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The complexities and challenges in conducting research with the mental health community

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Abstract

This paper explores the methodological challenges experienced while conducting longitudinal, multi-method research with people from the mental health community involved in the Housing and Accommodation Support Initiative (HASI). HASI is a partnership model between NSW Health, the NSW Department of Housing and Non-Government Organisations (NGO) whose core business is the provision of supported accommodation. Targeted to people with complex mental health problems, it provides secure, affordable housing, long-term support around accommodation and community participation, as well as active mental health case management. Based on interviews, surveys and secondary datasets, this paper explores the complexities and challenges of conducting, collecting, analysing and presenting research for this evaluation. It examines the ethical, practical and safety implications of interviewing people with severe psychiatric disabilities, and the problems associated with completing surveys. This paper has a practical focus, providing examples and lessons learnt from such a complex, but exciting, evaluation.

Introduction

This paper explores the methodological challenges experienced while conducting longitudinal, multi-method research with people from the mental health community who are involved in the Housing and Accommodation Support Initiative stage one (hereafter referred to as HASI). HASI is a partnership model between NSW Health, the NSW Department of Housing (DoH) and Non-Government Organisations (NGO) whose core business is the provision of supported accommodation. It is jointly funded by NSW Health and DoH and follows psychosocial rehabilitation principles (NSW Health Department 2002). It aims "to assist people with mental health problems and disorders requiring accommodation (disability) support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness" (NSW Health and NSW Department of Housing 2005: 3).

Established for over 100 people with complex mental health problems, HASI provides secure, affordable housing, long-term support around accommodation and community participation, as well as active mental health case management. It is a coordinated approach that brings together accommodation support workers from the NGO sector, case managers from Community Mental Health Services, housing providers from both DoH and Community Housing agencies, as well as participants of the initiative. Peak bodies that represent the users of mental health services are also involved in the implementation and monitoring of the program.

The Social Policy Research Centre at the University of New South Wales, was commissioned to evaluate HASI. This study was longitudinal in design, spanning a two-year period with three data collection phases.

What is HASI?

At a practical level, people involved in HASI are provided with a place to live, an accommodation support service to help with daily living and active mental health case management from a Community Mental Health team. Such support is provided through the coordinated efforts of those involved in the program, family members (when appropriate), and three agencies – namely, an NGO that provides daily home visits to help clients with furnishing and maintaining the house, shopping, low-income budgeting, self-care, community participation, education, employment, and/or accessing services; a Community Mental Health Service that provides mental health monitoring, care and treatment; as well as a housing provider that provides the dwelling.

People involved in the program have histories of substantial hospitalisation. Since becoming unwell with mental illness, many have spent most of their time in hospital than in the community. They also have histories of unstable tenancies, minimal social networks and exclusion from community activities, education and employment. The chronicity of mental illness among program participants is thus, for the most part, severe with almost three-quarters primarily diagnosed with schizophrenia. However, almost two-thirds had at least one other coexisting diagnosis.

Evaluation Methodology

A comprehensive evaluation of a community-based, multi-stakeholder program necessitated a longitudinal, multi-method and multi-layered research design, encompassing both qualitative and quantitative methods. Those consulted through the course of the study included program participants; family members and carers; managers and direct support providers from non-government accommodation support agencies; managers and case managers from Community Mental Health Services; personnel from government and non-government housing providers; managers from both NSW Health and DoH; as well as consumer advocates.

To maximise inclusiveness, it was important to provide each of these cohorts with various ways to engage with the study. Each research participant was thus invited to be part of an interview and complete survey material. For program participants, this included standardised measures of wellbeing; namely, the Personal Wellbeing Index (Cummins et al. 2003) and health-related questions used by the Australian Bureau of Statistics (ABS). Over the course of three fieldwork phases, 633 interviews were conducted. Of these, 219 were with clients of the program, signifying a participation rate between 75 and 80 percent for each phase. This suggests that the experiences of those directly affected by the program – the participants, were well represented in the context of the evaluation.

