade training).
   Strongly disagree   Disagree   Uncertain   Agree   Strongly agree
7. I have facilitated securing housing for clients (i.e., group home, independent living, residential setting, etc.) when necessary, even if clients did not want to be involved in the process.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

8. I have helped my clients pursue the goal of improving or expanding their friendships with others, even if they were not ready.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

9. Despite their objections, I have helped clients get involved in additional treatment programs if I feel that it would help them (e.g. club house, group therapy, AA or other support programs, etc.).

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

10. Even with expressed concerns from clients, I have encouraged my clients to seek additional types of treatment (i.e., occupational therapy, medication management, vocational rehabilitation, etc.).

    Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

11. I have not encouraged clients to use methods of transportation that are unfamiliar to them (e.g., carpool, bus, airplane) if they expressed any discomfort about trying new ways to get from place to place.

    Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

12. I do not facilitate the pursuit of employment goals or opportunities for clients if they sometimes told me that they are not ready.

    Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

13. When I feel my clients are not capable of collaborating, I determine treatment goals for them.

    Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

14. I have assigned therapeutic “homework assignments,” even though clients said that they did not want to complete them.

    Strongly disagree  Disagree  Uncertain  Agree  Strongly agree
Job Satisfaction Survey
Job Satisfaction Survey (JSS- Adapted) (Spector, 1985).

Please mark the correct answer that best fits how you feel about your current job.

1. I feel I am being paid a fair amount for the work I do.

   1  2  3  4  5  6
   Disagree Agree
   very much very much

2. There is really too little chance for promotion on my job. [Reversed]

   1  2  3  4  5  6
   Disagree Agree
   very much very much

3. My supervisor is quite competent in doing his/her job.

   1  2  3  4  5  6
   Disagree Agree
   very much very much

4. I am not satisfied with the benefits I receive. [Reversed]

   1  2  3  4  5  6
   Disagree Agree
   very much very much

5. When I do a good job, I receive the recognition for it that I should receive.

   1  2  3  4  5  6
   Disagree Agree
   very much very much

6. Many of our rules and procedures make doing a good job difficult. [Reversed]

   1  2  3  4  5  6
   Disagree Agree
   very much very much
7. I like the people I work with.

1  2  3  4  5  6
Disagree  Agree
very much  very much

8. I sometimes feel my job is meaningless. [Reversed]

1  2  3  4  5  6
Disagree  Agree
very much  very much

9. Communications seem good within this organization.

1  2  3  4  5  6
Disagree  Agree
very much  very much
Appendix K.

Specific Reciprocity Measure
(Van Horn, Schaufeli, & Taris, 2001)

In your work you maintain work relationships with clients, colleagues, and the agency. In each of those work relationships you invest something and you get something in return. Can you specify the investments and outcomes in each type of relationship?

Investment with Clients

**I1** How much do you invest in having personal contacts with your clients?

- Very
- Little

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**I2** How much do you invest in motivating your clients?

- Very
- Little

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**I3** How much do you invest in coaching your clients individually?

- Very
- Little

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**I4** How much do you invest in keeping order and discipline?

- Very
- Little

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**I5** How much do you invest in preparing for sessions/meetings?

- Very
- Little

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**O1** How much appreciation do your clients have for you?

- Very
- Little

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**O2** How much satisfaction do you get from the fact that your clients meet treatment goals?

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**O3** How much satisfaction do you get from the personal contacts with your clients?

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**O4** How much satisfaction do you get from your clients’ personal growth?

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APPENDIX L.

Demographics

1. Please indicate your sex: ______ Male ______ Female

2. Your age: ______ years

3. Ethnic Background:
   ___ African-American ___ Caucasian ___ Hispanic [Latino (a)]
   ___ Asian American ___ Native American
   ___ Biracial/multi-racial ___ Other

4. What is your religious affiliation?
   ___ Catholic ___ Protestant/Other Christian
   ___ Jewish ___ Buddhist
   ___ Muslim ___ Agnostic
   ___ Atheistic ___ No Affiliation

5. Marital Status:
   ___ Never Married ___ Currently Divorced
   ___ Married ___ Widowed

6. Partnership Status: ___ In a current partnership (check for YES)

7. Current Income:
   ___ less than $10,000 ___ $40,000 to $54,999
   ___ $10,000 to $19,999 ___ $55,000 to 64,999
   ___ $20,000 to $29,999 ___ $65,000 to 79,999
   ___ $30,000 to $39,999 ___ $ 80,000 +

