

# Reflections on developing a blended learning recovery programme for family carers of people who experience mental ill-health

## Abstract

### Purpose

This paper reflects on the development of a recovery-oriented training programme for mental health care-givers. It considers the effectiveness of using participatory research methods that promote involvement of people with diverse expertise to co-produce this programme. It presents a rationale for developing recovery-oriented training, which employs blended learning, comprising face-to-face and e-learning.

### Design

A small advisory group consisting of professionals, experts-by-experience (service users) and -by-caring (care-givers), and an academic, developed a blended learning programme about the recovery approach for mental health carer-givers. This paper details the participatory approach supported by an action research cycle that contributed to the design of the programme, and the specific impact of experiential knowledge on its development.

### Findings

Reflections on the *advisory group process* are described that led to the co-production of the course. This leads to consideration of the value of using this research approach to develop a carer-focused programme. The *content* of the

recovery-oriented training programme is presented which adopts blended learning. This leads to discussion of potential of this format to improve carers' access to training.

## Originality

It is proposed that this recovery-oriented course, building on a previous study, has the potential to positively influence outcomes for the training programme participants (the care-givers) and the person they support. It is suggested that blended learning may in part overcome some of the barriers carers experience to accessing and participating in traditional interventions. Reflections on the process of co-production underline the value of participatory research in designing this recovery-oriented course for carers.

## Research paper

Keywords: mental ill-health, informal carers, recovery, training, blended learning, education programme

## Acknowledgements

Anglia Ruskin University provided internal funding to support the development of this research.

## Introduction

Carers often have a positive and beneficial role in supporting the recovery of their family member who experiences mental ill-health (Repper et al, 2008; Fox, 2017). They often know the service user well and understand what supports and what hinders their well-being (SRN, 2009). Yet, mental health caring can have a significant and negative impact on carers' well-being and life opportunities (Hastrup et al, 2011). Despite recognition of these two factors, there are limited interventions available to inform, support and enable carer-givers to care for themselves and for their family member effectively (Yesufu-Udechuku et al, 2015); although it must be acknowledged that care-givers also often experience hope, joy and optimism as they support the person using mental health services during their recovery (Repper et al, 2008).

This article describes a small scale project funded by Anglia Ruskin University in 2016, which builds on earlier related research completed by the first author in 2013 (Fox, 2013). This current study describes the development of a blended learning course<sup>1</sup> on recovery for carers of people who experience mental ill-health. The article explores the *process* of co-production by an advisory group that led to the development of the course and then presents the programme *content*. It considers the potential of the programme to support care-givers to care both more effectively for themselves and for the person who receives their care. The methodological

---

<sup>1</sup> Lopez-Perez et al (2011) drawing on Garrison & Kanuka (2004) define blended learning as 'the integration of traditional classroom methods with online activities (termed 'e-learning')'.

limitations of the study are considered and final conclusions are presented which highlight future research plans to deliver and evaluate this programme.

## **Background**

Family carers often play an important role in supporting the recovery of their relative with mental ill-health (Repper et al, 2008; Fox, 2017); and can provide effective care from their intimate knowledge of assisting the person who uses services. Evidence from the Open Dialogue (Seikkula and Olsen, 2003; Seikkula, 2011), a collaborative practice model, demonstrates the effectiveness of involving carers in the support of people using services by promoting a three-cornered partnership between professionals, service users and carers (Fox, 2017). In this intervention, mental health practitioners work with the whole system around the service user, comprising their family, friends and significant others, with the entire network making decisions to support the service user. Excellent outcomes have been achieved which comprise service users taking less mental health medication, neither relapsing nor returning to hospital and furthermore, overcoming the social exclusion often associated with mental ill-health (Seikkula, 2011). This underlines the importance of involving carers in the support of people who experience mental ill-health.

Moreover, although recovery has been advocated in UK as playing an important role in mental health service delivery (DH, 2011), carers have had limited opportunities to learn about this approach (SRN, 2009; Fox et al, 2015); and indeed, as discussed later, carers need to have greater knowledge and understanding in this area. At the

centre of recovery is a commitment to a belief that a person who experiences mental distress can lead a good life despite managing the limitations of living with their mental health condition (Repper and Perkins, 2003). Teaching carers about recovery and ensuring that this belief underpins their care, has the potential to support carers to develop a relationship with the care recipient based on positivity and hope; this provides an opportunity to improve both the relationship between the carer and the service user and increase the focus on positive outcomes.