To maximise the robustness of the research findings, material was collected from additional sources with the aim of triangulating the various datasets (Blaikie 2000; Mathison 1988; Onwuegbuzie and Leech 2005). An additional source of information was the Client Information Database – a database designed specifically for the project, which was completed by the accommodation support providers during each phase of fieldwork. Its purpose was to collect quantitative information on client demographics, health services accessed by the client, living skills, level of social and

community participation, tenancy matters, as well educational and employment pursuits. It also required support workers to complete the Global Assessment of Functioning (GAF) scale (Jones et al. 1995; Moos, Nichol and Moos 2002; Söderberg, Tungström and Åke Armelius 2005) – a validated psychometric tool, used to gauge psychological, social and occupational functioning on a hypothetical continuum of mental health. Additional research material on client tenancies was sought from the housing providers, while NSW Health provided clinical data.

Interviewing

Regardless of research methodology, the ethical, practical and safety implications of interviewing should be addressed (NHMRC1999). This is especially important when the interviewees are vulnerable and/or have impaired cognitive abilities (Roberts 2000).

The people participating in HASI have severe mental illness, many of which involve psychosis, like schizophrenia. To understand the ethical and practical implications of interviewing people with psychiatric disability, it is important to be aware of the associated symptomatology.

The symptoms of schizophrenia are categorised as positive and negative symptoms (First and Tasman 2004). Positive symptoms include additional effects such as hallucinations (which can be visual or auditory) and delusions (which might involve paranoia) (Andreasen and Olsen 1982; Pogue-Geile and Harrow 1984).

Negative symptoms are deficits. They include flat affect, alogia, avolition, and asociality forming (Ratakonda et al. 1998). These are typically demonstrated through social withdrawal, apathy, limited and poor speech, minimal body language, nominal eye contact, as well as minimal spontaneous movement (Andreasen et al. 2005).

In addition to positive and negative indicators, people with schizophrenia can also experience a third dimension of symptoms – namely, cognitive dysfunction (Perlata, de Leon and Cuesta 1992). This is associated with concentration and memory problems.

Evidently, the symptoms associated with a psychotic disorder, like schizophrenia, can affect a person's ability to effectively organise his/her cognitive ability and behaviour according to social convention (Shaw et al. 2000). They can also create a number of barriers in an interview situation.

Ethical Considerations

In evaluating HASI, the rights of all interviewees (especially participants of HASI) and the ethical and moral responsibilities of the researchers were considered with much deliberation.

In accordance with the relevant university human ethics body, participation in the study was voluntary and participants could withdraw at any time without repercussion (UNSW Human Research Ethics Committee 2006).They could also select which components of the evaluation they would participate in; for instance, they could choose *not* to respond to particular interview or survey questions.

All interviewees were provided with an information form. This document provided the reasons for the study; the organisation responsible for the evaluation; the funding bodies supporting the study; and the nature of participant involvement. The interviewees were advised on the expected length of the interview, the possible use of recording equipment to aid data analysis, as well as the confidential and anonymous nature of their involvement. The document also provided contact details for the research team and the Ethics Secretariat.

Those receiving support through HASI were also advised that, with their permission, the research team would work with their accommodation support provider, their case manager and their housing provider to access further information about them. This included health and mental health status, hospitalisation admissions, and tenancy matters. However, they were also informed that this information would be aggregated and thus not identify individual program participants.

While all interviewees were advised that they might not directly benefit from the study, participants of HASI were reimbursed with a voucher for their time and effort. This served to acknowledge the value placed on the contribution made by participants of the program.

All consenting interviewees were required to sign a consent form to verify their assent. However, they were also provided with a withdrawal form, should they wish to revoke their consent.

Despite this disclaimer, the lengthy consent form asked much from the interviewees – this was especially the case for participants of the program and their family members or carers. They were being requested to reflect on their experiences with mental illness and the mental health sector – some of which were negative, if not painful. Given the longitudinal nature of the study, they were also asked to be part of repeated form filling; this was an arduous practice for some, especially those that had traversed the bureaucracy of the mental health sector for many years. Further to this, these individuals were being asked to engage with a stranger and divulge personal, if not sensitive information. While this in itself might be perturbing, it can be particularly disconcerting for those who are vulnerable; for those who have experienced exploitation at the manipulative hands of others; or those with a psychotic disorder.

While planning the study, the researchers deliberated on how they might respond to an invitation to be part of this study, if they were a participant of HASI, a family member or a carer. Needless to say, sentiments of hesitation, distrust and suspicion were discussed, particularly at the thought of a research team with access to personal information.