8. In what field of study did you complete your highest degree?
   ___ Psychology ___ Social Work
   ___ Sociology ___ Nursing
   ___ Education ___ Business Administration
   ___ Other (Please Specify) _______________________

9. Highest Education Level completed:
   ___ Some High School ___ Bachelors Degree
   ___ High School Diploma ___ Masters Degree
   ___ Some College ___ Doctoral Degree / MD
   ___ Associates Degree

10. The professional title that best describes my current role at the CSB is:
    
    a. Counseling/Psychotherapy
       ___ Masters level counselor
       ___ Substance abuse counselor
Marriage and family therapist
Rehabilitation therapist
Occupational therapist
Social work
Staff psychologist
b. Medical
Nurse/RN/LPN/CN/CNA
Psychiatrist
c. Case manager/direct services staff
Direct care/services staff
Case manager
d. Other: _____________________________

11. Have you held any other positions at this agency? ______ Yes ______ No
What position(s)? ____________________________________

12. How long have you worked in the mental health field?
_____ Years _____ Months

13. How long have you worked for the current agency?
_____ Years _____ Months

14. How long have you been providing helping professional services?
_____ Years _____ Months

15. Approximately how many clients are on your caseload currently?
Less than 10  25 to 29
10 to 14  30 to 34
15 to 19  35+
20 to 24

16. Approximately how many hours per week do you spend in direct contact with clients?
Less than 5  20 to 24
5 to 9  25 to 29
10 to 14  30 to 34
15 to 19  35+

17. What population of clients do you work with primarily?
Adults experiencing a chronic mental illness (i.e., serious mental illness)
Adults with a developmental disability
_________ Adults with substance use disorder
_________ Children and Adolescents with emotional problems
_________ Children and adolescents with a developmental disability
_________ Other: _____________________________________

18. What model or theory of mental health service do you work mostly with?
_______ Broker Model
_______ Clinical Case Management Model
_______ Modified ACT Model
_______ PACT Model
_______ Recovery Model
_______ Rehabilitation Model
_______ Strengths Model
_______ Uncertain or Do Not Know

19. What is the approximate percentage of your clients currently receiving Supplemental Services Insurance (SSI) or Social Security Disability Insurance (SSDI)? ___________ %
Appendix M.

Human Subjects Review Board Approval Letter

<table>
<thead>
<tr>
<th>HSRB MEMBERSHIP</th>
<th>2010-2011</th>
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<tbody>
<tr>
<td>Amy Morgan, HSRB Chair Kinesiology <a href="mailto:amorgan@bgusu.edu">amorgan@bgusu.edu</a></td>
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<tr>
<td>Mary Hare, HSRB Vice Chair Psychology <a href="mailto:mhare@bgusu.edu">mhare@bgusu.edu</a></td>
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<td>D. Wayne Bell, M.D. Wound Health Corp. 309-6225 <a href="mailto:speakeding07@comcast.net">speakeding07@comcast.net</a></td>
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<td>Cheryl Conley Alzheimer's Assn., NW Ohio <a href="mailto:conleyc@bgusu.edu">conleyc@bgusu.edu</a></td>
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<tr>
<td>Rodney Gabel Comm. Sciences &amp; Disorders <a href="mailto:rgabel@bgusu.edu">rgabel@bgusu.edu</a></td>
<td></td>
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<tr>
<td>Hillary Harms Office of Research Compliance <a href="mailto:hharms@bgusu.edu">hharms@bgusu.edu</a></td>
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<tr>
<td>Lisa Lockwood Theatre &amp; Film <a href="mailto:lockwood@bgusu.edu">lockwood@bgusu.edu</a></td>
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<tr>
<td>Montana Miller Popular Culture <a href="mailto:mmiller@bgusu.edu">mmiller@bgusu.edu</a></td>
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<tr>
<td>Jeannie Novak Intervention Services <a href="mailto:jnovak@bgusu.edu">jnovak@bgusu.edu</a></td>
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<tr>
<td>Ashutosh Suhoni Family and Consumer Sciences <a href="mailto:asuhoni@bgusu.edu">asuhoni@bgusu.edu</a></td>
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<tr>
<td>Marie Task Psychology <a href="mailto:mtask@bgusu.edu">mtask@bgusu.edu</a></td>
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July 8, 2011

TO: Lawrence Osborn Psychology

FROM: Hillary Harms, Ph.D. HSRB Administrator

RE: HSRB Project No.: H11T286GE7

TITLE: Recovery-Oriented Services and Consumer Collaboration: Interdisciplinary Perspectives of Community Mental Health Care Providers in Virginia

You have met the conditions for approval for your project involving human subjects. As of July 8, 2011, your project has been granted final approval by the Human Subjects Review Board (HSRB). This approval expires on June 15, 2012. You may proceed with subject recruitment and data collection.

