



The quality of the working alliance between chronic psychiatric patients and their case managers: process and outcomes

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Keywords: nurse–patient relations, professional–patient alliance, schizophrenia, therapeutic alliance, working alliance

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Accepted for publication: 29 March 2011

doi: 10.1111/j.1365-2850.2011.01741.x

Accessible summary

- The working alliance between chronic psychiatric patients and their case managers is an important vehicle for successful treatment and support.
- A good working alliance has a positive effect on the patient's functioning.
- The quality of a working alliance depends on both patient characteristics and the case manager's behaviour.
- The results indicate that working alliances are established in the first 3 months of a patient–case manager relationship.
- Further research into the development of working alliances is necessary.

Abstract

The concept of a working alliance is rooted in psychotherapy and has been studied extensively in that field. Much less research has been conducted into working alliances between chronic psychiatric patients and their case managers. The aim of this review was to identify what is known about the working alliance between chronic psychiatric patients and their case managers. An extensive survey of the literature produced 14 articles for this review. The results of studies conducted show that a good working alliance has positive effects on the functioning of patients, and that the quality of the alliance depends on both patient characteristics and the behaviour of the case managers. The results also indicate that the working alliance is largely determined in the first 3 months of the contact. Further research into the development of working alliances is necessary.

Introduction

The focus in theories on psychiatric nursing is generally on nurse–patient relations. We refer to Peplau's (1952) theory of interpersonal relations in nursing, Patterson & Zdenak's (1976) theory of humanistic nursing and King's (1981) theory of mutual goal setting. The most commonly used definition of a working alliance is that of Bordin (1979): 'Collaboration between the client and the counselor based

on the development of an attachment bond as well as a shared commitment to the goals and tasks of counseling.' In this definition the 'attachment bond' refers to the human relationship between the patient and the care provider, whereas 'goals' refer to the agreement upon outcomes, and 'tasks' to the mutually accepted responsibilities of patient and their care provider to achieve these goals. Bordin's definition makes clear that it is not only the agreements between patients and their care providers about goals and

tasks that are important, but that the development of a personal attachment bond is also material to that end. The quality of the working alliance depends on the strength of the agreement about goals and tasks, and on the strength of the attachment bond.

The concept of a working alliance is rooted in psychotherapy and has been the focus of extensive research in that discipline, showing that the working alliance in psychotherapeutic relationships is a good predictor of the results that can be achieved (Horvath & Symonds 1991, Martin *et al.* 2000, McCabe & Priebe 2004). Much less research has been conducted into working alliances between chronic psychiatric patients and their case managers. Although many publications refer to such alliances as being a significant contributing factor to the success of case management models (Marshall & Lockwood 1998, Marshall *et al.* 1998), it is unclear which precise factors impact the development of a good working alliance and whether the existence of a good working alliance does, in fact, have a positive influence on the functioning of patients from the target group of this review.

The aim of this literature review is to identify what is known about the working alliance between chronic psychiatric patients and their case managers. In the Dutch mental health care, case management teams consist of different disciplines (psychiatrist, nurse, social worker). The case manager is usually a community mental health nurse, who guides and supports chronic psychiatric patients in their daily lives in the community. They provide all kinds of practical support, and assist them in coping with symptoms of illness. Their position is similar to that of the community mental health nurse in British mental health care.

The focus of this review is on the working alliance between these case managers and chronic psychiatric patients. The main questions were as follows:

1. What is known about the relationship between: (i) the quality of working alliances between case managers and chronic psychiatric patients; and (ii) the level of the patients' personal and social functioning?
2. What is known about the relationship between: (i) specific characteristics of chronic psychiatric patients and case managers; and (ii) the quality of the working alliance existing between them?
3. What is known about the way in which working alliances between chronic psychiatric patients and case managers develop over time, and what role must be attributed to the context in which that development occurs?

Method

The Medline, Cinahl and Psycinfo databases were searched using the following keywords: working alliance, therapeutic

alliance, therapeutic relationship, nurse–patient relations and professional–patient relationship. All keywords were used in combination with schizophrenia, as that keyword was considered to be the most appropriate reference to the subject group of chronic psychiatric patients. The search period covered the period from 1980 to June 2010.

