"Life is Vanilla": Reconceptualising Recovery and Recovery-Oriented Practice in a

Hospital-based Mental Health Service

by

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Thesis

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Abstract

This thesis reconceptualises recovery and recovery-oriented practice in the context of admission to a hospital-based mental health service. While mental health reform in Australia introduced policies to support recovery-oriented practice, little has changed in inpatient settings focused on managing risk and remediating acute symptoms. Previous studies indicated that consumers' recovery experiences in this context may not mirror that of consumers living in the community. Using a Participatory Health Research approach, eight mental health professionals, a consumer advocate and an academic researcher formed a research partnership to understand recovery better and enhance recovery-oriented practice in a hospital-based mental health service. The methods comprised consumer focus groups (n = 17 participants), an online survey for staff (n = 17), and interviews with managers (n = 7). Co-researchers analysed the feedback from the consultations using inductive thematic analysis, identifying eight themes under three meta-themes: the conceptualisation of recovery, relational recovery, and recovery interventions. Three primary findings reflect the experience of recovery during an inpatient admission: 1) Recovery can be reconceptualised as a spectrum of experience from challenges to living well, including the existing CHIME processes and a new process, everyday living; 2). Relational recovery, encompassing connectedness, empowerment and hope, is key to recovery during a hospital admission; and 3) Interventions that enhance connectedness or reduce symptoms support recovery. Staff co-researchers actioned changes to their practice based on the findings, including introducing activities of everyday living, creating a visitors' book for consumers to share messages of hope, improved identification and support for carers, and commencing recovery planning earlier in an admission. Further research is required to validate the reconceptualisation of recovery as a spectrum, confirm the vital recovery processes during a hospital admission, and explore how Participatory Health Research can facilitate practice changes.

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Thank you to the consumers and staff who participated in the research. I hope that this research contributes to enhancing practice at Sunshine Clinic [pseudonym] and developing a better understanding of recovery.

Finally, I would like to thank my family and friends who have supported my study. Special thanks to my biggest cheerleaders, my parents and partner.

Candidate's Statement

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Nature of Candidate's Contribution

In conducting the study, I was responsible for the acquisition of data, analysis, interpretation

of data, and writing the manuscript. I conceptualised and designed the systematic review in

collaboration with my co-authors. All co-authors reviewed the manuscript and approved of

the final version. My contribution to the publication was 85%. My co-authors, Professor

Sarah Blunden and Dr Wendy Madsen, contributed 10% and five percent respectively.

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Table of Acronyms and Initialisms

CBPR	Community-Based Participatory Research
CEO	Chief Executive Officer
CHIME	Connectedness, Hope, Identity, Meaning and Empowerment
COAG	Council of Australian Governments
ECT	Electroconvulsive therapy
HREC	Human Research Ethics Committee
IMR	Illness Management and Recovery
IMR	Integrated Recovery-oriented Model
MAP	Motivational Aftercare Planning
MHN	Mental Health Nurses
MHRM	Mental Health Recovery Measure
MHRS	Mental Health Recovery Star
MHS	Mental Health Service
MORE	Mood Disorders Occupational Rehabilitation and Education
NUM	Nurse Unit Manager
OD	Open Dialogue
OT	Occupational Therapist
PAR	Participatory Action Research
PARIHS	Promoting Action on Research Implementation in Health Services
PET	Protected Engagement Time
PICU	Psychiatric Intensive Care Unit
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QATSDD	Quality Assessment Tool for Studies with Diverse Designs
QI	Quality Improvement
RAQ	Recovery Attitudes Questionnaire
RAS	Recovery Assessment Scale
RCT	Randomised Controlled Trial
RKI	Recovery Knowledge Inventory
RO	Recovery Oriented
ROCA	Recovery-Oriented Care Approach
ROP	Recovery Oriented Practice
RSA	Recovery Self-Assessment
rTMS	Repetitive Transcranial Magnetic Stimulation
SUPR	System of Unit Psychiatric Rehabilitation
VHA	Veterans' Health Affairs
WRAP	Wellness Recovery Action Plan

Chapter 1. Introduction

This thesis addresses the literature gap about recovery and recovery-oriented practice in the context of admission to a hospital-based mental health service. Examining this problem aims to expand our understanding of recovery during a hospital admission and inform recovery-oriented practice in this setting. Sections 1.1 to 1.3 introduce the concept of recovery and recovery-oriented practice, the research problem, question and assumptions, and the study's significance. Sections 1.4 to 1.6 describe the relationship between the thesis and research, its structure, and relevant terminology. The chapter concludes with a summary and my reflection on beginning this research.

