## Developing and Using Vignettes to Explore the Relationship between Risk Management Practice and Recovery-Oriented Care in Mental Health Services

Holley, Jessica-Rose

Gillard, Steve\*

\* [sgillard@sgul.ac.uk](mailto:sgillard@sgul.ac.uk) St George’s, University of London, London, UK

## Abstract

There is a lack of literature evaluating the development and use of vignettes to explore contested constructs in qualitative healthcare research where a conventional interview schedule might impose assumptions on the data collected. We describe the development and validation of vignettes in a study exploring mental health worker and service user understandings of risk and recovery in UK mental health services. Focus groups with mental health workers and service users explored study questions from experiential perspectives. Themes identified in the groups were combined with existing empirical literature to develop a set of vignettes. Feedback focus groups were conducted to validate and amend the vignettes. Following use in research interviews, results suggested that the vignettes had successfully elicited data on issues of risk and recovery in mental health services. Further research using creative, comparative methods is needed to fully understand how vignettes can best be used in qualitative healthcare research.

**Introduction**

In this article we report a vignette development process within a larger qualitative study which explored the impact of risk management practice upon the implementation of recovery-oriented care with the aim of informing practice (Holley et al., 2016). A traditional, clinical concept of recovery is generally equated with cure in which an individual returns to their previous state before the illness (Whitwell, 1999). In recent years a more individualised understanding of recovery and mental health has developed that has been defined as: ‘A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness’ (Anthony, 1993; p.527). Recovery-oriented care is an approach that has been introduced into mental health services in the UK and elsewhere to support service users’ individual recovery journeys by promoting self-management of long-term conditions and patient ‘choice’ (e.g., Department of Health, 2008). Recovery-oriented policies have stressed the importance of mental health services supporting people to function as full citizens by helping them to develop: ‘stronger social relationships, a greater sense of purpose, the skills they need for living, working, improved chances in education, better employment rates and a suitable and stable place to live,’ (Department of Health, 2011: 21).

The concept of risk is most commonly understood in mental health care as a likelihood of an event happening with potential harmful outcomes for the self and others (Morgan, 2000). In the UK, risk management practice is part of an established, structured approach whereby mental health workers are expected to identify and reduce any risks in the interests of service users’ health, safety or for the protection of other people (Department of Health, 1994). The concept of risk in the context of mental health services has, however, come under scrutiny due to a lack of differentiation between risks which need to be minimised and positive risk taking, which service users might be encouraged to experience (Boardman et al., 2010).

A literature search – reported elsewhere (Holley et al., 2016) - revealed only a very small number of studies that explored issues of both risk management and recovery-oriented care, noting that risk management could act as a barrier to social inclusion (Bertram & Stickely, 2005; Fitch et al., 2007) and that mental health services users could express concerns about risk of relapse related to stress and discrimination associated with returning to work (Marwaha & Johnson, 2005) and independent housing (Forchuk et al., 2006).

## Background

The challenge we faced in our study was to explore, in a structured way, participant understandings of complex areas of mental health practice that are conceptually contested – the promotion of individual recovery and risk management – without imposing a particular frame of reference or set of assumptions on those constructs through the application of a structured data collection tool (e.g. a traditional semi-structured interview schedule). A hermeneutic approach to phenomenological enquiry posits that researcher and research subject, together, make sense of the phenomenon under investigation, the knowledge that they (co) produce being contingent on both the knowing subject and the interpretive stance of the researcher. Critical awareness of this ‘double hermeneutic’ is found in psychological (Smith and Osborne, 2003), counseling and psychotherapy (McLeod, 2003), and nursing research (Benner, 1994), among other disciplines. As such, interviewing has been described as an active process through which knowledge is ‘socially constituted … [through] the action taken to obtain it’ (Holstein &Gubrium, 2004 p.141). The role of the interviewer as, inevitably, a co-constructor of data has been explored in various fields, one suggestion being that the researcher might project an ‘imagined subject’ onto the interviewee as the interview account is produced (Miller, 2010), so shaping the data through social interaction in the interview space. From the field of family therapy research it has been noted how the interviewer uses conversational techniques, such as ‘positioning’ themselves and the interviewee socially, to shape an emerging story (Kogan, 1998). In response to these challenges, vignettes offer a methodological tool which potentially enables the researcher to explore the varied meanings individuals might attach to particular constructs without overtly imposing their own understanding through the data collection process. As such, vignettes must contain sufficient context for respondents to have an understanding about the situation being depicted whilst being loose enough to allow respondents to define the situation in their own terms (Barter & Reynold, 1999).