Furthermore Mackay and Pakenham (2012) found that higher optimism, social support and better quality of the relationship between carer and the service user were associated with better adjustment for the person using services.

Despite evidence of the importance of involving carers in supporting their relatives' treatment (Seikkula and Olsen, 2003; Seikkula, 2011), interventions to support care-givers to provide effective care is lacking (Yesufu-Udechuku et al, 2015). Family therapy is one of the best known forms of carer interventions with an extensive evidence base for its utility (Burbach, 1996; Allen et al, 2013). Training developed by Burbach (1996), in this tradition, acknowledges the importance of diagnosis and the high Expressed Emotion tradition of behaviour management, but also builds on psycho-education (giving information about the mental health condition and diagnosis) by teaching carers how to problem-solve (enabling them to manage their behaviour in response to the service user's actions). However carers may have to commit a lot of time and travel a long distance to take part in such programmes; moreover research shows that these factors may be a barrier preventing carers from participating in either research or interventions (Taskenen et al, 2011).

In order to make training more accessible for carers, it is important to explore alternative formats for developing and implementing effective training programmes. Lobban et al. (2011) investigated how young care-givers themselves, believed that a carers training programme, The Relatives Education and Coping Toolkit, could be developed into a supported self-management intervention. They suggested essential components were information about: psychosis and the different treatments available; accessing help during a crisis; understanding the legal rights of relatives; and learning how to manage symptoms. In further research, Darcy et al (2011) emphasised the importance of involving service user expert experience in providing support to carers in receipt of an online intervention. In this approach, service users provided carers with information about mental ill-health which gave the carers an 'insider view point' about the nature of mental ill-health and how its impacts on service users' lives. It is important to propose alternative ways to deliver training to carers, and to consider barriers which hinder their access to traditional interventions.

The needs identified above, firstly for information on recovery, secondly for accessible training, and thirdly for the development of interventions in alternative media formats, make space for the potential development of innovative programmes that encompass a variety of learning formats and course designs that can respond to the needs that carers have. E-learning, by itself, is useful in a number of ways, as it allows people to organise their participation at convenient times (Johnson et al, 2010, Young and Randall, 2014) and reduces the need for travel (Johnson et al, 2010, Young and Randall, 2014). However online learning can fail to support the

development of a sense of community and peer support for training participants (Smyth et al, 2012). In contrast, blended learning with its combination of face-to-face and e-learning (Lopez-Perez et al, 2011), has greater potential than e-learning alone, because it facilitates increased peer support through the face-to-face elements (Smyth et al, 2012), overcoming the isolation experienced solely with e-learning. Indeed, Chien and Norman (2009) found that despite the lack of research aimed at identifying the effective ingredients of mutual support in mental health carers support groups, there is an increasing recognition of its benefits in delivering carer support. The evidence base makes the case for the potential of developing recovery training for mental health carers in an alternative media format, which promotes experiences of peer support as integral to its delivery.

Funding was awarded from Anglia Ruskin University in 2016 which enabled the first author to further develop the initial training programme on recovery that was described in Fox (2013). This article now sets out the methodology of the research; the following sections present the findings that highlight both the *process* of designing the programme and identify the *content* that has been developed. Finally discussion will focus on the potential utility of the course alongside the methodological limitation of the design.

## **Methodology**

This study utilised an action research methodology (Kemmis and Mc Taggart, 1988) to improve and develop a training programme on recovery. Action research is often

used to support practice-based inquiry (Winter and Munn-Giddings 2001) because its formative and iterative research model (Kemmis and Mc Taggart, 1988) allows improvements to be fed into the project as it develops. The training programme was developed with support from an advisory group led by the first author. This project built on participatory methods in which control of the research process was shared (Reason and Torbert, 2001) between the different members of the advisory group. This involvement sought to reflect Arnstein's (1969) ladder of participation where citizens hold power through a partnership approach.

The group consisted of two carers A-M S (second author), and Carer 2, a service user, representatives from the local Recovery College and another professional who works with carers in the local mental health early intervention team (LK, third author). Each member was invited to attend and contribute to the course development because of their expertise and interest in this field. Involving carers directly in designing this course, helped ensure that the training reflected the expressed needs of family carers and built on their wisdom. Accordingly Beresford (2001) notes the value of including people in the research process who have diverse kinds of wisdom, knowledge, and relevant experience. This ensured the inclusion of practice, academic, experiential and caring perspectives in the co-production of the course.

