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How can I design a recovery-oriented e-learning website for people with mental health difficulties?

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Abstract

This paper presents my living theory, developed as I sought to improve my practice as a mental health professional, and as I answered my research question: "How can I design a recovery-oriented e-learning website for people with mental health difficulties?"

Information technology has the potential to increase learning opportunities, promote inclusion and improve the quality of life for people with mental health difficulties. However, this group currently experience significant inequalities in accessing and maximising the potential of online learning interventions, due to lack of consideration by designers of their specific learning, usability and accessibility needs.

In the course of my research, I attempted to use technology to enhance and support the learning of people with mental health difficulties in a day service in south Dublin, and to encourage a recovery-oriented mental health service delivery, which has hope, inclusion, learning by doing and group support as its guiding principles. This enquiry involved the design and evaluation of an e-learning website for this group of service users.

Keywords: E-Learning; Recovery; Mental Health; Living Theory; Usability; Accessibility.

1. MY CONTEXT

1.1. EVE CHERRYFIELD OS CENTRE

I am the assistant manager, or supervisor-in-charge, of EVE (Eastern Vocational Enterprises) Limited Cherryfield, a large occupational service (OS) centre providing training and rehabilitation services in Walkinstown, Dublin 12. EVE Cherryfield is one of 23 EVE Limited centres in the Greater Dublin area providing day services for people with mental health difficulties.

I have always had a firm belief in the provision of training and education as a means for individuals to exercise control over their lives. Over the years I have worked in EVE Limited, I have also come to believe in the power of technology to support the delivery of education for people with learning and cognitive difficulties, such as those with living with a mental illness.

1.2. RECOVERY IN MENTAL HEALTH

> Recovery "involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993, p. 20).

Mental illness affects over one in four European adults, and currently over 700,000 Irish people. It is estimated that by 2020, depression will be the highest ranking disease in the developed world (Mental Health Employment and Training Consultative Forum, 2007). Despite this, mental illness is still surrounded by a societal stigma which can have a catastrophic effect on a person's quality of life and contribute to social exclusion and isolation, exacerbating the personal trauma and symptoms of their disorder (Department of Health and Children, 2006).

For many years, mental health services have operated from a clinical model, where things were done 'to and not with' service users, disempowering and disenfranchising them, and further increasing the distress and debilitating effects of their illness (US Freedom Commission on Mental Health, 2003). However, these services are currently undergoing a paradigm shift in their ethos and practice, which is helping to build a more community-based and user-centred approach, informed by the principles of recovery.

Interest in the development of a recovery ethos and recovery-oriented service in mental health practice has grown considerably over the last fifteen years, and recovery has been adopted as public policy in the US, New Zealand and the UK (O'Hagan, 2001; Department of Health, 2001; US Freedom Commission on Mental Health, 2003). With the establishment of the Mental Health Commission in Ireland in 2002 and the release of 'A Vision for Change', the Department of Health and Children's national policy on mental health (2006), services in this country have begun to embrace recovery as the next stage in their development.

EVE Limited, as a frontline day service provider, considers itself at the vanguard of the Irish recovery movement and is committed to developing and delivering a "hope-

inspiring recovery-oriented service" (EVE Limited, 2008, p. 6). To meet this challenge, strategic objectives include raising awareness of the recovery model, programmes encouraging "collaboration between peers, people who use our services, and staff" (ibid., p.10), and evaluation tools to capture recovery-oriented processes and outcomes.

1.3. IT AND THE INTERNET IN MENTAL HEALTH SERVICE DELIVERY

In their Digital Divide Forum Report of 2005, the European Commission stated that IT (Information Technology) has the potential to improve inclusion and quality of life for its citizens, particularly those individuals who are at most disadvantage in society, including those with disabilities and mental illness. The report identifies the Internet as providing a means for such individuals to access information, contribute to society and access opportunities, including education, otherwise denied to them.

There is however, a considerable inequality in Internet access and usage, particularly among those with disabilities, learning difficulties and mental health issues in an Irish and European context. Current Irish policy for addressing this 'digital divide' is to improve IT literacy, access to technology and broadband access throughout the country, but as yet many people with disabilities have limited access and opportunity compared with the rest of the population (Gallagher et al., 2008).

The Internet can have the potential to help achieve the goals of a recovery-oriented service; service users can interact with each other in a dynamic environment, achieve a sense of independence and self-determination, and escape isolation and social stigma (Dobransky and Hargittai, 2006). McVanel-Viney et al. (2006) contend that mental health services should include recovery content in any e-learning programmes. However EVE Limited, like many other health service providers, "lack(s) a clear rationale for why they are developing and providing e-learning (online learning interventions)" (Mandinach, 2005, p. 1818) and has not embraced the opportunities the Internet provides to meet their objectives of promoting the recovery model and supporting recovery-oriented programmes and learning interventions.

1.4. WHAT ARE MY CONCERNS AS I RESEARCH MY PRACTICE?

The aim of this enquiry is to generate an explanation of my educational influences on myself and my practice. In adopting a living theory approach to my research (Whitehead and McNiff, 2006), I outline my concerns as I ask myself the question: how do I improve what I am doing? This research was carried out as part of the M.Sc. in Education and Training Management (e-Learning strand) at Dublin City University.

My primary concern is to use technology, specifically Internet-based e-learning, to enhance and support the learning and personal development of people with mental health difficulties, and to encourage a recovery-oriented mental health service delivery. My secondary concern is that such technology is appropriately designed for such users in a way

that maximises its potential, and does not constitute a barrier to learning or exacerbate the 'digital divide' (Dobransky and Hargittai, 2006).

The focus of my research was the design and development of a recovery-oriented e-learning website for mental health users in general, and EVE Cherryfield service users in particular. I evaluated this website, named EVE Cherryfield Online, in collaboration with a group of service users to determine if it is appropriately designed and helps to promote and support a recovery-oriented ethos and service delivery within my centre and throughout the EVE Limited organisation.

2. LITERATURE

I explored three main themes in the literature to inform my understanding of my research:

1. The Recovery Model in Mental Health
2. Web Design for People with Mental Health Difficulties
3. Developing E-Learning Content for People with Mental Health Difficulties

2.1. THE RECOVERY MODEL IN MENTAL HEALTH

The traditional, medical model of mental health has, in the past, narrowly focused on "symptom reduction, rapid stabilisation and interventions… individuals are seen in terms of their illness" (Swarbrick, 2006, p. 312), an approach which often overlooks a person's interests, skills and potential to achieve personal goals (ibid.). In recent times, however, the study and practice of mental health has been moving from "a focus on pathology and decline towards a recovery paradigm" (McVanel-Viney, 2006). Recovery in this context is not synonymous with a 'cure' for mental illness; rather it is distinguished by "its emphasis on the individual's active participation in self-help activities" (Jacobson and Greenley, 2001, p. 483).

William Anthony, in his seminal article *Recovery from Mental Illness* (1993), predicted the rise of the recovery model in mental health services throughout the 1990s, and how this would come to inform the vision and strategies of these services. He outlined what he believed to be the main principles of a recovery-oriented service, or what he called 'assumptions', including: that mental health professionals are facilitators of a person's recovery, but recovery itself is the task of the individual; the importance of non-mental health services such as education, sports and peer support; that recovery can occur even though symptoms reoccur; and the understanding that recovery is not a linear process, that setbacks and periods of little change will occur on the road to recovery.