Within the context of the health and social sciences, vignettes are real life (anonymized), fictional or composite case scenarios developed to portray real life situations which aim to elicit individuals’ perceptions, attitudes, beliefs and social norms (Finch, 1987). Vignettes have been described as narrative ‘interpretations of the person, experience, or situation that the writer describes,’ (Ely et al., 1997: 70). Research participants are presented with vignettes and their responses explored by asking them to comment on how they feel about, or what they think might happen in fictitious scenarios (Spalding and Phillips, 2007). As well as text, vignettes can make use of videos, pictures and photographs to animate discussions on particular topics (Young et al., 2007).

Vignettes have been used in both quantitative and qualitative health and social care research (Gould, 1996; Hughes and Huby, 2002; Spalding and Phillips, 2007; Wilks, 2004; Kaye, 2006; Fredelius et al., 2002). In quantitative research vignettes can be shown to respondents as part of a survey to elicit their judegments on specific scenarios (Atzmuller & Steiner, 2015). For example, vignettes were used in a cross sectional, multi-country survey to examine the differences in expectations for health amongst adults in the community with participants asked to rate items that reflected individual norms and expectations for health (Salomon at el., 2004). In qualitative research vignettes can be used to explore how respondents’ own experiences impact upon their understandings of context-specific information within vignettes (Rapley, 2007). For example, vignettes-based interviews were conducted with twenty-one participants from the clinical public health community, and the marketing, food and beverage industries to elicit their perspectives on promoting unhealthy foods and beverages to children and adolescents (Jackson et al., 2015).

The use of vignettes has been shown to facilitate collection of data on sensitive research topics by providing simple, non-threatening means of engaging participants (Farmer et al., 2006). In particular, vignettes desensitize difficult topics and allow participants to interpret case scenarios from the perspective of vignette characters. Through the vignette character, participants are given the opportunity to distance themselves from particularly sensitive areas of discussion that relate to personal experiences they may feel uncomfortable disclosing (Hughes and Huby, 2002). For example, in one study, in-depth, vignette-based interviews were conducted with female care-givers of elderly people to explore conflict in the relationship between carer and care receiver (Rahman, 1996). In addition, Gibson and colleagues (2012) used vignette scenarios to explore beliefs, assumptions and experiences of children with cerebral palsy and their parents regarding the importance of walking.It is a matter of choice whether participants talk about personal experiences when interpreting vignettes (Young et al., 2007).

When developing vignettes, the validity of the case scenarios that are constructed should be considered to ensure that data are collected that enable the researcher to adequately address research questions (Gould, 1996). To increase the validity of vignettes it has been suggested that a panel of experts could help make suggestions and filter out ambiguous or unrealistic scenarios (Flaskerud, 1979). While vignettes have been used as a tool to prompt discussions within focus groups (e.g. Brondani et al., 2008), ideas, thoughts, and perceptions elicited through focus group discussions can also be used to ensure validity from a participant perspective in the development of vignettes (Gould, 1996).

Despite this extensive use of vignettes in health and social research, there is a lack of literature that specifically explores and explains how vignettes might be developed and validated with the purpose of eliciting participant understandings of contested constructs. In this article, we describe the preliminary phase of a study in which a series of vignettes were developed. We then reflect on the use of the vignettes as an interviewing tool in one-to-one interviews with mental health workers and service users.

**Aims**

The aims of this article are: 1) to illustrate the process of developing and validating vignettes designed to elicit data around contested health care concepts; 2) to explore the extent to which it is possible to demonstrate the usefulness of vignettes as an approach to eliciting data around contested concepts.