Four meetings were held. Although the group comprised six members, it was regularly attended by a core of three participants and myself: LK (professional, third author), A-M S (carer, second author), who had been involved in developing and delivering the initial programme in Fox (2013) and carer 2, who was a governor of



the local mental health trust and had attended the original programme in 2013 as a participant. The service user representative attended once but was unwell throughout the period, and the two other invited professionals were unable to attend regularly. Only the three regular attendees were invited to the final meeting. Service users and carers were paid for their participation in the advisory group meetings and for travel expenses in recognition of the value of their contributions.

Figure 1: The action research cycle and process of developing the course.

We<sup>2</sup> built on the collective knowledge of the group members rather than merely focusing on my individual knowledge as a researcher. The action research cycle, detailed in Figure 1, shows how each of the four meetings fed into the development of the training programme. Meeting 1 reflected the *planning* stage of the action research cycle, meeting 2 the *act* stage, meeting 3 the *review* stage, and meeting 4 the *reflect* stage. Figure 1 illustrates the tasks undertaken in each of these meetings and how they accorded with the action research cycle. The collective processes depicted on the outside of the circle show how the group participated in *collective meaning-making* as they engaged in blue sky thinking, building on their knowledge and experience as they thought about the key components of this programme focused on recovery. The next stage depicts the *collective action* in which the group developed and agreed the blended learning format, commenting on the case studies

---

<sup>2</sup> In this section, we begin to refer to the first person, (I and we) as we reflect on our involvement in the project.

that comprised the e-learning component of the course. The third stage involves, *collective reflection* which led to the group recommending revisions to the course, and finally the group used *collective evaluation* of the whole project to lead to *forward planning*. Throughout the process, we continually reflected on programme developments for the action research cycle is ‘...a process which alternates continuously between inquiry and action, between practice and innovative thinking – a developmental spiral of practical decision-making and evaluation reflection’.

(Winter and Munn-Giddings, 2001, p. 5).

Detailed notes were taken of the meetings; and minutes recording the discussion, the agreed actions and decisions taken were circulated. Finally, in order to enable evaluation of the group process, short evaluation forms were circulated at the end of each advisory group meeting; the group members’ comments are presented as part of the reflections on the development of the course.

### *Ethical approval*

Ethical approval was gained from Anglia Ruskin University Ethics committee on 11.03.2016. Informed consent to participate in the research was obtained from all advisory group members.

## **Results**

### *Reflection on the process*

This section describes how the group process was underpinned by the action research cycle; it reveals the decisions we made about the content and format of the training programme and how these choices were linked to theoretical assumptions about the design of the course.

The group met in an advisory capacity four times during 2016: April, June, September and December. Their collaborative input directed the course development and design, and their different expertise contributed to the successful development of the course. The first meeting in April (Meeting 1), depicted in Figure 1, reflected the *planning* stage of the action research cycle. The group engaged in *collective meaning-making* as the discussion enabled us to explore the many different ways in which the programme could be developed, building on the carers' understanding and the value they placed on recovery. The two carers in the group both reflected on their own circumstances as people with limited time, who led busy lives and had caring commitments; they reported how learning about recovery had impacted positively on their lives as both had been involved in either directing or participating in the original 2013 programme. This discussion led us to think about both the content and format of the training programme and the theoretical assumptions we would make about its development: there should be a focus on the positivity of recovery, how it could indirectly improve outcomes for the care recipient, and how carers needed to have regard for their own recovery and well-being.

The carers conveyed some practical elements that should comprise the programme content: such as accessing a carer's assessment, and learning how carers could

take care of themselves. In reflection of their own experiences as carers with many time commitments, they recommended the consideration of either social media or online learning as a possible format for the educational programme. I had not previously considered developing the programme in an e-learning format, however following instruction from the advisory group meeting, I was asked to explore and report back the potential formats for the programme delivery; similarly we began to consider the content of the course and how the carers' reflections on the importance of recovery could inform the design.