At a more personal level, Mary Ellen Copeland, having experienced many years of mental illness, and frustrated at the lack of hope or constructive wellness strategies or programmes available to her, through personal research, peer support and advocacy initiatives, developed the Wellness Recovery Action Plan (WRAP) system (Copeland, 1997). She believes that this system has helped her to achieve long-term wellness and stability and

can be used to bring recovery to others. WRAP encourages mental health service users to learn recovery and self-management skills and strategies for dealing with mental health difficulties and symptoms in order to improve their wellness and quality of life, adopting five key recovery concepts of hope, personal responsibility education, self advocacy, and group support as the foundation of an individual's effective recovery.

As a mental health service closely involved in the training and rehabilitation of people with mental health difficulties, EVE Limited can support the learning of its service users, and influence not only many of Anthony's (1993, 2000) recovery criteria, particularly lifelong learning, empowerment, self-advocacy and development, but also the collaborative and social element of learning, peer support and self-determination espoused by Mary Ellen Copeland (1997). Learning tools in information technology (IT), here described as e-learning, can provide opportunities for users to direct their own learning, as well as improve their social and collaborative skills, factors central to the recovery model (Grabinger et al., 2008).

2.2. WEB DESIGN FOR PEOPLE WITH MENTAL HEALTH DIFFICULTIES

> "One of the difficulties in designing a website for persons with mental illness… is that there has been no usability research on the types of designs that are effective" (Rotondi et al. 2007 p. 204).

The Internet and associated learning interventions, such as e-learning tools and websites, have the potential to help people with mental health difficulties escape social isolation and the stigma associated with mental health, increase their sense of independence and self-determination, improve the level and quality of communication with others, and support social interaction that would have otherwise been difficult (Dobransky and Hargittai, 2006). This suggests that an appropriately designed e-learning website could support the development of a recovery-orientation within my service.

To date, very little research has been published concerning the design, development or evaluation of e-learning websites for people with mental health difficulties (Rotondi et al., 2007) and this poses a challenge to the introduction of such a website as a framework to support recovery. In order to design a site which meets the needs of this user group, usability and accessibility concerns must be approached not just in the traditional sense, but also in a way which addresses the specific concerns of those with mental health issues, including cognitive impairments, effects of medication on concentration and memory, and social and learning issues pertinent to mental health users (Rotondi et al., 2007, Grabinger et al., 2008). In addition the evaluation of design elements must be a factor considered in judging the success of any e-learning intervention (Nielsen et al., 2001).

The World Wide Web Consortium (W3C) develops technologies and standards to maximise the potential of the Internet. It has developed guidelines for making web content more available to users with disabilities, providing access regardless of the situation or circumstances, and to enable them to find information more easily and quickly (World Wide Web Consortium, 1999; 2008). Some of the more general accessibility guidelines contained within these documents include:

- consistent layout and presentation

- clear navigation tools
- using clear and simple language throughout
- good contrast between foreground and background colours
- dividing large blocks of information into more manageable ones

Jakob Nielsen defines usability as a quality attribute assessing how easy user interfaces are to use, or more specifically, the methods for improving ease-of-use as part of the design process (Nielsen, 2000). He developed heuristic evaluation, a method of identifying usability problems in the design of computer software and Internet websites (Nielsen, 1994). In general, Nielsen believes in keeping it simple when designing instruction, advises consistency and clarity in colour design, navigation and search features, and warns designers against using flashy new web technologies such as animations and pop-ups at the expense of clear and precise content delivery and design (Nielsen, 2000).

Although the W3C guidelines and Nielsen's usability heuristics address many of the concerns of people with mental health difficulties, there is still a need to specifically meet the particular needs of this user group, some of which are not adequately addressed by these approaches. Many people who experience mental illnesses such as depression, bipolar disorder, anxiety disorders and schizophrenia can often experience cognitive, behavioural and learning difficulties associated with these disorders, including an inability to think logically, and a decrease in energy, concentration and memory (American Psychiatric Association, 1994). In addition, many of these symptoms can be exacerbated by the effects of medication taken during treatment of these disorders (ibid.). Such cognitive impairments can include detrimental effects on "attention, memory, language… problem solving and social interaction." (Grabinger et al., 2008 p. 65).

As many mental health users have issues learning and remembering the structure of a site and how to use it, Rotondi et al. (2007) recommend the benefits of a flat hierarchy, a simple design of the site where users need only navigate one or two pages deep to obtain desired content, as well as an emphasis on 'paging' over scrolling, so that most information is contained within the screen at any one time, minimising mouse usage which can often be a difficulty for target users. Other design features advised are the provision of a constant navigational toolbar at the side or bottom of each page (or both) and to minimise drop down menus and pop-ups (Rotondi et al., 2007).

Grabinger et al. (2008) present similar recommendations for design, and also state their hope that developers will make appropriate use of Web 2.0 technologies such as chat, video and blogging: "the field of (Web 2.0) applications gives us the opportunity to increasingly diversify teaching and, thus, improve learning accessibility for all students, not just those with disabilities" (p. 63). They advise that multiple forms of content and e-learning delivery can increase the retention and improve the learning of people with psychiatric disabilities.

2.3. DEVELOPING E-LEARNING CONTENT FOR PEOPLE WITH MENTAL HEALTH DIFFICULTIES

> "In addition to the cognitive benefits attained directly from education, the maintenance of social networks is also vital to mental health" (Githens, 2007, p. 332).

Similar to the design of the site, e-learning content and instructional design contained within it should consider established theory and best practice, while also examining the specific needs of people with mental health difficulties as its target user group (Grabinger et al., 2008). It is important that the development of content leads directly and seamlessly from the design stage (Gagne et al., 2005). Ravenscroft (2003) writes about the need for e-learning to "design for usability and plan for sociability" (p. 11). He also suggests that such instruction needs to focus on how to develop the learner's thinking and reasoning, whilst supporting social skills and making the learner take an active part in developing learning communities.

Second-generation Internet tools, including multimedia advances in video and audio, instant messaging, Chat facilities, and social networking sites such as Facebook, are very promising tools when applied to e-learning, and can encourage collaboration and interactivity or an 'architecture of participation' between learners (Kamel Boulos and Wheeler, 2007). Web 2.0 tools promote active and engaged learning, and can encourage users with disabilities due to its democratic and social nature, where content is never permanent and can be generated by users themselves (ibid.).

This suggests that an e-learning website for people with mental health difficulties should contain a number of different learning and instructional strategies that can suit the needs of different types of learners. Adopting this approach would give learners the freedom to choose their own path to learning advised by Copeland (1997) as a path to recovery: assuming a personal responsibility and the willingness to determine their own educational direction.

Kim and Baylor (2006) contend that what is often missing in e-learning is empathetic social encouragement and interaction with others. Kamel Boulos and Wheeler (2007) coin an exquisite phrase, 'architecture of participation', to describe the use of Web 2.0 social technologies such as Chat, video, text etc. to improve the learning process. The social aspect of e-learning cannot be underestimated (ibid.) as it can help support recovery-oriented collaboration, social activity and learning, the cornerstones of a recovery service (Anthony, 2000).