Efforts to request consent from program participants were further vexed by the chronic nature of their mental illness. In particular, those with a psychotic disorder often found it difficult to maintain concentration for extended periods, comprehend the information provided to them, or articulate concerns or questions about the evaluation process.

Why then was the participation rate in the study, particularly among program participants, so high; and what strategies were used to uphold participants' rights and respectfully respond to their concerns?

The first important lesson was to effectively engage with each program participant and demonstrate *bona fide* interest. This meant spending extended periods with them and, when necessary, reiterating or paraphrasing information about the study. It also meant requesting explicit permission to speak with them using a consent form. While the consent of legal guardians was also requested (when appropriate), it was also requested from those who were appointed a legal guardian.

A critical part of the engagement process was working with key workers from the NGOs who provided the participants with direct support. In most cases, they served as a conduit between the researcher and the program participant, verifying that the interests of the researcher were *bona fide*. This process often commenced by meeting with the key workers to provide context to the study and explain the methodology. It was also an opportunity for the research team to learn about the program participants and the most appropriate ways to engage with them – the research techniques were then modified accordingly. Armed with this knowledge, the key workers were then encouraged to invite participants to contribute to the evaluation and facilitate meeting opportunities with the researchers.

Engaging with key workers was an important step in the project because most people in the program were vulnerable to exploitation and had histories of low trust levels. Thus, by using personnel who had a trusting relationship with the participants, suspicions about the motives and intentions of the evaluation were (partly) overcome. Additionally, by using a non-confrontational approach, participants were less likely to feel pressured to participate.

Upon meeting with individual program participants, time was taken to develop rapport. This often involved a brief chat before the consent form was presented. Substantial time was spent *discussing* the consent form, rather than merely presenting it devoid of dialogue. The purpose of the consent form was briefly explained and then participants were asked if they preferred to read it themselves or with the assistance of the researcher. By phrasing the options as such, the participants were respected and their dignity maintained, even if they had low literacy levels. This was the case for a number of program participants. For some, the onset of mental illness, which is typically during adolescence (Sawyer et al. 1992; Sawyer et al. 1990), affected their schooling, while others experienced poor comprehension because of their symptoms or substance use issues. As verified by their facial expressions and body language, for these individuals, there was some relief in knowing that their difficulties did not have to be explicitly disclosed to an outsider. Having the researcher discuss the form was presented as a *preference*, rather than a requirement.

Ethical Lessons
By considering the ethical issues of interviewing people with chronic mental illness, a number of valuable lessons have been learnt. Notably:
- Use a third party to assist in establishing the relationship between the researcher and interviewee;

- Factor in time to develop rapport with the participant before the consent form is presented;
- Allow sufficient time to discuss the consent form – the consent process alone could take up to half-an-hour;
- Ensure the participant understands the details within the form; and
- Provide people with options so that consent can be granted for different components of the research.

Practical Considerations

Managing interviews in any study involves addressing both methodological and practical issues (Denzin and Lincoln 2000; Morse 2001; Wengraf 2001). The *medium* is one of the first considerations. Face-to-face interviews are an effective way to engage and develop rapport with an interviewee, and in turn, elicit testimonies of great depth (Sturges and Hanrahan 2004). With people who experience mental illness, like a psychotic disorder, this is no exception.

In addition to practical issues like audibility, interview location requires other considerations. These include the interviewee's preference, researcher safety, and the presence (or absence) of other people. Meeting in a quiet café in a small country town, for example, may compromise the confidential nature of the interview; similarly, conducting the interview in the presence of family members or a key worker might influence the interviewee's responses.

At times it was difficult to balance the personal preferences of a program participant who agreed to be interviewed, with researcher safety. However, compromises were often found in quiet public places. For instance, when a program participant had a recent history of violence or boundary issues, it was inappropriate for a young, female researcher to conduct the interview in the person's home. The program participant was thus invited to nominate an alternative location, which sometimes included the office space of the accommodation support provider. However, a popular choice was a quite café as this provided an opportunity to go out in the community and get shouted a cup of coffee.

Seating arrangements also constitute an important consideration as these can affect the interview (Berg 2001; Fontana and Frey 1994). For instance, if the interviewee smokes cigarettes (which was the rule, rather than the exception for HASI participants), the interviewer may need to consider conducting the interview outdoors – lest the researcher be overcome by smoke or the interview is episodically stopped for 'smoko' breaks. In some interviews with HASI participants, this occurred approximately every fifteen minutes.