After the first meeting LK recorded:

*Good conversation. Brainstorming. Small group facilitating. Good resource.*

A-M S recorded

*A comprehensive first meeting and I feel the project has legs again and is growing and developing in the best way to serve carers in the modern world.*

The participatory nature of the process is reflected in LK's comments above and how she felt the group as a whole could contribute to the project. A-M S reveals her investment in the project; she had been involved in developing and facilitating the original 2013 project and was excited to see it being re-designed.

In the second meeting in June (Meeting 2), reflecting the *act* stage of the action research cycle represented in Figure 1, we engaged in *collective action* to develop the programme. I presented some of the content I had read about the medium of 'e-

learning', particularly focusing on the utilisation of case study design reported in research into online midwifery education (Young and Randall, 2014), as is discussed in the next section. The service user representative suggested that all sessions could be online, offering a rolling programme of support. However key factors in the success of the programme delivered in Fox (2013) had been the elements of peer support that carers built through face-to-face learning; research similarly reinforces that mutual aid is effective in the development of carer support (Chien and Norman, 2009). After long discussion and reflection, we decided on a blended learning format that would combine both face-to-face and online learning.

After the second meeting LK recorded in response to what went well:

*Exchange of ideas. Clear planning. Ideas from different viewpoints.*

Carer 2 recorded in response to the same question:

*interaction.*

These comments reflected the group's ownership of the process as they talked about the inclusive nature of the group; they also reveal the collective processes of decision-making that governed the study, reflecting the participatory nature of the methodology.

The Faculty learning technologist (GE, fourth author) assisted in sourcing an appropriate learning management system for the programme and in setting up the learning activities. I developed some of the initial material for the course drawing on suggested topics and content from the advisory group. The case studies were sent

to the advisory group members for their comments and reactions, asking them: how would they respond as carer, service user, or practitioner to such a case? Paper drafts of the online programme with suggested responses to the case studies, and appropriate information web-links that would support future training participants to understand different aspects of recovery-oriented care, were then sent to social work team colleagues and to members of the advisory group for comment.

In the third meeting in September, (Meeting 3), the *review* phase of the action research cycle, illustrated in Figure 1, the blended learning programme was *collectively reviewed* on the white screen<sup>3</sup>. JF took the group through the learning activities. I (JF) wanted to develop collaborative online learning tasks to enable the carers to develop mutual support as they engaged in e-learning. However, the manager from the Recovery College, who attended this session, recommended that online tasks should be reflective rather than collaborative, with each task completed individually by each participant. This was to ensure that only appropriate information could be posted online, resolving potential issues we might encounter in moderating discussion. This recommendation related to experiences that she had encountered when setting up online learning courses for the local Recovery College. Thus, it was decided that rather than undertaking collaborative learning online, programme participants would be asked to individually reflect on the case study activities and

---

<sup>3</sup> A white board is a digital technology that allows information on the user's computer screen to be projected onto the wall onto a digital white screen. This enabled the members of the group to see the online activities that were displayed on the computer screen in order to discuss the suitability of the e-learning.

their responses would be shared electronically with me; these responses could then be anonymised and reported in the face-to-face discussions.

Amendments were made to the specific wording and the use of graphics within the course. For example, A-M S suggested that the word 'well-being' be featured alongside the word 'recovery,' as she felt this to be a less confusing idea for some carers who, from her experience, sometimes felt antipathy to the recovery concept<sup>4</sup>. Carer 2 also recommended that supplementary material should be available online if any course participants missed a face-to-face session.

At the third meeting LK responded to the question what went well:

*Good rapport, open discussions, positive people. Very structured.*

Carer 2 recorded:

*Discussion. Ideas generation*

LK records how we worked effectively as a team ensuring that all viewpoints were heard, but nevertheless that there was an effective plan of action as revealed in 'very structured'. Carer 2 similarly reflects on the open discussion in the group.

---

<sup>4</sup> Sometimes the concept of recovery is perceived as being word that denotes *cure* from mental illness; recovery was understood in the context of our study as emphasising that a service user can lead a good quality of life even though they continue to experience mental health symptoms which may place some limitations on their lives.