1.1   Recovery and Recovery-Oriented Practice

Recovery is a complex concept, with many definitions identified in the literature (Jacob, 2015). Chapter 2 discusses the most robust conceptualisation of recovery, connectedness, hope, identity, meaning and empowerment (CHIME) (Leamy et al., 2011). However, studies validating CHIME were completed in community settings (Bird et al. 2014; Slade et al., 2012; Stuart et al., 2017; Van Weeghel et al., 2019) and we do not know if CHIME reflects the experience of consumers during a hospital admission. Chapter 3 identifies limited research on consumer perception of recovery in inpatient settings. In this context, consumers talked more about difficulties, including disconnectedness and hopelessness, than the positive processes of CHIME (Bredski et al., 2015; Eldal et al., 2019). Subsequently, the current research is required to understand recovery in the context of admission to a hospital-based mental health service.

The current study took place in a private, hospital-based mental health service located in a private general hospital in regional Australia. Understanding the context for this study required knowledge about the role of hospital-based mental health services and the national

policy that informs practice (Commonwealth of Australia, 2013a, 2013b) discussed in Chapter 2. While most mental health services are community-based, hospital-based mental health services still play a critical role in supporting people during acute illness episodes (Bowers, 2005). In hospital settings, medical interventions that promote clinical recovery predominate (Smith & Gridley, 2006; Waldemar et al., 2016). However, the national policy requires that practice also supports personal recovery (Commonwealth of Australia, 2013a, 2013b).

1.2   Significance of the Study

To date, there is limited research exploring recovery and implementation of recovery-oriented practice in inpatient settings (Osborn & Stein, 2019; Waldemar et al., 2016). National policy in Australia requires mental health services to support recovery (Commonwealth of Australia, 2013a, 2013b). However, a substantial barrier to implementation is that health professionals do not clearly understand what recovery-oriented practice looks like in an inpatient setting, resulting in recovery-oriented practice being more rhetoric than reality (Cleary et al., 2016; Slade & Hayward, 2007).

This thesis aims to expand our understanding of recovery in the context of a hospital admission and to inform recovery-oriented practice in this setting. This thesis contributes to this understanding in two ways. First, it reconceptualises the notion of recovery based on consumers' perception during a hospital admission. Second, it promotes understanding of what recovery elements are crucial during a hospital admission to help professionals identify which aspects of practice need to be more recovery-oriented.

1.3   Research Problem, Question and Assumptions

The problem addressed by this thesis is that we know little about how consumers conceptualise recovery in the context of admission to a hospital-based mental health

service. Therefore, professionals do not know how to support consumer recovery in this setting.

I identified this problem when working as a clinical psychologist in the mental health service that is the focus of this study. My role was to implement group therapy programs for consumers in the inpatient ward and a new day-patient service. I did not know how to be recovery-oriented while working within this medical model of practice. I looked at the literature for guidance and found limited research on recovery in hospital-based mental health services (Osborn & Stein, 2019; Waldemar et al., 2016). I wanted to contribute to developing research-based evidence to inform my practice and that of other professionals working in this setting. The Nurse Unit Manager and I talked about how we could collaboratively address this problem. At the time, I had the opportunity to commence my PhD and left the service to work at a local university. This change in my circumstances provided the opportunity to facilitate the project we had discussed on the ward.

We formed a research group comprising eight staff members, a consumer advocate and myself as the external researcher, and this is discussed further in Chapter 4. We anticipated that having a better understanding of recovery would help staff know how to better support recovery in this context. To achieve this end, we developed a research question: **How can we enhance and deliver recovery-oriented practice at Sunshine Clinic [pseudonym]?** Answering this question involved understanding consumers' recovery experience, what professionals were already doing that was helpful, and how we could improve practice. Inclusion of the word 'deliver' reflected co-researchers clear expectation that answering this question would contribute to research knowledge and practical action in the local setting.