The learning theories and teaching strategies espoused by Vygotsky and others (Wood and Wood, 1996; Van Der Stuyf, 2002), in relation to collaboration and scaffolding techniques, or support systems for learners which are gradually taken away as a learner begins to achieve their goals independently, contain elements which echo those of a recovery-oriented service, and can be adapted to the needs of users with mental health difficulties. Grabinger et al. (2008) recommend the use of scaffolding techniques, multiple examples of online learning such as video, audio and games, a chat facility and instant messaging in support of web-based e-learning for users with psychiatric disabilities. Such approaches can be seen to follow the personal recovery principles of self-determination,

education, collaboration and peer support espoused by leading mental health recovery commentators (Copeland, 1997; Kelly and Gamble, 2005).

That is not to say that this approach is not without it own challenges in the mental health field. For example, not everyone may be comfortable and confident in a social learning setting, a particular issue for people with mental health difficulties (Barnes & Tynan, 2007). However, meeting the criteria of a recovery-oriented service through the adoption of social cognitive learning approaches, including scaffolding elements, may bring very positive results.

3. METHODOLOGY

3.1. ACTION RESEARCH LIVING THEORY

> "A living theory approach means that people produce accounts to show how and why they are claiming to have become better practitioners." (McNiff and Whitehead, 2000, p. 199).

Action research is defined by Elliot (1991) as "the study of a social situation with a view to improving the quality of action within it" (p. 69). This form of study concerns itself with the uniqueness of every situation, rather than seeking to produce theory which can be generalised across a larger population (Farren, 2008). By engaging in action research, practitioners decentralise the production of knowledge from the confines of academia and theorists, centralising instead the practitioner and their own context (Winter, 1998). Approaching research in this way also recognises and embraces the knowledge and experience of the reflective practitioner, where action research is "a voice with which to speak one's experience and one's ability to learn from that experience" (ibid. p. 54).

Whitehead's living theory approach (Whitehead, 1989) can be differentiated from other forms of action research in that it places the living 'I' at the centre of any enquiry. He proposes that education, including research, is a value-laden activity, and that practitioners must seek to live their values in their practice and use them as standards of judgement against which to evaluate their practice and learning. Central to this approach is the concept that "my values are often denied in my practice and I experience myself as a living contradiction" (McNiff and Whitehead, 2000). You may state that you believe in, or value, something, but for a variety of reasons may not be able to live, or practice, according to this value.

Living theory proposes that the researcher practitioner begin any enquiry with the question 'how do I improve my practice?', and from there seek to discover how well they are living their own values in their practice, developing an action plan to help structure such an enquiry (Whitehead and McNiff, 2006). The researcher then gathers evidence to show how they have developed their own learning and also how this learning has influenced the development of others, or the significance of the research. The theories developed are living theories; values are subject to change, theories develop and grow over time. Any claims that are made are subject to both personal and social validation, through personal reflection and the use of critical friends and validation groups (ibid.).

If I am to be ontologically and epistemologically honest, I feel that not only must I be involved in my research, but 'I' must be at the centre of my research, with my personal values as standards of judgment against which I, my practice and my research should be judged. I believe that research into my own practice necessitates active participation and reflection. I do not see myself as separate from the world, rather as one who "creates their own knowledge" (Whitehead and McNiff, 2006, p. 23).

3.2. MY EDUCATIONAL VALUES

The declaration of your values is the first step in a living theory approach to research, and will come to inform and influence every subsequent stage of the enquiry process (McNiff, 2002). My values are:

- *Hope:* the belief that things do and can improve and get better, for myself and for the people I work with who are dealing with mental illness.
- *DIY:* people learn through doing things for themselves, rather than a well-meaning educator or carer doing things for them. I have observed the latter approach many times in mental health and believe it to be counterproductive.
- *Self-paced and self-directed learning:* can improve the quality and efficacy of any learning experience, especially in adult learners with widely differing abilities.
- *Group support:* people achieve more working and learning together than alone.

3.3. DATA COLLECTION METHODS AND ANALYSIS

The data collected in the course of my research should show the action as it unfolds and be used to generate evidence to support any claims to knowledge or conclusions that I will make (Whitehead and McNiff, 2006). My analysis of this evidence should also contribute to a deeper understanding of the research issue by clearly identifying what is valuable, and demonstrating how the aims of my research have been realised (ibid.).

I used a variety of research methods or instruments for data collection, including learning journals, interviews and focus groups with participants and emails with course colleagues. An action research approach can lend itself primarily to qualitative methods such as individual interviews with service users, with data considered in context and a more in-depth and subtle analysis adopted (Denscombe, 2007). However, some elements of my research, such as the accessibility and usability evaluation of EVE Cherryfield Online, benefitted from a more specific, quantitative form of data collection and analysis (Mason 2002).

Working with people with mental health difficulties necessitates that any research that I undertake adheres to the strictest ethical framework. Whitehead & McNiff (2006, p. 77) call for "high moral awareness throughout, and an agreed framework of action." To this end I liaised with the EVE Ethics Committee and gained approval for my research in Summer 2008. This ethical approval has given me the green light to continue my research with users of my service. I developed information and consent forms for my research group, using a

framework recommended by the National Disability Authority (NDA) in their Guidelines for Including People with Disabilities in Research (2002). All research participants signed consent forms and most agreed that their image and real names could be used; where this consent was not given I have used false names.

3.4. RIGOUR AND VALIDITY

Detractors of an action research approach, mainly from the traditional, positivist school of research (Denscombe, 2007), argue that it is, by its very nature, subjective and biased in its interpretation of data and its conclusions (Winter, 1998). I believe that my research satisfies what has traditionally been considered the reliability and validity of its results, but which I prefer to define "in more appropriate terms such as quality, rigour and trustworthiness" (Golafshani, 2003, p. 602).

Winter's criteria of rigour in action research (Winter, 1989) are used to test any claim to knowledge and include dialectic critique, suggesting the questions: Is there a contradiction present in my research and have I attempted to resolve it; and have I used the different viewpoints and insights of programme colleagues, service users and others to socially construct my knowledge? Reflecting upon these criteria and my own values that emerge through my practice as living standards of judgement will test my claim to knowledge and add to the quality and trustworthiness of my research (Whitehead and McNiff, 2006).

Habermas (1984) suggests that any enquiry submit to his 'criteria of social validity', that the truth of any claim to knowledge is comprehensible, sincere and appropriate. I have used a validation group of colleagues on the M.Sc. in Education and Training Management (e-Learning) at Dublin City University (DCU) and others, as well as a 'critical friend', or someone external to my studies to review my research, to aid the validity of my claims in relation to these criteria (Whitehead & McNiff, 2006), and to examine any conclusions in the light of my standards of judgment.

In addition validation group meetings for our research group were structured around the following questions adapted from Habermas' framework of social validity and applied in a living theory context (Farren, 2006, p. 102):

4. Is the account of my learning comprehensible?
5. Is there sufficient evidence to justify the claims being made?
6. Are my educational values clearly revealed and justified?
7. Is there evidence of my learning in the learning of others?

By addressing Winter's criteria of rigour and Habermas' of social validity, my research and any claims and conclusions I make are authentic, trustworthy and thorough.