When discussing potentially sensitive matters, it can be useful to sit perpendicular to the interviewee. This arrangement enables the interviewee to avoid eye contact if he/she becomes uncomfortable or embarrassed. However, when interviewing in people's homes, this is not always possible. This might be consequent to limited furniture or interviewee choice of where to sit; for instance, he/she might prefer to sit at a kitchen table with only two opposing chairs, or he/she might prefer to sit on the cleanest part of the lounge, which is devoid of cigarette ash and food scraps. And for those experiencing paranoia, there might be a preference to sit closest to the door for

safety reasons. Thus, while interview techniques are useful, interviews need to be tailored to meet individual need and circumstance.

A further logistical consideration is the time of day for the interview. While interviewee preference is important, people with severe psychiatric disability can be poorly affected by their illness, their psychotropic medication or their substance use habits. When arranging interview times, the researchers worked around many factors, including the cyclical nature of the participants' mental illness; the time people typically woke (which was late morning for many); existing commitments (including employment, education, shopping routines, and recreational activities); medication side-effects (which typically included drowsiness); as well as substance use habits (in most cases, the key workers could advise on the times when program participants with substance use disorders were most cognisant). For example, in the case of one interviewee who was dependent on alcohol, the most appropriate meeting time was after the first alcoholic drink of the morning, as it relieved his anxiety, but preceded subsequent intoxication.

Certain techniques help to facilitate an interview that will elicit detail and depth from a research participant (Wengraf 2001). These include commencing with simple questions to ease the individual into the research process; ensuring that questions are brief, simple and jargon-free; ensuring that questions are appropriate for the individual – culturally and developmentally; seeking clarification by, for instance, requesting examples; noting further questions to return to at a later stage in the interview, so that conversational flow is not disrupted; allowing the interviewee to determine the pace of the interview; and using facial expressions, body language and paraphrasing to demonstrate interest and comprehension (Perks and Thomson 1998). The value of some of these techniques is particularly apparent when interviewing people who experience chronic mental illness (Davidson 2003; Hasin et al. 1996; Jack 1999) – as was the case in the evaluation of HASI.

In the evaluation, allowing program participants to govern the pace of the interview and demonstrating *bona fide* interest and comprehension were particularly useful, especially when interviewing individuals with a psychotic disorder, like schizophrenia. They often experienced disordered thoughts; this was exhibited by erratic speech that fleeted from one topic to another; the use of fabricated words; the nominal use of correct grammar; and sudden changes in volume, rhythm, tone or speed of speech. People with a psychotic disorder might also take extended periods to respond to questions or they might not respond at all (Cohen and Docherty 2005; Docherty 2005). Given the chronicity of mental illness experienced by the program participants, many demonstrated the aforesaid behaviours in varying capacities, regardless of their primary diagnosis. It was thus important to listen attentively to all responses, because a pertinent response might be missed.

The flat affect often associated with psychotic disorders, like schizophrenia (Salem and Kring 1999), can be difficult in the context of an interview. Standard facial, body and vocal queues may be absent throughout the whole process. The research team managed this by reminding interviewees that they could choose to end or break from the interview at any time.

Because of symptoms like flat affect, oft-cited research advice, like the use of open-ended questions (Berg 2001; Wengraf 2001), did not always work well when interviewing people with severe mental illness. Some program participants were so taciturn, that responses were restricted to 'yes', 'no' or 'don't know'. To manage this difficulty, the research team employed satisfaction scales to elicit responses. For example, a question like, 'Are you happy or unhappy with your home?' was then followed by, 'Are you very unhappy or just a little bit unhappy?' Similarly, although the interview schedule included ten-point Likert scales, the scale was often collapsed into three categories (for instance, 'content', 'mixed feelings' and 'discontent') and then broken down further to elicit a final score.

It was also important to repeat or paraphrase questions, allowing the individual time to reflect and respond. Yet, much discretion was needed in this process. While the researchers were cognisant of the possible noise inside the individual's head, they also did not want to cause undue frustration, lest the individual terminate the interview prematurely. An analogy that most people can relate to might be found in those frustrating situations when we find ourselves trying to speak to someone on the telephone, while another person is talking to us in the room. Similarly, people with schizophrenia can become distracted by delusions and/or hallucinations, making concentration very difficult. For instance, one interview with a HASI participant went for approximately 90 minutes, yet only covered about ten percent of the questions. This was because the interviewee was distracted, unable to concentrate, quiet and mostly unresponsive. When a response was finally provided, it was mellifluous, and if she was not heard, she would not repeat herself when asked.