## Methods

To develop and validate vignettes we adopted a qualitative approach combining focus groups and data extracted from a literature review in a number of stages. Mental health workers and people using community mental health services were recruited to separate focus groups that met in two rounds. As such, the vignettes were amended and refined as an iterative process of moving back and forth between data and literature. The first author carried out recruitment, data collection and data analysis.

Focus groups about risk and recovery in mental health services could invite discussion about sensitive, personal subject matter. Focus group participants were informed that all data collected would be kept confidential and anonymized, that their participation was voluntary, and that they had the right to withdraw at any time. This information was included in the participant information sheets provided to participants. Ethical approval for the study was obtained from South East London National Health Service Research Ethics Committee. Written informed consent was obtained from participants prior to them taking part. Service user participants were given a £10 payment for taking part in each focus group.

***Setting***

The study took place in community mental health teams in a UK Mental Health National Health Service Trust (statutory health service provider) in London.

# ***Sampling and recruitment***

Mental health workers and people using community mental health services were recruited using a purposive sampling strategy to select ‘information-rich cases for in-depth study,’ (Patton, 1990:182). Of the fourteen mental health workers recruited, seven were community mental health nurses, four were social workers and three were occupational therapists. Of the eight service users recruited, four had a diagnosis of schizophrenia and four had a diagnosis of bi-polar disorder. The recruitment process is described in detail in the full account of the study on which this article is based (Holley et al., 2016). We note here the limited socio-demographic data we collected of participants in the vignette development stage of the study (we collected age, gender and ethnicity data for participants in the main interview stage of the study) and consider the implications of this in the discussion below.

**Step 1: Developing the vignettes**

The aim of the first round of focus groups was to identify content for vignette scenarios designed to elicit participant perspectives and understandings of risk management and recovery-oriented care. Focus group schedules were informed by national policies on risk management practice (Department of Health, 1993; Department of Health, 2007) and recovery-oriented care (e.g. Shepherd et al., 2008; 2010), and the limited literature exploring how risk management practice impacts upon recovery-oriented care (as referred to in the introduction). Schedules for mental health worker focus groups included topics exploring participants’ understandings of: 1) how recovery-oriented care and risk management practice policies are implemented into practice; 2) how managing risk may affect the implementation of recovery-oriented care; 3) the differences between their own and service users’ perspectives on risk. Schedules for service user focus groups included topics exploring their understandings of: 1) recovery-oriented care; 2) how risk affects individual recovery; 3) differences between their own perspectives of risk compared to mental health workers.

Four focus groups were conducted by the first author, two with mental health professionals and two with service users. Focus groups lasted between 45 minutes and one hour, were digitally recorded and transcribed verbatim.

A thematic analysis approach (Braun & Clarke, 2006) was used to analyse data from the exploratory focus groups. Data were coded with the primary study’s research question in mind, mapping data onto theoretical concepts of risk management practice and recovery-oriented care. The focus group transcripts were read and categories related to issues of risk management practice and recovery-oriented care were identified by the first and second author. A constant comparison method (Green & Thorogood, 2004) was used to group the categories with similar content together.

Two categories were identified through the focus group transcripts - 1) situations involving risk management practice and recovery-oriented care; 2) tensions between recovery-oriented care and risk management practice - each with several sub-categories. A checklist was developed which comprised these emerging focus group categories (see table 1).

A second checklist was derived from the limited literature that explored both risk and recovery, as cited in the introduction (see table 2). We derived checklists from both the literature and focus groups because, a) the literature was minimal, and b) we did not have the resources to conduct a further focus group and assess the extent to which our data might have been ‘saturated’. Checklists were used to ensure that the content of vignettes reflected both focus group participants’ understandings of risk and recovery and the findings of the literature.

**[Insert Table 1 and Table 2 here]**

***The Vignettes***

In total, five vignettes were constructed. The scenarios represented in the vignettes were: 1) A service user wanting to stop their appointeeship (where an individual - such as a mental health worker – is appointed to take responsibility for the finances of another) in order to gain financial independence; 2) A mental health worker attempting to reduce service users’ dependency on their parents in order to prepare them to live independently; 3) A service user starting a college course and experiencing discriminatory attitudes from other students; 4) A service user wanting to return to employment following from a previous break-down at work; 5) A service user known to be vulnerable wanting to move out of supported accommodation into independent housing. See Figure 1 for example of a vignette.