At the commencement of the research, we had three assumptions about our study. First, we expected that consumers' who were accessing inpatient mental health services description of recovery would mirror Leamy et al.'s (2011) CHIME conceptualisation. We based this assumption on the evidence that several systematic reviews had validated Leamy's (2011) findings with consumers living in the community (Slade et al., 2012; Stuart et al., 2017; Van Weeghel et al., 2019) and accessing mental health services (Bird et al., 2014). Second, we expected to find that staff were already doing recovery-oriented activities. For example, several co-researchers facilitated recovery-oriented group programs and were involved in developing recovery care plans with consumers. Third, we thought there would be areas of practice that could be more recovery-oriented. This assumption stemmed from our collective experience working in the hospital-based mental health service where the medical model was the status quo.

I was an active participant in this study, so I maintained a reflective diary to document my biases, insights and reflections that impacted this research. Excerpts from my reflective diary are included at the end of chapters one to eight.

1.4   Research Approach and Methodology

This study used a Participatory Health Research approach from the initial research question to the methodology, analysis, and actions, detailed in Chapter 4. Participatory Health Research's central assumption is that the people whose life or practice is the study's focus are active participants in the research process (International Collaboration for Participatory Health Research, 2013; Wright et al., 2018). Research takes place *with* co-researchers rather than *on* subjects (Abma et al., 2019). A strength of Participatory Health Research is that it is flexible and innovative to meet the needs of the local community (Leavy, 2017). The methodology cannot be predetermined, but emerges through participants,

i.e., co-researchers, coming together to share their knowledge (Abma et al., 2019; Merriam, 2015).

Our co-researcher group choose to use qualitative methodology to answer our research question, including interviews, focus groups and a qualitative online survey. The focus groups provided a group setting, familiar to consumers, to communicate with researchers in a relaxed and flexible format (Bloomberg & Volpe, 2018). We designed the individual interviews with managers to capture their perspectives while maintaining their anonymity. The online survey provided all staff at the hospital with the opportunity to contribute to the research, in line with the value of maximising participation (Abma et al., 2019). The goal was to obtain comprehensive, richly-descriptive findings that reflected insiders' perspectives on recovery in the local setting (Merriam, 2015).

We chose inductive thematic analysis to analyse the data (Guest et al., 2011). Using thematic analysis allowed us to identify themes from our stakeholder's consultations and was relatively simple, thus empowering all co-researchers to participate in the data analysis. In the analysis phase, co-researchers collectively explored and analysed themes identified through our consultation with consumers and professionals.

We evaluated our research's quality using measures of trustworthiness and authenticity (Lincoln et al., 2011). Trustworthiness comprises credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). Authenticity is the extent to which the research is meaningful and useful (Guba & Lincoln, 1989; Schwandt et al., 2007).

The research partnership culminated in an action plan developed by co-researchers based on our findings, and we shared the action plan with all participants and key

stakeholders at the hospital. While the project formally finished after we disseminated the plan, staff co-researchers continued to action the outcomes, and I wrote the thesis.

1.5 Relationship between the Thesis and Research

Completing this Participatory Health Research thesis required two parallel and connected processes between my independent work of the thesis and collaboration with co-researchers to co-design and implement the research (see Figure 1-1.). The thesis process and the study incorporated planning, action and reflection phases, consistent with Kemmis et al.'s (2013) approach to participatory research.

Before commencing the research partnership, I completed a literature review for my PhD Confirmation of Candidature and sought ethics approval to form the research partnership. Once we started the partnership, which is discussed further in Chapter 4, I worked collaboratively with co-researchers to develop the research question and methodology. All co-researchers were part of the subsequent ethics application to consult with stakeholders, including consumer focus groups, individual interviews with managers and an online staff survey.

The consumer advocate and I co-facilitated the consumer focus groups, and I independently completed all interviews with managers. My role in the research group was to facilitate meetings and bring all critical decisions back to the group for discussion and agreement. All co-researchers participated in the inductive analysis and decision making about the themes identified through this process. Once we identified themes and sub-themes, I independently analysed and synthesised the research literature relevant to the thesis.

I shared knowledge learnt through the research literature with co-researchers. We collaboratively completed an assessment of the current recovery-oriented practice in

Sunshine Clinic and decided on priorities for action. Before finishing the research, we agreed

on how the research findings and action plan would be disseminated and reflected upon what

Figure 1-1

Conceptualisation of the research

we had learnt across the project. Once the study was complete, I wrote the thesis, including

the analysis and synthesis of the findings, and the implications for practice and research.