During the first round of selections, all titles and abstracts of publications found ($n = 814$) were reviewed in terms of relevance by two separate reviewers (M. dL., B. vM.). Publications were selected if they touched on the therapeutic alliance between chronic psychiatric patients and their mental healthcare providers in relation to any of the following subjects: the functioning of patients/outcomes of treatment, characteristics of care providers, context features and development of the working alliance. Upon agreement between the two reviewers, the full text of the publication was downloaded and examined. In case of dissent, the publication was downloaded for a new review during the second round of selections. In the first round, 47 abstracts were selected.

In assessing the full text of a publication, the reviewers narrowed the definition of 'mental healthcare providers' as a selection criterion. Papers discussing working alliances between patients and psychotherapists were excluded because the kind of working alliance described in those papers was different in nature from that to be examined in the context of this literature review. Following this second round, 26 publications remained.

The next step consisted of a quality review based on the criteria used by the Cochrane Library for appraising: (i) systematic reviews for observational studies; and (ii) randomized controlled trials. Qualitative research was assessed on the basis of the criteria formulated in the critical appraisal skills programme (Public Health Resource Unit 2006). The critical appraisal skills programme consists of 10 criteria to assess the quality of qualitative research.

The reviewers were eventually left with 14 papers which were included in this review.¹

The publications selected were first classified according to type of study: two reviews, 10 quantitative studies and two qualitative studies. Then, the publications found were organized by subject matter: nine of the papers discussed the effects of a working alliance on the patient's functioning; 11 addressed the characteristics of patients and case managers and the influence of those characteristics on the quality of the alliance; and three described the development

¹The list of publications excluded in the first round of selections is available from the authors.

of working alliances over time. Some of the studies covered two of these subject matters and were consequently used twice.

Results

Relationship between quality of alliance and functioning of patients

The literature reviews of Howgego *et al.* (2003) and McCabe & Priebe (2004) provide insight into the scientific literature available until 2003 and 2004, respectively, regarding the relationship between the quality of a working alliance and the functioning of the chronic psychiatric patient.

Howgego *et al.* (2003) examined seven studies (two meta-analyses and five research papers). Of these studies, five concerned working alliances in psychotherapy, the other two the working alliance in a case management context. The two case management studies discussed (Neale & Rosenheck 1995, Solomon *et al.* 1995) involved patients with a chronic psychiatric disorder, mostly schizophrenia, and with fairly high care demand levels. Based on these two case management studies the authors conclude that there was a significant relationship between the quality of the working alliance and the patient results, i.e. a decrease in symptoms, an improved level of functioning and social skills, an increase in the quality of life, better medication compliance and higher satisfaction with the care received.

McCabe & Priebe (2004) included 22 studies in their review, six of which concerned chronic psychiatric patients and their case managers (Gehrs & Goering 1994, Neale & Rosenheck 1995, Priebe & Gruyters 1995, Solomon *et al.* 1995, Klinkenberg *et al.* 1998, Tattan & Tarrier 2000). The larger number of publications discussed by McCabe and Priebe, as compared to the number reviewed by Howgego *et al.*, can be explained by the fact that McCabe and Priebe were less strict in their research methods and included studies which Howgego *et al.* excluded on the basis of quality criteria. In four of the case management studies assessed, the patients had several psychiatric disorders; the patients in the other two studies suffered from a psychotic disorder only. The correlation between the quality of the alliance and the patient outcomes was qualified as significant in two of the six studies, but no significant positive correlation was established in the other studies. In three of the six studies, the working alliance was assessed using the Working Alliance Inventory of Horvath & Greenberg (1989). The other studies were based on various other instruments. The quality of the working alliance was assessed from the perspective of either the

patients or the case managers, or from both perspectives. In five studies, the quality of the working alliance was assessed in both groups, whereas two studies measured only the quality of the alliance from the patients' perspective and one study focused on the quality of the alliance from the case managers' perspective. Based on the review of 22 studies McCabe and Priebe concluded that a relationship existed between the quality of the working alliance and improvements in the patients' level of functioning. This conclusion applied to people suffering from depression, addiction, psychoses or post-traumatic stress disorders. A similar relationship was identified in patients with mixed diagnoses. Furthermore, the authors concluded that, in relation to psychotic/schizophrenic patients, the views of the care providers about the quality of the working alliance were better predictors of the treatment results than the views of the patients. This conclusion contradicts that of the psychotherapy study, in which the patients' views about the working alliance were found to be better predictors of the treatment results. Concerning the six studies with chronic psychiatric patients we have to be more cautious in drawing conclusions because in only two of the six studies a positive correlation was found.