**[Insert figure 1 here]**

**Step 2: Checking respondent validity**

A second round of focus groups were conducted approximately a month after the first round to further establish the validity of vignettes from the perspective of study respondents, gather feedback and make amendments to the vignettes as necessary.

All participants from the first round of focus groups were contacted by email or telephone to invite them to take part in the second round. Five out of the fourteen mental health workers and seven out of the eight service users took part in the second round of focus groups (focus groups with mental health workers and services users were again held separately). In the second round of focus groups participants were presented each of the vignettes and asked: 1) whether they thought vignettes portrayed real life situations; 2) whether mental health worker and service user perspectives were represented; 3) whether they thought any amendments needed to be made.

Focus groups were again transcribed verbatim. Data were extracted from the interview transcripts representing either feedback that endorsed the vignettes as they were or proposed alternative content for each of the vignettes. Participants validated the vignette scenarios by relating them to their own or others’ experiences. Comments that challenged the content of the vignettes included the need to define concepts more clearly and the extent to which information presented was realistic or not. Vignette 1 has been used as an example to illustrate how the vignettes were amended following the focus group participants’ feedback. See table 3 for the feedback comments and figure 2 for the amended vignette.

**[Insert Table 3 here]**

**[Insert Figure 2 here]**

**Step 3: Applying the vignettes**

In the main study, the vignettes were used in qualitative one to one interviews with eight mental health workers and eight people recruited from the same community mental health services as the focus group participants. A full account of the recruitment process and description of the sample can be found in the report of the primary study (Holley et al., 2016).

Participants were presented with the five vignettes sequentially and were asked a series of questions such as ‘what do you think will happen next in this scenario?’ and ‘what do you think the mental health worker should do?’ Participants were also asked whether the vignettes related to their personal experiences and if so, to describe what had happened to them in similar circumstances.

The detailed findings of the study are presented elsewhere (Holley et al., 2016). In this article we aim to explore the potential to demonstrate the usefulness of vignettes as an approach to eliciting data around contested concepts - in our case risk and recovery in mental health services - without explicitly defining those concepts through the interview. To do this we looked for data from the vignette interviews that illustrated understandings of recovery-oriented care and risk management practice as commonly represented in the risk and recovery policy literature, as well as data that expressed more individualised understandings of risk and recovery. We explored whether the vignettes elicited conceptually similar responses within each of the participant groups (mental health workers and service users). We note that this analyses (presented below) is illustrative in nature, reflecting our aim of exploring the potential for vignettes to elicit data around contested healthcare constructs.

Mental health workers provided similar responses to one another when describing what they thought was likely to happen next in the vignettes. They described what they would do hypothetically in the situation and these responses often mirrored a recovery-oriented approach - stressing the importance of devolving responsibility back to service users - typical of much recovery policy literature (e.g. Department of Health, 2011):

And it is about balance because he, he makes an informed decision, he has capacity, yes, he has schizophrenia but he has capacity to make decisions about how he spends his money.

I don’t see what the main problem is. He wants to move into the flat and I think it’s uh, we should support him to be independent […]

[…] so, within each step, there are tiny little things, incremental stages towards each step […] you provide the hope that this person can move forward.

However, when asked explicitly by the interviewer to relate the vignettes to their own experiences, mental health workers were more likely to highlight the difficulties of balancing priorities of risk and recovery in real-life practice:

She feels that she’s a child you know she um, that’s the thing, “I need to manage my money because I’m not able to do certain things.” And we’re like, “not really because you’re always drunk, you’re always drinking.”

And I thought, “Oh well, something’s got to be done here.” And so, I did advocate for that. And the next thing was that he burnt the house down. So, my stock with Housing was low (laughs).

But anyway, at the end of the day we realised that the risks were escalating so much that really, we couldn’t really ask him to take much responsibility for his, managing his own risks.

Unlike mental health workers, service users were more likely to discuss what they thought would happen next in the vignettes by comparing the scenario to similar experiences of their own, often without the need to be prompted by the interviewer:

[…] well, with me I’ve had problems since I was 16, I’ve been off it 3 times and all those 3 times, not including this time now, I’ve become, you know, something’s happened and I’ve become unwell.