A fourth and final meeting was held in December (Meeting 4), in which the group reviewed the blended learning training programme. This incorporates the final element of the action research cycle of *reflection*, depicted in Figure 1, as *collective evaluation for forward planning* took place. Final evaluation of the process was mainly positive comprising:

*Yes, JF (first author) has worked extremely hard to use the ideas of the carers and recovery advisory group to make this project work. (LK).*

*I am pragmatic and am pleased to see the finished programme with blended learning set in. (A-M S)*

The group felt that the current plans for the programme were appropriate in the short term, but in the medium term, we should seek to develop the course with better graphics and design a brand to support its identity. Concerns were also expressed about the difficulty of accessing further funding to deliver and evaluate the course; there was some disappointment and concern that this work would stall. Suggestions for improvement of the meeting format were very practical, and included the provision of refreshments.

The action research cycle underpinned by participatory methods supported the successful *process* of developing the course, whilst the different perspectives of the advisory group members were helpful in determining the content and format of the programme. In the next section, the *content* of the training course is described.



### *The course content*

The training programme seeks to enable the carers to understand the principles of recovery and well-being through the medium of blended learning. The programme comprises three face-to-face sessions and two online sessions which are delivered over the course of three months. The three face-to-face sessions are supplemented by online material that provides opportunities for the participants to revise elements of the course. The online learning component features case studies, building on the work of Young and Randall (2014) who developed this format to deliver e-learning for midwifery students. This format enables the participants to reflect on the possible actions they might take in a situation that is partly removed from their own personal circumstances, reducing any potential distress that they may experience.

Approximately 10 – 12 participants would be recruited to take part in the programme, as this is an optimum group size (Doel and Sawdon, 1999).

The first face-to-face session focuses initially on agreeing guidelines for participation in the programme. The content enables the participants to reflect on the role of caring, encouraging the participants to consider their own health and well-being. Carers are introduced to the recovery concept and how recovery-focused care can facilitate a greater sense of hope and optimism for both themselves as the carer and for the service user.

The second session explores how carers can gain support for themselves. It is an online session utilising a case study approach. This case explores the emotions of

caring for a family member, explaining the rights to a Carer's Assessment by the local authority and its potential for being a positive experience. The second part of the online session encourages participants to complete an exercise to consider the process of recovery and how they themselves might have encountered similar experiences in their own lives.

The third session is conducted face-to-face and in this session participants share their own experiences of recovery upon which they reflected in the online session. JF shares her own journey of recovery, which can be found to be very powerful enabling the participants to learn about the reality of illness symptoms such as paranoia, psychosis and depression. The potential ways in which professionals can support recovery is then discussed with a focus on Wellness Recovery Action Planning (WRAP), a process which enables service users to recognise and evaluate their own wellness plans to support their recovery.

The fourth session builds on session three and is utilised online. A case study is presented to provide carers with information about the new professional roles and support processes which reflect a recovery approach to service provision. The use of direct payments and individual budgets are introduced and carers are encouraged to access web-links to different elements of recovery support, such as shared decision-making in mental health management, the Hearing Voices Network, and information on the role of peer support workers.

In the final session we reflect on a carer's own journey of recovery as well the service user's journey of recovery (Fox et al, 2015). We consider what elements

might comprise a carer's recovery and how that may contribute to their experiences of being able to live 'beyond' the illness of their relative and begin to see themselves as a 'parent', 'partner' 'sibling', 'adult child' or 'friend' of the person they support, rather than just as a 'carer'. At the end of the programme carers are encouraged to access further training offered by the local Recovery College; (for example, such as setting up your own group).

## **Discussion**

The next section explores the five aspects that are integral to the design of the training programme and contribute to the potential success of the course delivery. Firstly, the programme seeks to convey the importance that a recovery approach places on hope and optimism and its potential impact on both the carer and the care recipient; secondly, the training seeks to help carers to understand the direct experiences of service users, and how they and the service user may experience issues differently; thirdly, the programme seeks to connect with the wisdom from the diverse perspectives of the advisory group that influenced the design of the programme; fourthly the blended learning approach seeks to make the programme more accessible to participants than traditional programmes; finally the importance of peer support is recognised as integral to the development of this programme. Each of these aspects is discussed in more detail below but accords with components identified in the literature review as fundamental to the effective design of carer interventions.

Firstly the programme focuses on reinforcing hope and optimism for carers. This is key to building a sense of positivity in the lives of people who experience recovery. Moreover, teaching carers about the opportunities in recovery and encouraging them to apply this in their care-giving role, can indirectly improve the outcomes of the service user as they begin to focus on the potential for success in their lives (Repper and Perkins, 2003; SRN, 2009). This emphasis on optimism can also reduce carer burden (Fox et al, 2015) as care-givers begin to consider the prospects related to recovery, rather than the obstacles that hinder the service user from leading a good quality of life. These elements are at the centre of this newly developed course.