1.6   Structure of the Thesis

This section provides an overview of the chapters in the thesis. What is covered in

each chapter is briefly described, along with each chapter's contribution to the thesis.

Chapter 2. 'Recovery in the Australian Context' provides the background to the

emergence of recovery and mental health reform in the Australian context. The chapter also

provides an overview of research on recovery and recovery-oriented practice, the role of

inpatient mental health services, private hospitals, and the local context. This chapter situates

the current study in the broader social and research context.

Chapter 3. 'Recovery in Hospital-Based Mental Health Services' reports the findings of systematic reviews exploring recovery and recovery-oriented practice in hospital-based mental health services. The chapter reviews the conceptualisation of recovery and recovery-oriented practice in this context and explores how hospital-based mental health services have implemented recovery-oriented practice. This chapter provides research evidence against which to compare the current study's findings.

Chapter 4. 'Research Approach and Methodology' explains the Participatory Health Research approach and the qualitative methodology was used in the current study. This chapter provides a roadmap for other services to develop similar projects using a Participatory Health Research approach to practice improvement.

Chapters 5 to 8 present the study's findings and analysis and synthesis in relation to the research literature. Chapter 5 presents the findings of the conceptualisation of recovery in the context of a hospital admission. Chapters 6 and 7 present the findings of what staff do that supports consumer recovery. Chapter 8 brings together the findings from Chapters 5 to 7 to reconceptualise recovery and recovery-oriented practice in a hospital-based mental health service.

Chapter 9. 'Conclusions' summarises the findings, highlights the thesis's contribution, discusses the strengths and limitations of the research and makes recommendations for further research and practice.

1.7   Terminology

This section describes the key terms used in this thesis to clarify each term's application in this study.

Recovery. The research literature identifies four main types of recovery: clinical, personal, relational and service-defined. Clinical recovery equates to a cure and focuses on the remission of symptoms (Slade, 2013). Personal recovery is defined as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Commonwealth of Australia, 2013a, p. 17). Relational recovery is part of personal recovery, highlighting the interpersonal process of connectedness with others (Price-Robertson et al., 2017). Service-defined recovery measures recovery in service-defined terms, e.g., length of community tenure before re-admission (Schrank & Slade, 2007). The focus of this thesis is on personal recovery. The term 'recovery' refers to personal recovery, unless clinical, relational or service-defined recovery is explicitly stated.

Recovery-oriented practice. In the Australian National Mental Health Policy, recovery-oriented practice refers to applying capabilities that support consumers to "live a meaningful and contributing life" (Commonwealth of Australia, 2013a, p. 4). Recovery-oriented practice is what mental health professionals do to support consumers' recovery (Slade, 2013). In the literature, recovery-oriented practice has been referred to as an approach, a model, and a framework (Wimpenny, 2002). For clarity in this thesis, the term 'approach' will describe the general philosophy that supports recovery-oriented practice.

The Medical Model. Shah and Mountain's (2007, p. 191) definition of the medical model is used in this thesis, as it presents a simple overview of the model without interpretation of its strengths or shortcomings. "The medical model is a process whereby, informed by the best available evidence, doctors [health professionals] advise on, coordinate or deliver interventions for health improvement".

Co-researchers. The term 'co-researchers' describes the research partners directly involved in designing and implementing the Participatory Health Research project central to

this study. The words 'we' or 'our' refer to co-researchers, and the term 'I' is used when discussing my work concerning the thesis.

Consumer. While the term 'patient' continues to be used in hospital-based settings, the term 'consumers' is used in national mental health policy and practice guidance (Commonwealth of Australia, 2013b) and this thesis. The term 'consumer' refers to people with lived experience of mental health challengeses. The term 'patient' will be used verbatim in participants' quotes. I acknowledge that some consumers may prefer other terms, such as 'service user' or 'person with lived experience' (Commonwealth of Australia, 2013a); however, the term consumers will be used throughout this thesis for consistency.

Mental health challenges and mental illness. The term 'mental health challenges' refers to a broad range of issues impacting a person's mental health. The term 'mental illness' refers to acute symptoms and emotional distress experienced by a consumer during a hospital-based admission.

Professionals. The term 'professionals' refers to all staff working at the hospital. Professionals include a range of staff from administration officers to nurses, allied health professionals and managers.