Yeah, I mean one college course I wasn’t very well at the end of it but I managed to finish it but I think the tutors knew I wasn’t very well but they weren’t quite sure what was going on so they helped me with a bit of the work […]

‘[…] but then it comes back to his illness he should really tell his employers to give him a bit more leeway if they were half decent.’

Interviewer: ‘Mm. Did you ever, did you always make it clear to your employers?

Never. That was my undoing […] lost lots and lots of jobs.’

These responses felt more idiosyncratic than those offered by mental health workers. The way in which service users made sense of what might happen next in the scenarios did not seem to be shaped by the constructs of recovery offered by the recovery policy literature, and were more likely to be guided by concerns over the very real risk issues that seems to be present:

Nah, they won’t let him. They’d be stupid if they did because he won’t be able to cope. And they’ll cop it in the neck if things go wrong and it’s bound to looking at this [...] And if he lets them down, well, he will have to go back on an appointee-ship but for how long I don’t know. He’s got to prove himself again.

[…] she’s got to realise that if she’s in a position where this cycle is happening and the way she reacts to it is by further um, extending the time that she’s going to have to be taken care of in this kind of more extreme sort of way you know, she’s just not going to get herself together basically if you see what I mean.

## Discussion and reflections

This article illustrates the various stages we undertook to develop, validate and apply vignettes in a study of recovery and risk in mental health services. We discuss the extent to which the vignettes enabled us to avoid imposing meanings of recovery and risk on mental health worker and service user interviewees and instead allowed them to use their own personal experiences and perspectives to attach meaning to the vignette scenarios (Rapley, 2007).

***Reflections on the development of vignettes through focus groups***

As suggested by Gould (1996), the exploratory focus groups proved useful in the vignette development stage, demonstrating the validity, in the context of our participants’ personal experiences, of vignettes that might otherwise have been grounded in only a very limited literature that explicitly explored recovery orientated care in the context of risk management practice. Flaskerud (1979) noted the importance of using a panel of experts to help make suggestions and filter out ambiguous and unrealistic scenarios. In our vignette validation stage, feedback focus group participants identified two important details that impacted on the way in which vignettes communicated: 1) the extent to which the demographic details of the vignette characters were realistic to the specific vignette in question (e.g. being too young to be on an appointee-ship); 2) the inclusion of demographic details of the vignette character (Hughes and Huby, 2002; Gould, 1996). We note, however, the limitations to our ability to validate our vignettes. The literature we used was limited, as was our focus group population. That we did not collect complete socio-demographic data in the development stage of the study contributed to this. Experiences and understanding of mental health and of recovery can be gendered and shaped by culturally–specific experiences, including in relation to issues of discrimination and marginalisation. In not making identity explicit in the development stage in the study, and the resulting ‘identity-neutral’ nature of our vignettes, we limited the potential of the study to elicit explicitly gendered or culturally relevant responses to the vignettes.

***Eliciting participant perspectives: reflections on using the vignettes***

We noted how, when making sense of the vignettes, mental health workers initially tended to respond in the abstract, using language that reflected an idealized version of recovery-oriented care (Holley et al., 2016). For example, they focused on the importance of devolving responsibility back to service users rather than referring to their professional responsibilities to manage and reduce exposure to potential risks (e.g., Waterson, 1999). Given that we did not make explicit reference to policy and practice in the interview, it is possible to conclude that mental health workers responded in a way that reflected their workplace exposure to institutional recovery policies (the language of recovery was very prominent in the policies of the local mental health organisation). It might be that vignettes lacked sufficient detail to prompt specific consideration of risk by mental health workers (although as we saw, service user participants needed no further prompting to reflect on the risks implicit in the vignettes). Alternatively, Farmer and colleagues (2006) suggest that some participants interpret vignettes from the perspective of the vignette characters as a means of distancing themselves from potentially sensitive subject matter. Arguably, for mental health workers, this abstract response may have been a way of protecting the confidentiality of their clients and their professional practice.