The final approved version of the consent document(s) is attached. Consistent with federal OHRP guidance to IRBs, the consent document(s) bearing the HSRB approval/expiration date stamp is the only valid version and you must use copies of the date-stamped document(s) in obtaining consent from research subjects.

You are responsible to conduct the study as approved by the HSRB and to use only approved forms. If you seek to make any changes in your project activities or procedures, send a request for modifications to the HSRB via this office. Those changes must be approved by the HSRB prior to their implementation.

You have been approved to enroll 200 participants. If you want to enroll additional participants you must seek approval from the HSRB.

Good luck with your work. Let me know if this office or the HSRB can be of assistance as your project proceeds.

Comments/Modifications: Please add the text equivalent of the HSRB approval stamp to the "footer" area of the online consent document.

c: Dr. Catherine Stein

Research Category: EXPEDITED III
(Informed Consent)

Department of Psychology
Bowling Green State University
Bowling Green, OH 43403

Purpose
You are invited to be in a study that focuses on measuring the presence of recovery-oriented mental health services provided to individuals with serious mental illness. In addition, I am interested in measuring the presence of different variables regarding the relationship you have with your clients.

Eligibility Requirements
You are eligible to participate in this study if you are at least 18 years old, currently employed at this CSB, and currently provide direct mental health services (i.e., case management, nursing services, occupational therapy, rehabilitation therapy, psychotherapy/counseling, psychological services such as assessment and diagnostics, and psychiatric services) to individuals with serious mental illness.

Procedure
Your participation will involve completing a questionnaire on the Internet. I estimate that your total participation will take about 20 minutes or less to complete. The information that you will provide is anonymous.

Risks
The anticipated risks to you are no greater than those normally encountered in daily life.

Benefits
By participating in this study, you may have the opportunity to reflect upon the types of services you provide for clients with serious mental illness and the degree of therapeutic relationship you have with them. You also have opportunity to learn about how psychologists conduct research on this kind of topic. Additionally, for your participation in this study, you have the opportunity to be entered into a random raffle should you choose to (i.e., win one of two $75 Visa gift cards).

Confidentiality
Your responses to the questionnaire used in this study are anonymous. You will not be asked to provide your name anywhere in the study. The principal investigator will only access your responses to the questionnaires and any other information you provide. Your participation in this study is voluntary and you can refrain from answering any or all questions without penalty or explanation. Additionally, all data will be published in aggregate form.

Those participants choosing to enter the random raffle will be redirected to a separate page to enter their name and email address. This information will be stored separately from all survey data and destroyed upon completion of the study.
Online Survey Participation
Because the Internet is not 100% secure in terms of privacy, please do not leave the partially completed survey open or unattended if completing it on a public computer. You may want to clear the browser page history and cache when finished with the survey and should completely close the browser window upon completion of the survey.

Your Rights as a Participant
You are free to withdraw consent and to discontinue participation in the project at any time. You may click on the “X” at the top right hand corner of your computer window to exit the survey. Your responses will not be saved until you click the “Submit” button at the end of the survey.

Should you choose to withdraw or not participate in this research study; it will not impact your employment standing/relationship with your respective agency or Bowling Green State University.

As a participant, you have the right to have all questions concerned with the study answered by the researcher, and you may request a summary or copy of the results of the study after its completion. You may request a copy of this consent document.

- If you have any questions or comments about this study, you can contact the Principal Investigator, Andrew Osborn, M.Ed., at (419) 372-4567, losborn@bgsu.edu or the Project Supervisor, Dr. Catherine Stein, at (419) 372-2301, cstein@bgsu.edu

- If you have any questions or concerns about your rights as a research participant please contact the Chair of BGSU’s Human Subjects Review Board, 309A University Hall, at (419) 372-7716, hrbc@bgsu.edu

Your completion of this online survey indicates your voluntary consent to participate in this research investigation. You may refuse to participate in this investigation or withdraw your consent and discontinue participation in this study at any time. If you are eligible to participate and wish to give your consent and continue, please select the option below and click on the “Next” button.

I have been presented with and have read the statement of risks and benefits of participating in this project and I agree to participate. I certify that I meet the eligibility requirements for this study.