Managers. The term 'managers' refers to the managers and consultant psychiatrists who participated in the study. Managers and consultant psychiatrists are grouped under the term 'managers' for this study as they are part of the service's management team. Each group was small, so combining them protected the anonymity of individual participants.

Use of Pseudonyms for Sunshine Clinic and Unity Hospital. The term 'Sunshine Clinic' is the pseudonym used to describe the current study's mental health service to

anonymise the service and participants. The term 'Unity Hospital' is the pseudonym used to refer to the private hospital where Sunshine Clinic is located.

Use of Pseudonyms for Participants. Pseudonyms are used for all participants in the study to protect their anonymity. The aliases used for professionals, managers, and co-researchers are gender-neutral to preserve participants' anonymity. These groups were predominately female; so male participants could have been identified by gender. Pseudonyms for managers are all names starting with 'R' to differentiate their responses from other professionals. The aliases used for consumers reflect the gender of participants.

1.8   Chapter Summary

This thesis aims to expand our understanding of recovery and recovery-oriented practice in the context of admission to a hospital-based mental health service. To better understand the local context, we sought to answer the research question: How can we collaboratively enhance and deliver recovery-oriented practice at Sunshine Clinic? Understanding recovery in this context was intended to help co-researchers to identify what aspects of their practice could be more recovery-oriented. I completed this Participatory Health Research project in collaboration with co-researchers and then analysed and synthesised of our findings as the thesis's independent work.

1.9   My Reflection: In the Beginning

I began this project with some trepidation. As a professional, I felt like an outsider stepping into a space that did not belong to me without lived experience of mental health challenges. I thought that I might be criticised by mental health advocates who did not believe I should have a voice in this discussion. I came from a position of power and privilege because of my background and professional standing. I had to empower my co-researchers and consumer participants to share the decision-making and control equitably. .

Also, I felt that for hospital-based mental health services to become more recovery-oriented, professionals needed to get involved and work with consumers to make this happen.

I wanted to make a difference in the local setting where I worked, and I wanted to do research with, rather than on, people. At the beginning of this project, I realised that Participatory Health Research is collaborative, action-oriented and reflective. I felt excited about this new way of working, like travelling in a new land. I could not pre-plan the trip with participatory research as I needed to take the journey with my co-researchers. It was interesting to be an active participant in the research process rather than a detached observer. My previous research used a positivist approach and quantitative methodology, with the project all neatly pre-planned. The current research turned my ideas about how to do research upside down.

Looking back, I think that choosing to do participatory research was a more difficult path to take than doing research planned and executed by the researcher. For me, doing participatory research involved slowing down to take the journey with my co-researchers and negotiating the unexpected turns along the way as we worked through 'knots', i.e., challenges, and changed our direction based on our learnings along the way. However, now I have paused to reflect on the journey, I can't see myself doing research any other way. It was so powerful to have people who the research affects actively involved in designing and implementing the study and bringing a wealth of lived experience in the local setting. It may have been a more challenging path, off the beaten track, but it was also more rewarding. As we did the project together, I could see changes to recovery-oriented practice happening in real-time, as my co-researcher applied their learning from the study directly into practice.

Chapter 2. Recovery in the Australian Context

This chapter aims to provide the background to recovery-oriented practice in Australian mental health services. Sections 2.1 to 2.2 detail the emergence of recovery and provide an overview of mental health reform in Australia. Section 2.3 reviews research on the conceptualisation of recovery. Sections 2.4 to 2.5 introduce recovery-oriented practice and discuss the tension between the medical model and the recovery approach. Section 2.6 discusses the characteristics of hospital-based mental health services, and Section 2.7 describes the local context. The chapter concludes with a summary and my reflection.

2.1   The Emergence of Recovery

The way people view mental illness has changed over several decades (Mental Health Commission of New South Wales, 2017; Piat & Sabetti, 2009). A driving force in that change has been the consumer movement, which developed in response to the poor treatment of people with mental illness in mental institutions in the 1960s to 1970s (Davidson, 2016; Rosen, 2006). The advocacy of the consumer movement, along with significant advancements in psychotropic medication (Noordsy et al., 2000) and economic drivers of policy reform in Australia (Gooding, 2017), such as the cost of maintaining institutional care, led to the deinstitutionalisation of mental health care.