In summary, the quality of the working alliance between chronic psychiatric patients and case managers has been found to have positive effects regarding the following patient outcomes: decrease in symptoms, improved level of functioning, improved social skills, better quality of life, better medication compliance and higher satisfaction with the care received.

Characteristics of patients and case managers

The database search produced 11 publications of studies addressing the characteristics of patients and case managers as factors impacting the quality of the working alliance. In all studies concerned, the characteristics of the patients and case managers were treated as independent variables and the quality of the working alliance as the dependent variable. In four of the studies, an assertive community treatment team was the research subject, three studies involved various types of teams (including an assertive community treatment team and teams of consumers) and four studies contained no specification of the type of team involved. The type of study also varied. There were four cases in which the study involved a secondary analysis of data in the context of a more comprehensive study not primarily focusing on the quality of working alliances.

Several instruments were used to assess the quality of the working alliance. Five of the studies made use of different versions of the Working Alliance Inventory (Horvath &

Greenberg 1989). Self-constructed questionnaires were used in four studies and qualitative methods for the quality assessment of working alliances were applied in two other studies. In five studies, both the patients' views about the working alliance and those of the care providers were inventoried, whereas three studies gauged the patients' views only and three other studies focused exclusively on the views of the care providers. In eight of the studies, the quality of the working alliance was rated at a single point in time; in two studies, there were two reference points, and one study made use of three reference points. In almost all studies, the symptomatology of the patients was measured. Other variables in the various studies were: mental and social functioning of the patients, illness awareness, homelessness and substance abuse. None of the studies contained a quantitative specification of the characteristics of care providers.

As regards the patient characteristics affecting the quality of the working alliance, the following picture emerged from the studies.

Demographics appear to have little influence on the quality of the working alliance. Only the study conducted by Draine & Solomon (1996) reported that age was an influencing factor: older patients developed better working alliances than younger ones.

Patient characteristics which affect the quality of the working alliance are primarily in the domain of symptomatology, especially symptoms of hostility, mistrust, alienation, inadequate adaptation skills and lack of illness awareness (Klinkenberg *et al.* 1998, Calsyn *et al.* 1999, Neale & Rosenheck 2000, McCabe & Priebe 2003, Prince 2007). Other influencing factors are homelessness, avoiding behaviour and hospitalization.

Solomon *et al.* (1995) and Sells *et al.* (2006) compared teams of professional case managers to teams of persons with consumers. Sells *et al.* (2006) observed that after 6 months, the working alliance developed between the consumers and patients was better than that established between case managers and patients. However, Solomon *et al.* (1995) did not see differences in quality in the respective working alliances over the longer term.

The behaviour of case managers, as perceived by patients, has an effect on the quality of the working alliance. Two aspects are material in this regard: what case managers do and how they do it. The activities of case managers which have a positive impact on the working alliance are mainly practical in nature, such as providing activities of daily living support and practical assistance with transportation and other everyday activities (De Leeuw 2003; Calsyn *et al.* 2006). From the case managers' perspective, cash management support is also considered to have a positive impact on the working alliance. Patients do

not share this view; however, they consider assistance in the management of their cash to have a negative impact on the quality of the working alliance (Neale & Rosenheck 2000). Setting boundaries –, e.g. by means of cash management, forced admission or verbal force and insistence – also adversely affects the working alliance (Calsyn *et al.* 1999, Neale & Rosenheck 2000, Prince 2007). Furthermore, the quality of the working alliance is influenced by the case manager's style of counselling. Key positive elements of the working alliance are empathy and respect, and an eye for both the healthy and ill sides of the patient. Also important is the ability of case managers to be a 'friend', that is, to add something extra to the alliance, something beyond the regular care package (De Leeuw 2003, Borg & Kristiansen 2004). Continuity of care – reflected in availability, reachability, accessibility and frequency of contacts over a longer period of time – also contributes to the quality of the working alliance (Calsyn *et al.* 1999, 2006, De Leeuw 2003, Borg & Kristiansen 2004).