4. IMPLEMENTATION AND EVALUATION

4.1. INTRODUCTION

My implementation includes two main cycles of action research: the first began as I introduced service users to the EVE Cherryfield Online website and concerns the evaluation of the design elements in the site, around the areas of usability and accessibility, particularly for users with mental health issues. Having addressed the technical elements of design, the second cycle deals with my attempt to evaluate how well the website meets the needs of a recovery-oriented service.

4.2. THE GENESIS OF EVE CHERRYFIELD ONLINE

As part of the MSc in Education and Training Management (E-Learning Strand) coursework, I designed a website for my service called EVE Cherryfield Online and presented it, along with a rationale, to my peers. I received very positive feedback both from the group and my tutors, and this project appeared to be a viable framework for further research. As my research progressed, I developed and added a number of multimedia artefacts into my site, including video and audio elements, a customised search engine, and chat facility.

In my practice both as an instructor and manager, I encounter time constraints, and often have to contend with large group numbers and varying levels of ability. I have found that I am not always able to provide a space for users to learn at their own pace, or to do things for themselves without stepping in and helping them, educational values I hold dear; in this sense I experience myself as a 'living contradiction' (Whitehead, 1989). I believed that the EVE Cherryfield website could be a framework to improve this area of my practice.

4.3. CYCLE ONE: USABILITY AND ACCESSIBILITY EVALUATION

I consulted with EVE Cherryfield service users, placing a notice on the centre information board and inviting volunteers to take part in the study. 17 service users took part from a total group of approximately 65 in EVE Cherryfield. I consider the participation of service users in my research to be a cornerstone of my personal values as I pursue my research enquiry. By not genuinely involving them in this process, I would be contradicting my own values, and going against good practice in my field, both from an ethical perspective (National Disability Authority, 2002), and also from the perspective of a recovery-oriented service (Anthony, 2000), which encourages the input of service users at every stage of service delivery and development.

4.3.1. Usability and Accessibility Questionnaire

The first stage of my study concerned the usability and accessibility evaluation of the EVE Cherryfield Online site. 12 users were asked to look at three different Irish mental health websites, completing a brief questionnaire after each one:

1. the EVE Limited site (www.eve.ie)
2. the EVE Cherryfield Online site (http://www.eve.ie/cherryfield/)
3. Mental Health Ireland (www.mentalhealthireland.ie)

Service users were asked to complete three simple tasks, recommended by Nielsen (2000), to get them to use each website:

1. navigate to two different pages within each site
2. try to find the latest mental health news and information
3. discover contact information

I designed an initial usability and accessibility questionnaire, based on the W3C Web Accessibility Guidelines (W3C, 2008) and including elements of Nielsen's usability heuristics (Nielsen, 2000). Following the test, users were asked to complete the questionnaire, rating 30 separate statements from 1 to 5, whether they agreed strongly or disagreed strongly with the statement. Examples of the statements around usability and accessibility included:

- The home page is attractive
- The site's content makes me want to explore further
- Information is easy to read
- It is easy to find my way around the site
- My mistakes are easy to correct
- The site provides information in different ways e.g. video and audio
- Screens have the right amount of information

The results of these tests are presented in figures 1 and 2 below. The initial questionnaire results seem to show a strong preference for the EVE Cherryfield Online site in comparison with the other two sites in all areas of usability and accessibility, and there is also a marked difference when factors relevant to mental health users are taken into account.

Figure 1 shows the total ratings given by users to these statements and readers should consider *the lower score to be preferable*. Figure 2 represents the percentage of answers given as Agree Strongly (1) or Agree (2) with the statements mentioned above, with *the higher result being preferable in this case*.