The Burdekin Report (Human Rights and Equal Opportunity Commission, 1993) was scathing of the quality of mental health services and the dire lack of community support post-deinstitutionalisation across Australia. Professional practise continued to be defined by the medical model of treatment. However, consumers were developing radical new ideas about living well, with or without symptoms (Davidson, 2016; Piat & Sabetti, 2009). First-person narratives of peoples' lived experiences of mental illness started to emerge (e.g., Deegan, 1988; Houghton, 1982; Leete, 1989; Lovejoy, 1982). Reflecting on the themes

from personal accounts of recovery, Anthony (1993, p. 15) coined a definition of recovery that is still widely cited two decades on:

> Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Personal accounts described the process of recovery *in* mental illness, rather than recovery *from* mental illness (Rogers et al., 2005). Recovery *from* reflects the concept of clinical recovery, which focuses on the remission of symptoms or cure (Slade, 2009). Recovery *in* equates to the idea of personal recovery derived from consumers' lived experiences of living well with mental illness (South London and Maudsley NHS Foundation Trust, 2010). Personal recovery reflects personal, social and political factors rather than medical factors (Davidson et al., 2010). While the definitions provide a clear distinction between personal and clinical recovery, the relationship between these constructs remains unclear. Resnick (2004) and Andresen et al. (2010) found a relationship between the severity of clinical symptoms and personal recovery. Conversely, Macpherson et al.'s (2015) found no relationship between symptom reduction in clinical recovery and personal recovery outcomes. There has been insufficient research to date to conclusively say whether there is a relationship between clinical and personal recovery. Whether there is a relationship or not between these constructs is not the focus of this thesis. This thesis is trying to understand personal recovery in the context of an inpatient admission. We can't know if there is a relationship between personal recovery to clinical recovery until we first understand how personal recovery is conceptualised in the context of an inpatient admission.

Supporting the notion of recovery were the findings from outcomes studies which demonstrated that most people with a mental illness experience a significant improvement in symptoms over time, with some people experiencing a full clinical recovery and others learning to live meaningful lives with residual symptoms (Bleuler, 1968; Ciompi & Clemens, 1980; Harding et al., 1987a, 1987b; Huber et al., 1975). These findings contrasted with the long-held belief that serious mental illnesses, such as schizophrenia, were chronic with a worsening trajectory (Clemmensen et al., 2012; Liberman et al., 2002; Ridgway, 2001). The weight of evidence from long-term outcome studies accumulated across several decades, with studies reporting varying degrees of remission of symptoms over time, ranging from two-thirds to less than a half of clinical samples (Rogers et al., 2005).

In the 1970s to 1980s, consumers were starting to access community-based health programs, outside of psychiatric hospitals (Smith & Gridley, 2006). By the 1990s, most public inpatient mental health services were based in general hospitals rather than stand-alone psychiatric hospitals (Vrklevski et al., 2017; Western Australia Centre for Mental Health Policy Research, 2008). The private sector simultaneously developed inpatient services accessed by consumers with private health insurance. These services tended to deal with less severe presentations and had a higher demand for psychotherapy (Rosen, 2006). The 1990s also saw the commencement of national mental health reform in Australia.

2.2   Mental Health Reform

This section describes the reform of the mental health system in Australia to support recovery. The focus is on policy, implementation plans and practice guidance (see Figure 2-1).

In 1992, the Australian Health Ministers endorsed the first National Mental Health Strategy to promote the mental health of Australians, preventing mental disorders, reducing

Figure 2-1

Mental health reform in Australia

the impact of mental disorders and assuring the rights of people with mental illness

(Department of Health, 2014). The National Mental Health Strategy's introduction was

timely, given the poor state of mental health care in Australia, as highlighted by the Burdekin

Report (Human Rights and Equal Opportunity Commission, 1993). During the first five years

of reform, 1993 to 1998, the focus was on structural changes within public mental health services (Department of Health and Ageing, 2013), and on severe, low prevalence illness, particularly psychoses (Australian Health Ministers, 2003). National Mental Health Standards (Australian Health Ministers, 1997) and an external accreditation process was established for all mental health services to ensure the quality of services (Rosen, 2006).

The Second National Mental Health Plan 1998 to 2003 (Australian Health Ministers, 1998) aimed to extend the reform to high-prevalence illness, such as anxiety and depression (Australian Health Ministers, 2003). The Second Plan (Australian Health Ministers, 1998) focused on health promotion and prevention, partnerships with other services (Department of Health, 2014) and measuring quality and effectiveness through the National Mental Health Standards (Australian Health Ministers, 1997). A review of the Second Plan referred to the importance of services focusing on "the person not the illness"(Australian Health Ministers' Advisory Council, 1997, p. 17), but recovery was not explicitly defined.