However, when prompted further in the interviews, we observed that mental health workers could relate the vignettes to their own experiences, and that the vignettes did elicit data on the complexities of their role as they tried to encourage service users in their recovery whilst also addressing their own responsibilities for managing risks. As such, in our primary study we reported a process whereby implementation of recovery-oriented policies became ‘contaminated’ by risk management procedure in mental health workers’ everyday practice (Holley et al., 2016), reflecting an illness management-type understanding of recovery (e.g., Gingerich and Mueser, 2005).

In contrast, service users seemed more ready to relate the scenarios to their own personal experiences from the outset of the interview. The policy language of recovery was largely absent from their accounts, while the awareness of risk expressed by service user participants reflected their lived experiences of challenging situations they faced in their everyday lives, rather than a practice-based perspective. This suggested, with service user participants at least, that our vignettes might have contributed to the eliciting of data without shaping participant responses in terms of a priori constructions of risk and recovery made explicit through an interview schedule. We do note, however, that while our interview guide invited mental health workers to respond to vignettes at an individual level, we had no equivalent prompts to ensure that service users also considered vignettes at a policy level. An implication for future research is that interview guides should be developed that enable researchers to explore a full range of possible responses where those are not initially elicited by the vignettes alone.

***Conclusion***

The vignette process described above demonstrated that it was possible to produce vignettes that elicited data relevant to our research question about the impact of risk management practice on recovery–oriented care. We were able to do this through vignette scenarios that explored issues of living in the community with a serious mental illness, rather than through explicitreference, in an interview schedule, to risk management practice or the promotion of individual mental health recovery.

In the vignette approach taken here we did not aim to discount the impact of the researcher on the knowledge production process (Miller, 2010). We remained interested in the socially constituted nature of the data we produced (Holstein & Gubrium 2004) - how our data reflected the roles of our participants as mental health 'service user' and 'worker' - but instead sought to filter out the voice of the researcher in the data elicitation stage of the process so as to hear more directly the subjective voice of our service user and mental health worker participants.

Our findings are indicative of some success in this respect. Even where our mental health worker participants formulated their accounts in terms of understandings of risk and recovery articulated in policy documents and practice guidelines, we were able to interpret this as responding to the organisational culture in which they worked, rather than language we had offered them in our interview. We note that future research might make explicit gender, ethnicity and other aspects of our social identity, in the development process, to explore whether vignettes might elicit data that responds to issues of marginalisation in relation to healthcare. In addition, the limitations of our method meant that it was not possible to attribute, with any certainty, the qualities of our data to the vignette approach (we did not explore with our participants the extent to which their responses might have been shaped by the interview process). Further research in this area might develop creative, comparative methods to more clearly indicate and optimize the potential of vignettes as tools for research into sensitive or contested constructs in healthcare.

**References**

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal*,*16*(4), 11–23. doi:[10.1037/h0095655](http://psycnet.apa.org/doi/10.1037/h0095655).

Atzmüller, C., & Steiner, P. M. (2015). Experimental vignette studies in survey research. *Methodology*.[doi: 10.1027/1614-2241/a000014](https://doi.org/10.1027/1614-2241/a000014).

Holley, J., Chambers, M., & Gillard, S. (2016). The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: A qualitative investigation. *Journal of Mental Health*, *25*(4), 315-322.doi: [10.3109/09638237.2015.1124402](http://dx.doi.org/10.3109/09638237.2015.1124402).

Benner, P. (Ed.).(1994). *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. Sage publications.

Bertram, G.,& Stickely, F. (2005). Mental health nurses, promoters of inclusion or perpetuators of exclusion? *Journal of Psychiatric Mental Health Nursing*, *12*(4), 387-395. doi: 10.1111/j.1365-2850.2005.00849.

Boardman, J., Craig, T., Goddard, C., Henderson, C., McCarthy, J., & McInerny, T. (2010). *Recovery is for all: Hope, agency and opportunity in Psychiatry*. London: Royal College of Psychiatrists.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi: d 72d26ebb4408e16ad32ca598114daf7.

Brondani, M. A., MacEntee, M. I., Bryant, S. R.,& O'Neill, B. (2008). Using written vignettes in focus groups among older adults to discuss oral health as a sensitive topic. *Qualitative Health Research*, *18*(8),1145-1153.doi: [10.1177/1049732308320114](https://doi.org/10.1177/1049732308320114).