Secondly, research underlines the importance of enabling carers to understand the direct experience that service users have of mental ill-health and how their symptoms impact on their recovery (Fox et al, 2015). The importance of understanding this knowledge is clear in Darcy et al's (2011) research which identified the usefulness of service users and carers sharing information about their experiences of recovery; and it was also highlighted as important in the focus groups that Lobban et al (2011) conducted. Furthermore, although carers and service users may have different perspectives of living with mental ill-health, a clear understanding of the different experiences can support and improve their relationships (Fox, 2017); accordingly carers need to connect with and understand the lived experiences of service users. In order to achieve this, service user and carer expert experience must support the development and delivery of carer training.

Thirdly, the methodology of action research supported by a participatory approach (Reason and Torbert, 2001) ensured the involvement of experts from different backgrounds in the development of the training programme, as described in the presentation of the *process* of the research. This focus enables carers to relate to the real lived experiences of mental ill-health, and consequently learn how to support positive elements of their relative's recovery journey. Accordingly, in our course, the case studies and learning activities were developed by people embracing the spectrum of different expertise; and the course itself will be facilitated by both a service user (myself) and a carer (the second author). Both the service user and carer facilitator emphasise the hope and optimism central to the recovery approach which are important in the design of this and other interventions (Mackay and Pakenham, 2011).

Fourthly, the blended learning approach in this training programme, with the combination of face-to-face and e-learning has the potential to meet the needs of carers, who may have diverse care-giving experiences; it may enable them to have more convenient access to training because caring and other occupational commitments may form a barrier to attending more traditional training (Taskenen et al, 2011). In order to be accessible, blended learning needs to be firstly intuitive in design (Jonas and Burns, 2010) as not all students are 'digital natives' (Jonas and Burns, 2010, Johnson et al, 2010, Farrington, 2014) and secondly, user-friendly as not all students able to access appropriate and effective technology (Jonas and Burns, 2010, Johnson et al, 2010, Farrington, 2014). In order to mitigate this, firstly, when our programme is delivered, an introductory session will be held prior to acceptance on the course to ensure that participants understand the nature of the

programme and are able to use the online resources. Secondly online material will be available in hard copy for those who require it to support their access; although an ability to utilise the programme online will form part of the necessary criteria to join the course.

Finally the face-to-face sessions developed in accordance with the blended learning format will enable the carers to build mutual aid, learning from each other's expertise; indeed Chien and Norman (2009) identify mutual and peer support as a central element in effective carer support. Moreover, in order to develop peer support further, the programme will be delivered to a closed group with a time-limited number of sessions (Doel and Sawdon, 1999); rather than offered as a rolling programme. Closed groups have a stable membership which often helps members to build mutual aid and support for each other more effectively than in open groups (Lindsey and Orton, 2014).

In summary, this programme recognises the importance of hope and optimism in mental health caring (Fox et al, 2015). It encourages carers to understand authentic service user experience (Fox, 2013). It is developed through the expertise of different stakeholders (Reason and Torbert, 2001) and it takes into account the busy lives of carers by offering training that is more accessible than traditional formats as it utilises a blended learning format. Finally it acknowledges the importance of mutual aid in developing carer support (Chien and Norman, 2009).

## **Limitations**

The blended learning course content created in this research built on a training programme which was developed from a small, exploratory study (Fox, 2013). The usefulness of the original course was evaluated through qualitative methods with a small sample of carers. These features perhaps highlight the limitations in the development of this current course and in the validity of its evidence base.

Lobban, et al (2013) reviewed the published evaluations of different family interventions in order to investigate the evidence of their effectiveness in improving outcomes for carers of people with psychosis, to identify the key elements of the content of effective intervention packages, and to identify methodological limitations in evaluating these interventions and how these can be addressed in future research. This study considered that in order to improve the validity of carers' interventions researchers should adhere more closely to Randomised Control Trial designs which used larger samples, true randomisation and blind assessors; and should use valid and reliable measures to evaluate their effectiveness. Although Lobban et al (2013) note that such approaches are seen as the gold standard in assessing the effectiveness of carers interventions; focusing only on such methods would firstly require many resources to evaluate the effectiveness of this programme; and secondly, more widely, would preclude the development of innovative and small scale interventions which have the potential to support carers in maintaining their well-being. Moreover this programme is currently in a developmental stage, which excludes such an evaluation format, however such plans might form the future direction of the study if it is found to be effective.