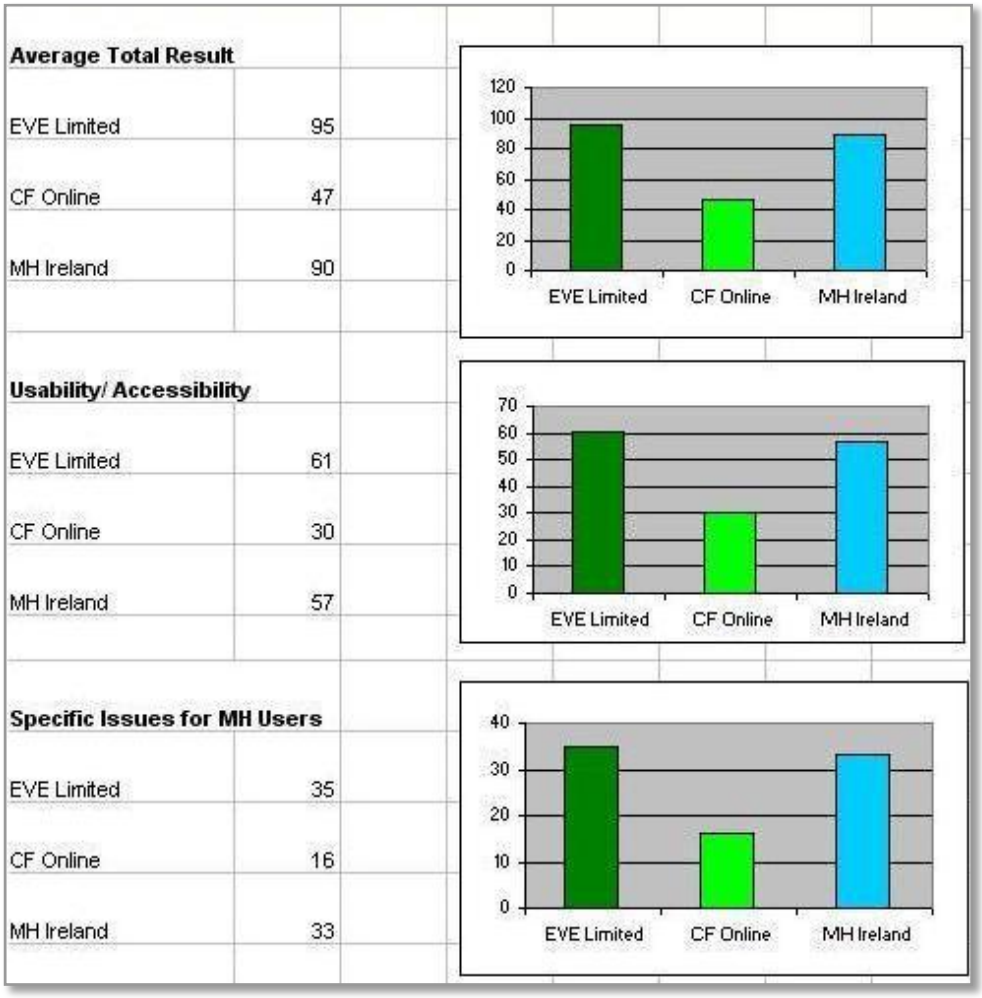


Figure 1. Data analysis

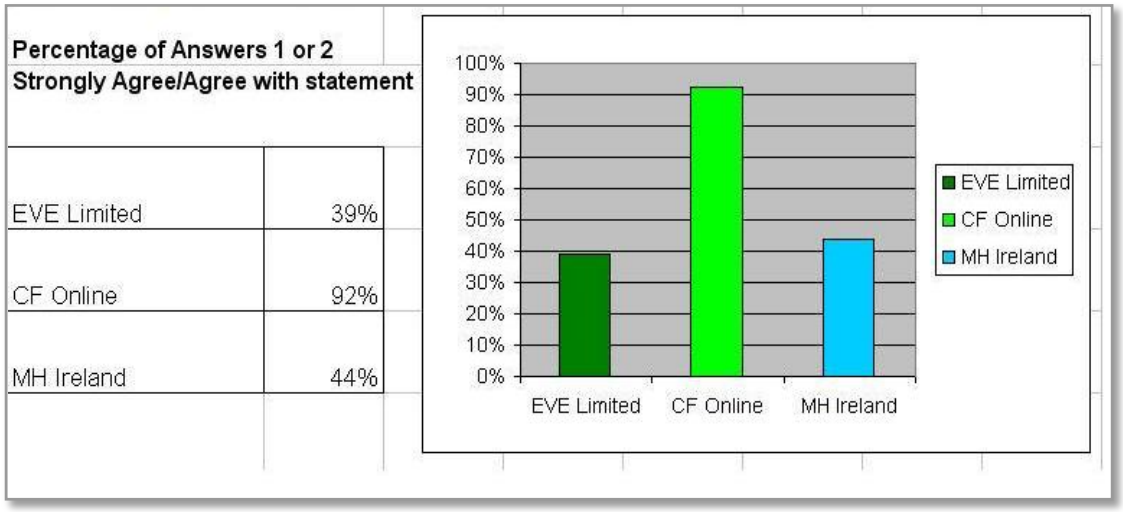


Figure 2. Percentage of answers 1 or 2 (*strongly agree/agree with statement*)

4.3.2. Focus Group Data

From the results of the questionnaire, I held focus groups with users to discuss what they thought of the results and, to delve deeper, why they thought that the EVE Cherryfield website was preferable to the others. These discussions suggested that by addressing the principles of the W3C accessibility guidelines (W3C, 2008), namely making information perceivable and understandable to users with disabilities, and by avoiding complex terminology and medical jargon, I have made the Cherryfield site more accessible to such users.

To focus on the navigation of the site, users felt that the use of clear, concise, and up-to-date information, as well as the consistency of language and presentation in the site (World Wide Web Consortium, 2008), also allowed them to access and understand information more easily. As I had followed the advice of Rotondi et al. (2007) by keeping to a flat hierarchy, minimising scrolling, and 'chunking' information on each screen, users seemed to find the site easier to navigate, and the amount of information was appropriate to their needs. They appreciated the presentation of content in multiple forms such as audio and video (Grabinger et al., 2008), features lacking in the other sites.

4.3.3. Interview Data

The themes that emerged in the focus group were also touched upon in the individual interviews I conducted later, firstly with Catherine (Video 1), who liked the customised search engine built around a scaffolding concept (Van Der Stuyf, 2002).

Video 1. Interview with Catherine

William and Mary T (videos 2 and 3), appreciated the different forms of content and consistency of layout and site structure.

Video 2. Interview with William

Video 3. Interview with Mary T.

The results of the questionnaire comparing EVE Cherryfield Online with other sites suggested that my research on usability and accessibility, with particular reference to the needs of mental health users in the design and development of EVE Cherryfield Online, its features and content, made it more suited to users of my service. The comments of users in the focus group and interviews generally seemed to confirm this, with most comments about the site in terms of usability and accessibility being very positive.

4.3.4. Reflection on Cycle One

I believed that I had gone a considerable distance towards addressing my concern that technology is designed with the needs of people with mental health difficulties in mind; I had shown that my website is appropriate to service users in terms of the design of its structure, tools and content, maximising their potential for learning, and does not exclude them on the grounds of their disability, as can be the case with many other similar sites.

The next stage of my research would seek to address my primary concern, that Internet-based e-learning could support a recovery-oriented mental health service delivery. This would necessitate going beyond the technical aspects of the site and its design: not only would I be evaluating the content and tools I had incorporated into the site in terms of its structure, learning elements, information and its delivery, but also examining how the site itself could contribute towards the recovery of its users.

4.4. CYCLE TWO: EVALUATING RECOVERY-ORIENTATION

I incorporated information about recovery into EVE Cherryfield Online to encourage users to learn about the model, and included avenues for further research by adding relevant links. I decided to use my stated values as standards against which to judge the efficacy of my site with service users, and its recovery-orientation. They are:

1. Hope
2. Learning by doing things for yourself
3. Self-paced/ self-directed learning
4. Support/ Group Support

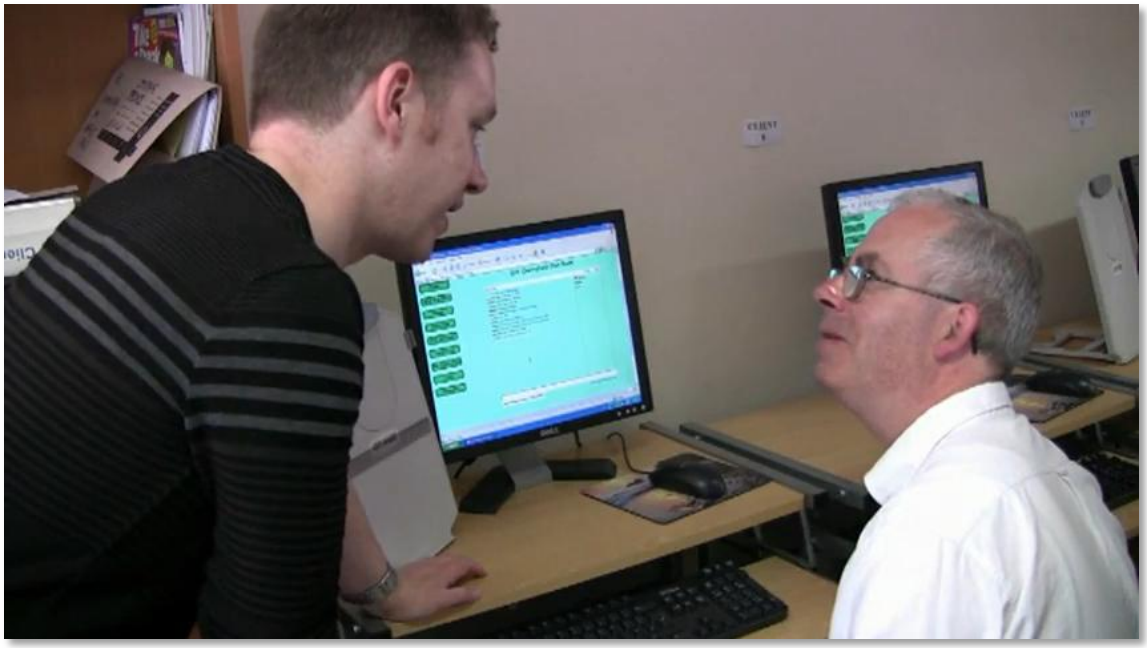
To achieve this, in May 2009 and following the usability and accessibility evaluation, I held two 45-minute sessions with users, looking more closely at some of the features built into the EVE Cherryfield site, including:

- The videos I had made of a centre tour and how to navigate the site
- The Chat facility
- The Customised Search Engine
- Links to computer training games and online IT training courses

The video links below provide examples of how I have taken some of my learning and shared it with others, and demonstrate how I have lived my values by encouraging learning

by doing and group support. In particular, they demonstrate the Chat facility, developed to encourage the group support element that is crucial in recovery, and the Customised Search Engine provided to encourage scaffolding techniques in learning (Van Der Stuyf, 2002).