Department of Health.(1993).*The health of the nation, key area hand book: Mental Illness*. London: Department of Health.

Department of Health. (1994).*Guidance on discharge of mentally disordered people and their continuing care in the community.*London: HMSO. Retrieved from <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/docu> ments/digitalasset/dh\_4120218.pdf.

Department of Health. (2007).*Best practice in managing risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*. London: Department of Health. Retrieved from http://www.gov.uk/publications.

Department of Health. (2008). *A common purpose: Recovery in future mental health Services*. London: Department of Health. Retrieved from http://www.scie.org.uk/publications/positionpapers/pp08.asp.

Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. London: Crown Copyright.Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/138253/dh\_124058.pdf.

Ely, M., Vinz, R., Downing, M.,&Anzul, M. (1997).*On writing qualitative research: Living by words*. London: The Falmer Press.

Farmer, J., Iversen, L., Campbell, N. C., Guest, C., Chesson, R., & Deans, G. (2006). Rural/urban differences in accounts of patients' initial decisions to consult primary care. *Health and Place*, *12*(2), 210-221. doi: [10.1016/j.healthplace.2004.11.007](https://doi.org/10.1016/j.healthplace.2004.11.007).

Finch, J. (1987). The vignette technique in survey research. *Sociology*, *21*(1), 105-114. doi: [10.1177/0038038587021001008](https://doi.org/10.1177/0038038587021001008).

Fitch, C., Simpson, Collard, S., & Teadale, M. (2007). Mental health and debt: Challenges for knowledge, practice and identity. *Journal of Psychiatric and Mental Health Nursing*,*14*(2), 128-133. doi: 10.1111/j.1365-2850.2007.01053.

Flaskerud, J. (1979). Use of vignettes toelicit responses toward broad concepts. *Nursing Research*,*28*, 210-212.doi: 0029-6562.

Forchuk, C., Nelson, G., & Hall, G. B. (2006). "It's important to be proud of the place you live in": Housing problems and preferences of psychiatric survivors. *Perspectives in Psychiatric Care*, *42*(1), 42-52. doi: 10.1111/j.1744- 6163.2006.00054.

Fredelius, G., Sandell, R., & Lindqvist, C. (2002). Who should receive subsidized psychotherapy?: Analysis of decision makers’ think-aloud protocols. *Qualitative Health Research*, *12*(5), 640-654. doi: [10.1177/104973202129120151](https://doi.org/10.1177/104973202129120151).

Gibson, B. E., Teachman, G., Wright, V., Fehlings, D., Young, N. L., & McKeever, P. (2012). Children's and parents' beliefs regarding the value of walking: Rehabilitation implications for children with cerebral palsy. *Child: Care, Health and Development*, *38*(1), 61-69. doi: 10.1111/j.1365-2214.2011.01271.

Gingerich, S., & Mueser, K. T. (2005). Illness management and recovery. In R. E. Drake, M. R. Merrens, & D. W. Lynde (Eds.). Evidence-based mental health practice: A textbook (pp. 395–424). New York: Norton.

Gould. D. (1996). Using vignettes to collect data for nursing research studies: How valid are the findings? *Journal of Clinical Nursing*,*5*(4), 207-212. doi: 10.1111/j.1365-2702.1996.tb00253.

Green, J., &Thorogood, N. (2004).*Qualitative methods for health research*. London: Sage.

Holstein, J. A., & Gubrium, J. F. (2004). The active interview. In D. Silverman (Ed.) Qualitative research: Theory, method and practice (pp. 140-161). London: Sage.

Hughes, R., & Huby, M. (2002). The application of vignettes in social and nursing research. *Journal of Mental Health Nursing*, *37*(4), 382-386. doi: 10.1046/j.1365-2648.2002.02100.

Jackson, M., Harrison, P., Swinburn, B., & Lawrence, M. (2015). Using a qualitative vignette to explore a complex public health issue. *Qualitative Health Research*, *25*(10), 1395-1409.doi: 1049732315570119.