Difficulty with decision-making is also symptomatic of schizophrenia (Hutton et al. 2002; Stroup et al. 2005). This was evidenced by a number of program participants, including the aforementioned interviewee. When a response was provided, it was typically followed by, "Oh no, I've said the wrong thing. I should have answered 'yes'. Oh, I don't know". To prevent (or at least, minimise) undue stress for the program participants, it was therefore important for the researchers to exercise much flexibility as they worked through the interview schedule.

While this suggestion demonstrates ethical research practice, it also raises methodological concerns. More specifically, it potentially breaches a cardinal rule of research – namely, the use of standardised questions to ensure reliability (Marshall and Rossman 1999). Flexible research practices introduce inconsistency in both the data collection process and the dataset. However, without such flexibility, it was likely that interviewee perceptions might not be represented in the study. To manage this issue effectively, the research team prioritised questions within the interview schedule, with the aim of attending to these first, if interviewee concentration waned.

However, the contribution of some participants relied solely on a casual discussion about HASI and their experiences with the program. This was because they could not or would not engage with a formalised interview schedule. For some, this was because of paranoia about the potential use of the data. These individuals were especially dubious about the use of recording equipment. Consequently, the researchers were not always able to use the interview schedule, let alone a recording device. Instead, observational research techniques had to be employed (sometimes unexpectedly), leaving the researcher frantically documenting personal notes, once

he/she had left the site. For this reason, it was important for each researcher to familiarise with the themes covered by the interview schedule, so that they may be translated into a casual discussion. It was also important for each researcher to allow ample time after the interview for the documentation of personal notes. Working through the standardised interview schedule facilitated this process.

To exemplify the value of flexibility when interviewing people with chronic mental illness, an example is presented. One program participant was extremely subversive during the first of three interviews. Despite agreeing to be interviewed, his speech was aggressive and defensive. He did not want a recording device used and refused to answer most questions. In subsequent interviews, the researcher organised to meet him in a café. During the second meeting, she did not introduce the recording device at all and commenced by asking whether he still preferred *not* to answer survey questions. As this was still his preference, the schedule was discarded. By the third interview, he requested to meet for lunch and he chatted about his life for approximately 90 minutes. This was one of the most insightful interviews conducted by the researcher. As this example demonstrates, while a semi-structured interview schedule can be useful, in some circumstances, the schedule has to be loosely defined.

In addition to flexibility with the use of research methods, flexibility was also needed with the use of researcher time. A number of program participants unexpectedly failed to attend the arranged interview because they were unwell, forgot about the interview, or were too intoxicated to be interviewed. Mental illness is often episodic (Schinnar et al. 1990); thus, changes in people should be expected over time. For instance, during the first phase of data collection, one female program participant was withdrawn, apathetic, non-communicative and disinterested; she was hospitalised during the second phase; and, in the third phase, she met with the researcher at a café, was well-dressed, interested in the interview, and was very articulate.

While the use of vouchers to reimburse program participants attracted many to the study, the researchers discovered that it was important to ensure they did not become a source of distraction. While presenting the voucher at the commencement of the interview proved its existence, leaving it in full view for the entire interview tended to distract the program participant. Within five minutes of one interview, the individual repeatedly asked if it was almost over because he wanted to be driven to the shops so that he may use the voucher.

While the wellbeing of the interviewee should be attended to throughout the research process, so too should the wellbeing of the researcher. One concern is that of safety. Given that the researchers worked independently and, at times, in remote locations, strategies were identified to ensure that personal safety was not compromised. These included advising fellow researchers of the interview times and locations; notifying fellow researchers (usually via a mobile telephone) when an interview was about to commence and again when the interview had ended; liaising with the accommodation support providers about the current wellbeing of program participants; selecting appropriate interview sites; where possible, arranging interviews during normal business hours (rather than evenings); exploring the possibility of two researchers conduct the interviews, when required; and providing the researchers with access to a 24-hour telephone service for employee support, should confidential debriefing be required.