Although the number of studies is limited and diverse in nature, they do reveal some trends in patient- and case manager-related factors that influence the working alliance. Material patient characteristics are found in the domain of the symptoms, whereas for case managers, it is mainly their behaviour that impacts the working alliance. Positive behaviour is the provision of practical assistance; negative is the setting of boundaries. The studies reviewed do not make clear whether these elements are lasting in nature or are capable of change over time.

Development of the working alliance

The third question in this review concerns the changes which a working alliance undergoes over time. How does the working alliance change over time, and what causes the changes? This question involves an examination of factors related to the patients and case managers, but also factors in the context of treatment and counselling.

To analyse the development of a working alliance over time, the reviewers searched for publications which rated the quality of the working alliance at two or more points in time or which discussed the development of the working alliance retrospectively. Three relevant publications were found.

Klinkenberg *et al.* (1998) observed that the early stages of the working alliance formed a good predictor of the quality of the working alliance later on. Little hostility and mistrust combined with high contact frequency were precursors of a good working alliance at a later stage. At a certain point in time, the quality of the working alliance apparently stabilized: it did not improve, but did not worsen either. The general rule seems to be that a working

alliance that does not work from the start has little chance of improving at a later point in time.

Calsyn *et al.* (2006) concluded on the basis of assessments 3 and 15 months after the start of the working alliance that neither the patients nor the case managers considered the quality of the working alliance to have undergone any material changes. Their study also confirmed that the case manager's opinion about the quality of the working alliance after 3 months was a good predictor of the quality of the working alliance after 15 months. A downside of this study was that the quality of the working alliance was not assessed at the outset of the relationship. The first assessment did not take place until 3 months into the relationship.

The study of Chinman *et al.* (2000), involving a population of nearly 3000 homeless people, provided for three separate assessments: at the start and after 3 and 12 months of the working alliance. Chinman *et al.* confined themselves to the patients' perspective of the quality of the working alliance. They observed a significant improvement in quality after 3 months, but noted that the working alliance remained more or less stable between the 3rd and 12th month.

The results of these studies indicate that the quality of the working alliance between patients and case managers is mostly determined in the first 3 months of their relationship. After 3 months, little or no change occurs, so that the first 3 months are apparently crucial to the development of the working alliance.

Discussion

This literature review shows that a good working alliance has a positive effect on the functioning of patients. The quality of the working alliance, in turn, is influenced by the attitude of the case managers and the practical support they offer. Positive symptoms of the disorder, as well as situations like homelessness and hospitalization, have a negative effect on the quality of the working alliance. Another factor with a negative influence on the working alliance is the imposition of boundaries by case managers.

The limited research conducted to date points to a tentative conclusion that the quality of the working alliance is determined primarily during the first 3 months of the relationship between a patient and a case manager. After that, the quality remains fairly constant. However, none of the studies reviewed included patients with whom no working alliance whatsoever was formed and none of the studies contained a proper analysis of the research dropouts. The focus of the studies may thus have been primarily on patients who were willing to create a working alliance and accept care. 'Difficult' patients, with whom the develop-

ment of a working alliance might be more time-consuming or to no avail, have thus far been left out of the picture. Furthermore, none of the studies explain why the working alliance does not change to any significant extent after the first 3 months.

The considerations above do not necessarily mean, however, that only good working alliances remain intact. Patients and case managers may well continue their relationship, even when they have not built up a good working alliance, if either or both of them feel that a continuation of the relationship is beneficial. Patients, for example, may continue the relationship because it will guarantee access to healthcare facilities or to the provision of care in case of an emergency. Case managers will have other reasons, such as professional ethics, or simply having no choice but to continue their provision of support (De Leeuw 2003).

It might be useful to study not only the way in which good working alliances are maintained, but also the reasons why working alliances are unsuccessful in full or in part.