Kaye, D. K. (2006). Community perceptions and experiences of domestic violence and induced abortion in Wakiso District, Uganda. *Qualitative Health Research*, *16*(8), 1120-1128. doi: [10.1177/1049732306292172](https://doi.org/10.1177/1049732306292172).

Kogan, S. M. (1998). The politics of making meaning: Discourse analysis of a ‘postmodern’ interview. *Journal of Family Therapy*, 20, 229–251. doi: 10.1111/1467-6427.00085.

Mancini, M. A., Hardiman, E. R., & Lawson, H. A. (2005). Making sense of it all: Consumer providers’ theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal*, *29*(1), 48-55. doi:[10.2975/29.2005.48.55](http://psycnet.apa.org/doi/10.2975/29.2005.48.55).

Marwaha, S., & Johnson, S. (2005). Views and experiences of employent among people with Psychosis: A qualitative descriptive study. *International Journal of Social Psychiatry*,*51*(4), 302-316.doi:[10.1177/0020764005057386](https://doi.org/10.1177/0020764005057386).

McCleod, J. (2003). *Doing Counselling Research* (second ed.). London: Sage.

Miller, R. E. (2010). Indeterminacy and interview research: Co-constructing ambiguity and clarity in interviews with an adult immigrant learner of English. *Applied Linguistics*, 32(1), 43-59. doi:[10.1093/applin/amq039](https://doi.org/10.1093/applin/amq039).

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

Patton, M. (1990). Purposive sampling. In M. Patton (Ed.), Qualitative evaluation and research methods (pp. 169-186). Beverley Hills, CA: Sage.

Rahman, N. (1996). Caregivers' sensitivity to conflict: The use of the vignette methodology. *Journal of Elder Abuse and Neglect*, *8*(1), 35-47. doi:[10.1300/J084v08n01\_02](http://dx.doi.org/10.1300/J084v08n01_02).

Rapley, T. (2007).*Doing conversation, discourse and document analysis*. London: Sage.

Salomon, J. A., Tandon, A., & Murray, C. J. (2004). Comparability of self-rated health: Cross sectional multi-country survey using anchoring vignettes. *British Medical Review*, *328*(7434), 258-264. doi: 10.1136/bmj.37963.691632.44.

Shepherd, G., Boardman, J., & Slade, M. (2008).*Making recovery a reality*. SCMH: London. Retrieved from http://http://www.ispraisrael.org.il/Items/00606/Making\_recovery\_a\_reality\_policy\_paper.pdf.

Shepherd, G., Boardman, J., & Burns, M. (2010).*Implementing recovery: A methodology for organisational change*. London: Centre for Mental Health. Retrieved from https://imroc.org/resources/implementing-recovery-methodology-organisational-change/

Simpson A. (2005). Community psychiatric nurses and the care co-ordinator role: Squeezed to provide ‘limited nursing’. *Journal of Advanced Nursing*, *52*, 689– 699. doi: 10.1111/j.1365-2648.2005.03636.

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), Qualitative psychology: A practical guide to research methods (pp.51- 80). London: Sage.

Spalding, N. J., & Phillips, T. (2007). Exploring the use of vignettes: From validity to trustworthiness. *Qualitative Health Research*, *17*(7), 954-962. doi: [10.1177/1049732307306187](https://doi.org/10.1177/1049732307306187).

Waterson, J. (1999). Redefining community care social work: Needs or risks led? *Health and Social Care in the Community*, *7*(4), 276-279. doi:10.1046/j.1365-2524.1999.00185.

Whitwell, D. (1999). The myth of recovery from mental illness. *The Psychiatrist*, *23*(10), 621-622.doi: 10.1192/pb.23.10.621.

Wilks, T. (2004). The use of vignettes in qualitative research into social work values. *Qualitative Social Work*, *3*(1), 78-87. doi: [10.1177/1473325004041133](https://doi.org/10.1177/1473325004041133).

Young, A. F., Chesson, R. A., & Wilson, A. J. (2007). People with learning disabilities, carers and care workers awareness of health risks and implications for primary care. *Family Practice*, *24*(6), 576-584. doi: [10.1093/fampra/cmm067](https://doi.org/10.1093/fampra/cmm067).