## **Conclusion**

This study has led to the development of a blended learning course for carers. The course focuses on improving carers' sense of hope and optimism (Mackay and Pakenham, 2012) through learning about recovery (Fox, et al, 2015). It provides carers with information about service provision and positive forms of recovery practice which are reported to be key to a carers' course (Fox et al, 2015). The format of the course enables the participants to undertake learning at times when it is most convenient, as blending learning proffers (Johnson et al, 2010, Young and Randall, 2014) but offers an opportunity for them to develop mutual peer support through facilitated group learning sessions, as important in carers' groups (Chien and Norman, 2009). This course presented in a blended learning format recognises the barriers to participation that time restraints place on family carer givers because of their caring responsibilities (Taskenen et al, 2011). The focus of delivery by a service user and a carer enables real lived experiences of mental distress to be shared with the carers, as important in best practice (Darcy et al, 2011). It builds on best practice examples of both blended learning and traditional face-to-face courses.

What are the next steps? Research shows that there can be many organisational enablers and barriers for developing and delivering blended learning courses. In education, academics may have to develop a course in their own time and may lack the skills and abilities to do this; moreover facilitating e-learning for students can lead to drain on academics' time (Jonas and Burns, 2010). Kiteley and Ormrod (2009) note that often e-learning is developed through a specific fund which means the course is not updated; they consider that sustainability needs to be built into designing e-learning modules and that academics need to work collaboratively with learning technologists to develop blended learning. The inclusion of learning



technologist expertise will therefore be central to future research development. Furthermore positive relationships have been built with influential staff and organisations during this period; this is a foundation to build future partnerships as we investigate further sources of funding to implement and deliver the programme.

## References

Allen, J, Burbach, F and Reibstein, J, (2013). 'A Different World' Individuals' experience of an integrated family intervention for psychosis and its contribution to recovery', *Psychology and Psychotherapy: Theory, Research and Practice* 86, 212–228

Arnstein, S.(1969) 'A Ladder Of Citizen Participation', *Journal of the American Planning Association*, 35: 4, 216 — 224

Beresford, P., (2001), 'Social work and social care: the struggle for knowledge'. *Educational Action Research* 9, 243 – 351.

Burbach, F. R. (1996), 'Family based interventions in psychosis – An overview of and comparison between family therapy and family management approaches', *Journal of Mental Health*, 5, 111–134.

Chien WT, Norman I., (2009), 'The effectiveness and active ingredients of mutual support groups for family caregivers of people with psychotic disorders: a literature review', *International Journal of Nursing Studies*, 46, 1604–23.

Darcy J, Brunsden, V & Hill, R., (2011), 'Exploring online support: informal caregivers' usage of a mental health discussion board', *Journal of CyberTherapy and Rehabilitation*. 4, 4, 477–482

Department of Health (2011) *No health without mental health: Delivering better mental health outcomes for people of all ages*, HMSO, London

Doel, M. and Sawdon, C. (1999) *The essential groupworker*. London: Jessica Kingsley Publishers.

Farrington, C, (2014), 'Blended e-learning and end of life care in nursing homes: a small-scale mixed-methods case study', *BMC Palliative Care*, 13, 31–47

Fox, J (2013) *An exploration of the role of carers in the recovery of people diagnosed with schizophrenia*, PhD: Anglia Ruskin University, Cambridge:

Fox, J, Ramon, S, Morant, N, (2015), 'Exploring the meaning of recovery for carers: Implications for social work practice', *The British Journal of Social Work*, 45 (suppl\_1): i117-i134.

Fox, J., 2017, 'Building on the recovery approach: the development of a conceptual model of service design for carers in mental health'. *Journal of Research, Policy and Practice*, 32,(3), 183-196

Hastrup, L, Van Den Berg, B, & Gyrd-Hansen, D. (2011), 'Do informal caregivers in mental illness feel more burdened? A comparative study of mental versus somatic illnesses', *Scandinavian Journal of Public Health*, 39, 598–607

Garrison, D. R., & Kanuka, H. (2004). 'Blended learning: uncovering its transformative potential in higher education'. *The Internet and Higher Education*, 7, 2, 95–105.