The studies reviewed show that working alliances can be assessed in a number of ways. There are, in fact, a great number of assessment instruments and methods available in this field. McCabe & Priebe (2004), for example, identified as many as 17. Many of the instruments have a patient version and a version for care providers. A few assess only the patients' views, or only those of the care providers. The downside of these differences in assessment method is that they prevent a full comparison between the studies conducted.

McCabe & Priebe (2003) observed that, for patients suffering from schizophrenia, the care provider's views about the quality of the working alliance were a better predictor of the results of treatment and counselling than the patients' views. Added to this was the fact that patients and care providers judged the treatment results in different ways: patients assessed their situation on the basis of 'subjective' factors, that is, through their own perception of personal circumstances, quality of life and treatment satisfaction; case managers used more 'objective' criteria, such as behavioural changes and decreases in symptoms, or in the gravity of the symptoms.

Given the different perspectives of desirable outcomes by patients and care providers, it is doubtful whether a comparison between the views of patients and care providers about the quality of their working alliance is useful.

The quantitative studies reviewed primarily provided information about the working alliance's determining variables and outcome variables, but failed to offer insight into the way in which those variables influenced the working alliance, or vice versa. Another complicating factor was that an independent variable in the one study was used as

a dependent variable in the other. An interesting variable in this regard was 'the presence of symptoms', as it was used as an independent variable in some of the studies and as a dependent variable in others. This may point to a circular connection: a decrease in symptoms will help improve the working alliance, and the improved alliance can contribute to a further decrease in symptoms. This hypothesis is supported by the finding that the setting of boundaries by case managers has an adverse effect on the working alliance. Case managers will be more inclined to set boundaries and impose restrictions (e.g. forced hospitalization, calling in law enforcement services) as patients have more symptoms and, as a result, exhibit more deviant behaviour. However, if the boundaries and restrictions initiated by care providers result in a decrease in symptoms, the room for the provision of practical support will expand, and practical support is precisely one of the activities which has a positive impact on the quality of the working alliance and, consequently, on the possibility of decreasing symptoms.

Practical recommendations

A good working alliance between chronic psychiatric patients and their case managers forms an important basis for the provision of quality care and contributes to the functioning of patients. Case managers will have to invest from the very beginning in building up a good working alliance with patients, as the first 3 months are crucial to the quality of the alliance. The provision of practical assistance and support aimed at the resolution of everyday problems burdening the patients appears to be a good angle for developing a working alliance which patients appreciate. During the first stages of the relationship, case managers should not focus too much on increasing a patient's illness awareness or on any undesired management of the symptoms. These issues are better discussed after a good working alliance has been created, at which stage the patient may be more receptive to advice. Developing a

good working alliance is clearly a difficult task, particularly when there are positive symptoms (such as mistrust) to be considered. It is evident from studies conducted that it is pointless to focus on those symptoms if patients are uncooperative. Case managers should, therefore, concentrate on practical matters in order to win the trust of patients and encourage them to undergo further treatment.

Not much is known at present of how working alliances develop over time. Future research into working alliances between chronic psychiatric patients and their case managers should focus on the processes involved as the alliance unfolds, which will require working alliance quality assessments at several points in time by means of diverse data sources. A purely quantitative approach will be insufficient to gain a better understanding of the development of working alliances, and a mere comparison of the views of patients and care providers on the basis of structured questionnaires will be useless given the discrepancies between their respective angles, which will only give rise to outcomes that are prone to divergent interpretations. A qualitative method is more suitable for a study into the views and perceptions of chronic psychiatric patients regarding the quality of the working alliance. For care providers, on the other hand, a structured questionnaire might well work. Longitudinal research and cohort studies will contribute to an enhanced understanding of the development of working alliances over a longer period of time. The studies should not only focus on the creation of a working alliance, but also on the question of whether a good working alliance is conducive to the treatment process.

Future studies should also include patient–case manager relationships which do not evolve into a working alliance or which develop into imperfect alliances that are nonetheless continued. It is these 'unsuccessful' relationships that should provide insight into the success and failure factors for good working alliances. Understanding and clarifying the views and perceptions of this difficult-to-reach group of chronic psychiatric patients poses a challenge to any researcher with an interest in working alliances.

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