Yet, despite the use of these strategies, there were still instances when researcher safety was potentially compromised. One interviewee, for instance, wanted to lock the door to his unit during the interview. This was cause for concern because of his recent history of violence, his inappropriate behaviour toward women, and the fact that the unit was located on the second-storey – a detail that only became apparent at the time of first interview. He was asked to keep the door unlocked, which was agreed to, and the researcher sat on the section of the lounge that was closest to the door. Subsequent interviews with this individual were held in a local café.

Another interviewee had a strong, if not imposing, physical presence that made the researcher feel quite uncomfortable. For example, he demanded that the researcher sit in the furthest corner from the front door; further to this, the tone, volume and content of his speech were erratic and undecipherable. Because of the precarious nature of the situation, the researcher decided to terminate the interview. Subsequent interviews with this individual were conducted at the office of the supported accommodation provider, in the presence of staff.

Interview Lessons

By considering the practical considerations of interviewing people with chronic mental illness, a number of valuable lessons have been learnt. Notably:

- When choosing the location, consider interviewee preference, noise levels and interviewer safety;
- Be flexible, even if a semi-structured interview is already being employed – this includes a preparedness to shorten the interview considerably, especially when the process potentially jeopardises the wellbeing of the interviewee or the interviewer;
- Exercise patience;
- Allow extra time, particularly when meeting with the individual for the first time;
- Expect that recording devices might not be used;
- Allow time immediately after the interview to complete the survey and expand on personal notes; and
- Ensure that cultural factors are considered prior to the interview.

Longitudinal Considerations

Given the longitudinal design of the study, it was imperative that all data collection methods were sound. This is because changes to these methods, even those that were nominal, would make it difficult to compare the datasets.

It was also imperative to sustain the interest of research participants throughout the two-year project; without their continued involvement, it would not have been possible to compare the datasets. This was aided by reviewing fieldwork notes and interview transcripts prior to subsequent interviews. The review helped to remind the researcher of the issues previously discussed with the individual, and the topics that needed further exploration. For instance, when one interviewee disclosed his children's names and his interest in cricket, the researcher noted this information. Upon reviewing her notes before the second interview, the researcher was able to enquire about the interviewee's children by name; she was also able to ask about

recent cricket scores. The preparatory efforts of the researcher helped to verify her sincere interest in the interviewee and maintain his involvement throughout the study. In fact, he was quite impressed with the researcher's memory. Subsequently, he became increasingly interested in the study and did everything he could to make the research process as seamless as possible. This experience was evident, not only among participants of HASI, but also among the other stakeholders who were consulted.

It is equally useful to record details like those participants who did not consent to the use of a recording device, or those who were uncomfortable about its use. This reminds the researcher to exercise sensitivity during subsequent interviews.

Longitudinally, it was difficult to conduct repeat interviews with some stakeholders because of substantial staffing movements. This was particularly the case among case managers of Community Mental Health Services, where staff retention was relatively low and staff responsibilities often changed. To maintain the involvement of case managers, interim reports that were prepared between the fieldwork phases proved useful. They provided new personnel with context for the study and the research findings to date. This information helped to engage them with the project.

However, it was important that the interim reports were devoid of identifying information. The reports did not disclose findings according to geographical location or service. This served to maintain the confidentiality of all those who contributed to the project.

Longitudinal Lessons
By considering the longitudinal issues of interviewing, a number of valuable lessons have been learnt that help to maintain research relationships throughout the evaluation. These include:
- Completing thorough field notes;
- Reviewing field notes and interview transcripts prior to subsequent interviews, as this serves as a reminder of previous discussions; and
- Ensuring that identities are protected in interim reports.

Conclusion
Conducting research with people who experience chronic mental illness presents numerous challenges and considerations that do not always align with standard research practices (Denzin and Lincoln 2000; Morse 2001; Wengraf 2001). This paper has explored some of these and the way they were effectively managed during the comprehensive evaluation of a community-based, multi-stakeholder program, known as HASI. Much was learnt through this study, including the ethical and practical considerations when conducting longitudinal research with people who experience high levels of psychiatric disability. While it is impossible (if not unethical) to recommend a definitive approach to research, this paper offers valuable direction to those who are keen to consult with individual who experience mental illness in a respectful and deferential manner.

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