Johnson N, List-Ivankovic J, Eboh, W., Ireland, J, Adams D, Mowatt E, Martindale, S., (2010), 'Research and evidence based practice: Using a blended approach to teaching and learning in undergraduate nurse education', *Nurse Education in Practice* 10, 43–47

Jonas, D, and Burns, B, (2010), 'The transition to blended e-learning. Changing the focus of educational delivery in children's pain management', *Nurse Education in Practice*, 10, 1–7

Kemmis, S. and Mc Taggart, R. (1988). *The action research planner*. Deakin University Press, Victoria

Kiteley, R, Ormrod, G, (2009) 'Towards a team-based, collaborative approach to embedding e-learning within undergraduate nursing programmes', *Nurse Education Today* 29, 623–629

Lindsay, T., and Orton, S., (2014). *Groupwork Practice in Social Work*. London: Learning Matters.

López-Pérez, M, Pérez-López, CM. Rodríguez-Ariza, L, (2011), 'Blended learning in higher education: Students' perceptions and their relation to outcomes', *Computers & Education* 56, 818–826

Lobban F, Postlethwaite A, Glentworth D, Pinfold V, Wainwright L, Dunn G, et al.(2013), 'A systematic review of randomised controlled trials of interventions reporting outcomes for relatives of people with psychosis'. *Clinical Psychological Review*; 33, 372–82.

Lobban, F., Glentworth, D., Haddock, G., Wainwright, L., Clancy, A., Bentley, R., et al. (2011), 'The views of relatives of young people with psychosis on how to design a Relatives Education And Coping Toolkit (REACT)', *Journal of Mental Health*, 20, 567–579.

Mackay, C & Pakenham, K. (2012). 'A Stress and Coping Model of Adjustment to Caring for an Adult with Mental Illness', *Journal of Community Mental Health*, 48, 450–462

Reason, P., and Torbert, W.R., (2001), 'Toward a transformational science: a further look at the scientific merits of action research', *Concepts and Transformations*, 6, 1, 1–37.

Repper, J. and Perkins, R., (2003), *Social inclusion and recovery: a model for mental health practice*, Bailliere Tindall, Edinburgh

Repper, J., Nolan, M., Grant, G., and Curran, M.,(2008). *Family carers on the Margins: Experiences of Assessment in Mental Health. Report to the National Coordinating Centre for NHS Service Delivery and Organisation R&D. NCCSDO*, London

Seikkula, J. (2011) 'Becoming dialogical: psychotherapy or a way of life?', *The Australian and New Zealand Journal of Family Therapy*, 32, 3 179–193.

Seikkula, J. and Olsen, M.E. (2003) 'The open dialogue approach to acute psychosis', *Family Process*, 43, 3, 403–418.

Smyth, S, Houghton, C, Cooney, A, Casey, D, (2012), 'Students' experiences of blended learning across a range of postgraduate programmes', *Nurse Education Today* 32, 464–468

SRN (The Scottish Recovery Network), (2009). *Carers and supporting recovery: a report commissioned by the Scottish Recovery Network*, SRN, Glasgow

Tanskanen, S., Morant, N., Hinton, M., Lloyd-Evans, B., Crosby, M., Killaspy, H., Raine, R., Pilling, S., and Johnson, S., (2011), 'Service user and carer experiences of seeking help for a first episode of psychosis: a UK qualitative study', *BMC Psychiatry* 11, 157–168.

Winter, R. and Munn-Giddings, C., (2001), *A handbook for action research in health and social care*, Routledge, London and New York

Yesufu-Udechuku, A, Harrison, B, Mayo-Wilson, E, Young, N, Woodhams, P, Shiers, D, Kuipers, E, Kendall, T. (2015), 'Interventions to improve the experience of caring for people with severe mental illness: systematic review and meta-analysis', *The British Journal of Psychiatry*, 206, 268–274.

Young, N and Randall, J, (2014), 'The use of blended learning to create a module about ill-health during childbirth for pre-registration midwifery students', *Nurse Education in Practice* 14, 87-91

Figure 1: The action research cycle and process of developing the course.