Video 4. Working with users on features of the EVE Cherryfield online site



Video 5. EVE Cherryfield Chat Demo

Following these demonstrations, we discussed the site itself and whether the values stated above had emerged in its design, or became apparent in their own usage of the site. These values are also discussed in the video interviews with Catherine, William and Mary T.

Hope:

Hope is a hugely important element in the recovery model, and has often been lacking in mental health service delivery (Jacobson and Greenley, 2001). In their feedback users suggested that information in the site, and the learning users did around the recovery model, gave them hope that they were not alone on their journey.

Learning by doing things yourself (DIY):

This area produced a wide variety of comments and opinions, many very positive, about the EVE Cherryfield Online site. That users were able to learn for themselves by really using the elements built into it shows that, by addressing technical and design issues and minimising their impact on users' learning, I have given them the freedom to maximise their own learning experience, which is a primary goal of the website.

Conversation returned to the positive accounts and results around the site's usability and accessibility; users felt that the very factors that allowed them to use the site and its features empowered them to make their own choices, and influence their own learning.

Self-directed /self-paced learning:

The focus group discussions made it very clear that service users found this to be a very important capability of the site, to support their own learning and recovery. It was mentioned here, and elsewhere, however, that the site is not suitable for total computer novices. Some prior experience is necessary.

Support/ Group Support:

Users suggested that accessing relevant information, including the use of the customised search engine, can support them in their recovery. They also felt that the Chat facility on the website could be an important element of group support.

4.4.1. Reflection on Cycle Two

As I reflected on my own learning and my values, I began to see how those values were very similar to the principles espoused by a recovery-oriented mental health service (Anthony, 1993; 2000). My work in this cycle of research developed into a wider evaluation of the site's conformance with recovery principles and criteria, informed by my own personal values. I discovered that the principles of recovery can be a meaningless list until I can show what they mean in practice; in this case some have emerged as my own personal values.

4.5. REFLECTION ON MY RESEARCH ENQUIRY

The data from the usability and accessibility evaluation suggested to me that, in general, my learning around these areas and their application in the design of my website and development of its content had a very positive effect on the user experience of my research group. E-Learning elements, including video, audio, and other elements such as the customised search engine and Chat facility, received very positive feedback from the user group. In particular, I believe that the integration of design elements that other research has shown to be beneficial to mental health users (Rotondi et al., 2007; Grabinger et al., 2008), such as paging information into smaller sections, and the use of multiple delivery methods in the EVE Cherryfield site, allowed users to maximise their learning potential.

When I came to evaluate the recovery-orientation of the site, it was clear to me that by addressing the technical aspects of usability and accessibility for mental health users in my design, and removing barriers to their online experience, users had been free to fully appreciate the content of the site, particularly its learning and recovery elements. I believe that this has been an important factor to many users, and may be applicable in other instances of online learning interventions for users with mental health difficulties.

4.6. RIGOUR AND VALIDITY IN MY RESEARCH

To address issues of validity, I met with my dissertation supervisor, Margaret Farren, on a number of occasions between February and June 2009, both in DCU and using Skype online telephony, to discuss my progress and submit drafts of my dissertation. I also met with my critical friend, Howard Donnelly, on three occasions and corresponded regularly by email.

A final validation meeting took place in DCU on in May 2009 where the M.Sc. group elaborated and clarified their research accounts in the presence of Jack Whitehead, Margaret Farren and Yvonne Crotty. As I was unable to attend the meeting, Margaret suggested I video record my presentation and upload it to You Tube. My research account was presented at this session. In the video recording, I discussed the data I had gathered, and how I proposed to analyse and present my evidence. This presentation can be accessed on YouTube (Part 1, Part 2). After this validation session Jack Whitehead added an online response, and the following comment to my presentation:

> I want to share your second video-clip with my own students and in a practitioner-researcher e-seminar I convene because of its clarity about the issue of social validation. It's a most impressive statement of the way you intend to account for yourself and what you are doing in terms of your values. (J. Whitehead, personal communication, May 2009)

From the feedback I received on YouTube from Jack Whitehead, I believe that my research fulfils Habermas' criteria of social validity (Habermas, 1984), namely that my account as a practitioner researcher is comprehensible, truthful, sincere and appropriate to its context.

I believe that I have demonstrated how I have collaborated with others, using their viewpoints and observations to socially construct my knowledge, as well as encouraging and

including plurality, or multiple voices and data sources, throughout my enquiry, as recommended by Winter's criteria of rigour in action research (1989). I have addressed the rigour of my research by seeking to deal with what I saw as a contradiction in my practice, that I was not always able to live my values of encouraging learning by doing and self-paced and directed learning, by introducing and evaluating EVE Cherryfield Online as a learning tool for my service.

My main concern in facilitating the focus group sessions and conducting the interviews myself was that I not be seen as influencing the scope and direction of the conversations. This is always a possibility as I have worked closely with all participants in the past as part of my role as a mental health professional; also participants were aware that I had designed and developed the site and this could influence their responses.

My supervisor and outside reviewers did raise minor concerns around leading respondents, particularly in the one-to-one interviews. I believe that, given the particular needs of some of the participants, I, as interviewer felt it necessary to provide direction within the conversation at times, including framing possible responses to move the process along. I accept the comments raised as to my potential influence, as this can be an area of concern in disability research (NDA, 2002), and will certainly consider this issue in any future research.

I believe, however, that by structuring my evaluation as I have done by firstly conducting a usability and accessibility questionnaire, analysing the results in a focus group setting, and later in individual interviews based around themes emerging from the focus groups, and building my recovery evaluation around the principles of the recovery model has made a considerable contribution towards improving the validity of my research. I also acknowledge my potential influence at all stages with participants.

I feel it is very important to acknowledge the commitment and enthusiasm of service users in EVE Cherryfield who gave their time and considerable effort to support this enquiry. I like to think that they influenced my learning as much, if not more, as I influenced theirs. I consider their voices to be a critical element in this research, and I have done my best to capture these in the presentation of my living theory. I believe them to be the most relevant and important validation group for my enquiry.

5. CONCLUSIONS

I began my research in an attempt to improve my practice as a mental health professional, as I asked my research question "How can I design a recovery-oriented e-learning website for people with mental health difficulties?"

I have shown that through careful consideration of the learning needs of users with mental health issues in the design of EVE Cherryfield Online, I have allowed users to concentrate on the learning content and tools incorporated into the site. Because the site successfully applied my own learning and addressed elements of usability and accessibility, with particular reference to the needs of people with mental health difficulties, users did not feel excluded from the learning process and were able to explore the site freely, maximising

their own learning experience, and providing themselves with the means to continue their journey of recovery.

I believe that the ontological and epistemological viewpoint which informs an action research approach to enquiry is compatible with the principles of a genuinely recovery-oriented service. Recovery is a personal journey; each individual must be free to follow their own path (Copeland, 1997), and mental health services should seek to facilitate, and not hinder the individual from this course (Anthony, 2000). I believe that a positivist, or overly scientific and detached approach to research, enquiry and service development, as is currently the standard in mental health services, can often reduce service users to mere research subjects (NDA, 2002) and can be contradictory to the recovery model which seeks to allow individual voices to be heard.

The inclusion of service users contributed enormously to the success of the EVE Cherryfield Online website. It is my hope that the future development of EVE Cherryfield Online be similarly influenced by the opinions and voices of service users, and my recommendation that those services and organisations seeking to develop their own web presence will also give their service users a voice in this process.

It is also my hope that this research, informed by current Irish and international policy and literature in the areas of recovery in mental health and the provision of web-based e-learning for users with mental health difficulties, implemented through my own action research-based study, will inform the future development of e-learning interventions for such users. The website study has already generated a lot of interest in the service user and staff population of EVE Cherryfield, as well as from many other EVE centres and senior management within EVE Limited itself. It is my goal to use this research as a platform to drive the development of a similar online presence throughout the EVE organisation.

I have stated that I value hope, a belief in learning by doing, self-directed and self-paced learning, and group support, as I seek to improve my practice as a mental health professional involved in the education and rehabilitation of people with mental health difficulties. These values have driven my enquiry, have provided me with the energy and motivation to complete my research, and will continue to inform and influence me as I continue to improve my practice in the future

I believe that I have made a valuable contribution to my own living educational theory, and have gone a considerable distance towards addressing what I saw as a contradiction between my values and my practice. It is my hope that that I will continue to improve my practice, and that my values as they emerge and develop will provide me with energy and enthusiasm long into the future. I am ultimately driven by the belief that my work is valuable and rewarding, and makes a genuine difference to my life and the lives of the people I work with every day.

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Appendix A

Usability and Accessibility Questionnaire

Post Test Questionnaire – Usability and Accessibility

For our last activity I'm going to give you a short questionnaire that I would like you to fill out. The questionnaire will give you a series of statements about the Web site. I would like you to rate your agreement with each statement as follows:

1. **Strongly Agree**
2. **Agree**
3. **Neutral**
4. **Disagree**
5. **Strongly Disagree**

WEB SITE: _____ CANDIDATE: _____

STATEMENT		RATING
1.	The homepage is attractive.	
2.	The overall site is attractive.	
3.	The site's graphics are pleasing.	
4.	The site has a good balance of graphics versus text.	
5.	The colours used throughout the site are attractive.	
6.	The typography (lettering, headings, titles) is attractive.	
7.	The homepage's content makes me want to explore the site further.	
8.	It is easy to find my way around the site.	
9.	I can get to information quickly.	
10.	It is fun to explore the site.	
11.	It is easy to remember where to find things.	
12.	The homepage is attention-getting.	
13.	Information is easy to read.	

Post Test Survey (cont.)

STATEMENT		RATING
14.	The site is well-suited to first-time visitors.	
15.	The site is well-suited to repeat visitors.	
16.	The site is designed with me in mind.	
17.	The site's content interests me.	
18.	The site's content makes me want to explore further.	
19.	The site is exciting.	
20.	The site has a clear purpose.	

21.	Screens have the right amount of information.	
22.	Information is written in a style that suits me.	
23.	It is clear how screen elements (e.g., pop-ups, scrolling lists, menu options, etc.) work.	
24.	My mistakes were easy to correct.	
25.	I didn't have to navigate a lot to get to the information I need.	
26.	This site is suitable for use by people with mental health difficulties.	
27.	This site provides information in a number of different ways such as text, video, audio etc.	
28.	This site allows me to change the way information is presented to suit my needs.	
29.	This site offers me the opportunity to give feedback on my experiences using it.	
30.	The site met my needs.	

Appendix B

Cherryfield Online Focus Group TRANSCRIPTS

First Session (Usab/Access)
16.04.09

Present: *Ronan (Facilitator)*
Service Users: Leo, William, Michael, Olive, Joan, Catherine, Phyllis, Mark

R	We've looked at three different websites over the last number of sessions and we discussed the results of our questionnaire and survey. We looked at the Mental Health Ireland Website, the EVE Limited Website, and the website that I have designed for Cherryfield, EVE Cherryfield Online site. (*Gives general results of survey – see Data Analysis.xls*) What I want to ask you today, in general, is why you gave the EVE Cherryfield Online sites more positive results compared with the other two sites in terms of usability, accessibility and suitability for users of our service. Would anybody like to say anything around that?
JOAN	Well I found that it was done in layman's language, it was clear and precise. There was no medical terminology so it was easier to understand. It's also easier to get in and out of the links. For instance, I went into the News link and found all the latest information about the centre and mental health.
R	Did that compare favourably with the other sites?
CATHERINE	On the other sites it was very hard to find out the latest information and on the Cherryfield site it was very easy.
R	OK. Did anyone else feel that?
OLIVE	Yes it was better than the Mental Health Ireland site. That was gibberish to me. It was probably for doctors and nurses or whatever. The Cherryfield site it was much easier to get into the … (*with prompting*) I mean the pages and links.
MARK	I thought our website was better than any of the others. I liked the colours and thought it was easy to read – it wasn't battering you with big long words or anything like that. It was easier to get into all the different subjects. I thought the music…. (*with prompting*) sorry the video tour was very good and easy to follow.
R	Did anyone else feel the video helped them?
LEO	I thought it was very clear and easy to understand. Also that you could make the print large so you could read it properly. I could go through the programs (*pages?*) quickly no problem.
R	Did the other two websites have any video or audio on them that you could find?

All	No.
PHYLLIS	I felt that everything on the Cherryfield website was in our language – plain and simple.
WILLIAM	I agree with (LEO) and (PHYLLIS) and what they were just saying that it was easy to understand and simple to work.
R	When you say 'simple to work', what do you mean by that? Was the Cherryfield site 'simpler to work' than the other sites we looked at do you think?
WILLIAM	The other ones were harder to find stuff on them, were harder to get sometimes… and Cherryfield you could get like a light.
R	Why do you think that was? What made it easier?
CATHERINE	It's the way it's displayed and the way the links are all on one side so you can go in and out of different things. Also the font size you could enlarge it and that's good for people who are visually impaired so you could make it as large as they need.
R	On the other sites were the links harder to follow or the text harder to read?
All	Harder. Yes.
JOAN	There was a lot of medical terminology which is more suited to doctors and nurses not service users.
R	And what about the amount of information on each page (*on the Cherryfield site*)? Is there the right amount of information – too much or too little do you think?
MARK	Yeah it was perfect, you know what I mean?
R	And what about the other sites?
WILLIAM	Too much information. I don't know what it means or how to use it.
R	Thank you very much everybody. The information you have given me here today will be a really great help in making this website as good as it can be.

Second Session: (Recovery)
01.05.09

Present: *Ronan (Facilitator)*
Service Users: Matthew, Leo, William, Michael, Olive, Catherine, Phyllis, Mark

R	At this stage I just wanted to get your opinion on whether the Cherryfield website meets the needs of a recovery-oriented service. We've been talking a lot in the centre and have gone to training and meetings (as a group – both staff and service users) about recovery – recovery in mental health. Do you all remember talking about recovery over the last few months?
All	Yes (*emphatically*)
R	What I would like to find out is does the site help in any way towards recovery? Firstly do you feel that the site in any way give you a feeling of hope?
All	Yes.
R	(WILLIAM) you were the first to say yes there. Why do you think the site gives you hope?
WILLIAM	It gave me information on how to get help.
CATHERINE	I think recovery is a unique journey a person goes through in order to be well and enjoy life again and I found the Recovery link (*on the website*) informative.
MATTHEW	It gives you information and lets you know about it. About recovery.
MARK	I think that it shows me that I'm not alone – there's other people out there with similar… I'll call it illness. The site helped me feel that with the information on recovery.
CATHERINE	Cherryfield also gives us support to help us in our recovery.
R	I suppose then another question is does the site provide us with support – another factor in recovery? If so, what kind of support?
LEO	It's very easy to read up and understand about recovery and that on the website. It's easy to look it up yourself on the site.
MICHAEL	I think it's amazing when you think about how far we've come in computers here and looking up the website is great and looking up information about EVE and the management.
CATHERINE	If I want to look up about my illness which is depression, I can get into it directly and find out the various supports to help with depression rather than just use Google, the search on the website is better.
WILLIAM	It'll probably help people if they want to find Cherryfield, y'know. Cause there was no website when I came to join Cherryfield. There's more information there now than there was at that time. I only found out about it when my brother got me in as he's the one that went in to find out about it. Only for that….

R	So if you had been able to look up information about Cherryfield even if you weren't in Cherryfield as a service user…
WILLIAM	Yeah at that time there was no information at all on it only that my brother got me in.
CATHERINE	When I came to Cherryfield first we were just in a room and we were doing repetitive contract work. I found it unstimulating. Now since (manager) came and all the changes are made and all the new classes, variety of classes and choice has contributed towards my recovery.
R	OK. One of the factors in recovery is education – providing yourself with education and knowledge so do you feel that the Cherryfield website in any way provides this?
JOAN	Yes you find out about recovery on it.
LEO	And you learn new skills from it like the computer skills and information on the classes here in Cherryfield.
R	So if you didn't know all about the different classes available you could look up the website?
All	Yes
R	Do you think it helps people help themselves or direct their own learning. That would be another area of recovery to direct and pace you own learning. One of the reasons I designed the site was so that people could dip in and out of it- they could use it as they wanted. Do you feel that the site provides that or not?
WILLIAM	Yeah like I could look at the video of the centre tour any time I wanted to. But before I came here I could barely even look at a computer.
R	Do you think you would need some experience with computers before being able to use the site?
All	Yes
R	So was there anything you found difficult to do?
PHYLLIS	Well I found it difficult to click on some of the links but that wasn't anything to do with the site just that I'm not too good with the mouse and I need more practice with it.
MICHAEL	Everything becomes simpler once you get all the knowledge into your head. It becomes simple to use the site then.
R	Does the website help you to do things at your own pace?
All	Yes.
R	In what way does it do this?
CATHERINE	There's no pressure. You can just go in and out of different links (*pages*?). There's no pressure you can go at your own pace.
MATTHEW	Like (CATHERINE) just said you can do your own thing like, at your own speed.

R	Is that important?
All	Yes
CATHERINE	It is important for people with mental illness because if pressure is put on somebody with a mental illness it causes stress and stress contributes to depression.
PHYLLIS	I feel I'd have to do things very slow so it would sink in. I don't work well in a class where someone is just talking.
R	Like a 2 hour class on recovery for example.
PHYLLIS	Oh I couldn't do it.
R	What way could the site help you with that?
PHYLLIS	You do it in a slow way as you press the buttons. You take it in as you go along. Not too much information at the one time.
All	Yes. That's right.
LEO	You get confused when you've to press too many buttons – when there's too much coming at you on the computer, you know what I mean? You just feel if you could learn one thing a day even, you could learn all the information one day at a time. You're doing it slowly and then you can understand it easily then you know.
R	Do you think the site works that way?
LEO	It does. You can pick up things much easier to understand using the links and that.
R	We spent about a half an hour earlier today just going through some of the different features of the site properly (*this was after the initial usability and accessibility trials a few weeks ago*). Did you feel that was enough? Will you need help after this? Hands up who would feel comfortable at his stage using the site now themselves? (*5 out of 8 hands go up*) And those who feel they would maybe need a little bit more help and guidance? (*3 out of 8 hands go up*).
OLIVE	I find it a little confusing looking at the music (*videos?*). I need a bit of help with that.
R	Another section of recovery would be empowerment. This means giving yourself the ability to do things you want to do in order to get better, in order to improve your wellbeing. Think of the word 'power' – to give yourself power. Do you feel in any way does the Cherryfield website empower you as a person or a service user?
MARK	It makes you feel like you're part of it. Using the site and even taking part today makes me feel I'm part of things.
R	What about those participants who haven't been involved in testing the site like you have? Do you think it could empower them in any way?

LEO	Yes. Other people might feel they'd be able to understand more… (pause) about Cherryfield using the website. It's plain and clear, you know what I mean.
R	What about someone who hasn't attended Cherryfield before and comes across the website? Could it empower them without having been here today?
MARK	Well it's great to know that the information's out there. Knowing that at any time you can look it up on the computer, that it's there for them. All the information you need is there for you.
MICHAEL	It's great that you can go down to your library (*to access the Internet*) and you know you can be part of it even when you're not in the centre.
CATHERINE	The website offers you tools to educate yourself about your illness. So that would make you have responsibility for yourself.
R	And could that be a form of empowerment to give yourself responsibility like that?
OLIVE	I felt that way when I was using it. I thought the Cherryfield website was much better that the other ones.
R	And another thing (*within recovery*) that's tied in with that is helping yourself. In Cherryfield in general we have the approach where we don't do things for you, more that you're encouraged to do things for yourself. Do you think the website meets those needs, do you think it helps people do things for themselves? Do any of the links, or videos etc. help in that way?
MATTHEW	It helps you along as you're exploring it. It makes it more easier going.
R	Is the site something you would go back to again of your own accord?
All	Yes.
LEO	It's easy to follow.
R	Why would you go back?
MICHAEL	If you hadn't been in it for a while you'd be inquisitive to go back and try it again
LEO	And because it's interesting.
CATHERINE	It's related to your illness and it gives you information about recovery and empowerment and about hope. And these are the tools that will aid your recovery.
R	Would I be right to say that you are positive about the site?
All	Yes.
R	Is there anything that could be done better in it? Any ways that it could be improved? Anything you'd like to see that maybe isn't there?
WILLIAM	Everything seems to be alright in it.
JOAN	I feel more confident. The fact that I was able to use it – going in and out of the different links and to find relevant information.

R	Would the other sites we looked at have given you confidence or made you go back to them again
CATHERINE	No. The information is just not there or that I could find. For instance if you want to find out about recent mental health issues it's just not there, whereas on this (*Cherryfield*) website you just click into news and you have it.
R	Thank you very much everybody. The information you have given me here today will be a really great help in making this website as good as it can be.