The concept of recovery was mentioned in the Third National Mental Health Plan 2003 to 2008 (Australian Health Ministers, 2003), using a recovery definition adapted from Anthony (1993). However, it was not until 2008 that the concept of recovery gained prominence in national mental health policy (Australian Health Ministers, 2008, p. 2), which espoused a vision for a mental health system that "enables recovery". Recovery was defined as:

> A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. (Australian Health Ministers, 2008, p. 30)

At this stage in developing the National Mental Health Strategy, differences between the private and public sector services became evident. The Select Committee on Mental Health (2006) found that as public sector inpatient beds continued to decrease, the number of psychiatric beds in private hospitals had increased by 37% between 1992 to 2003, accounting for 22% of all psychiatric beds. The committee was concerned that by focusing on inpatient services, the private sector was reinforcing the institutional approach, contrary to the public policy of deinstitutionalisation and provision of community-based services.

The Fourth National Mental Health Plan, 2009 to 2014 (Australian Health Ministers, 2009, p. 23), identified "social inclusion and recovery" as a priority. The plan expected that a recovery focus would underpin practice by professionals across the public and private sectors, including community-based and inpatient services (Australian Health Ministers, 2009). In 2010, updated National Mental Health Standards (Commonwealth of Australia, 2010) were published. These standards are used as part of the accreditation program for mental health services. Standard 10.1 "Supporting Recovery" outlined four specific criteria for mental health services:

1. Supporting and promoting recovery-oriented values and principles.
2. Treating consumers and carers with respect and dignity.
3. Recognising the lived experience of consumers and carers.
4. Encouraging self-determination and autonomy for consumers and carers. (Commonwealth of Australia, 2010, p. 21).

In 2012, the Council of Australian Governments (COAG) outlined a roadmap for mental health reform over the next ten years. The Roadmap release coincided with establishing the National Mental Health Commission to provide independent reports. The Commission's first recommendation was "Nothing about us, without us" (National Mental

Health Commission, 2012, p. 9), putting in place a regular, independent review involving consultation with people with mental health difficulties, their families and support people.

The next pivotal step in mental health reform was the formation of a National Framework for recovery-oriented practice, consisting of two documents: *Policy and Theory* (Commonwealth of Australia, 2013a) and a *Guide for Practitioners and Providers* (Commonwealth of Australia, 2013b). The National Framework described recovery-oriented practice as "the application of sets of capabilities that support people to recognise and take responsibility for their recovery and wellbeing and to define their goals, wishes and aspirations" (Commonwealth of Australia, 2013b, p. 2). The National Framework also indicated that services needed to support recovery by providing evidence-informed treatment, working in partnership with other agencies, and supporting consumer-led initiatives (Commonwealth of Australia, 2013b).

By the Fifth National Mental Health and Suicide Prevention Plan (Department of Health, 2017) the focus had shifted from recovery to wellbeing and suicide prevention in the community, however, the work of recovery reformation was far from complete. Mental health services were mandated to demonstrate recovery-oriented practice but there was no consensus on recovery's conceptualisation (Jacob, 2015) nor evidence-based guidance for practice (Davidson et al., 2009). The following two sections review the status of research on the conceptualisation of recovery and guidance for recovery-oriented practice.

2.3   Conceptualisations of Recovery

Research on recovery is prolific, with many definitions identified in the literature (Jacob, 2015). Pilgrim (2008, p. 299) posits that there is little consensus about recovery, because is it a "polyvalent concept" that changes depending on your perspective. There are also some consumer groups, such as Recovery in the Bin (2017), who belive that recovery

has be co-opted by professionals who use it to control people living with mental health challenges. Despite these diverse opinions, there has been a conserted research effort to conceptualise recovery from a consumer perspective. To summarise the findings, I have focused on several systematic literature reviews and validation studies conducted over the last decade (see Table 2-1). These studies provide an overview of the conceptualisation of recovery from the research literature.

Ellison et al. (2018) identified four components of personal recovery frequently cited across studies: individualised and person-centred, empowerment, purpose and hope. Leamy et al. (2011) identified five processes of recovery: CHIME, which were confirmed by subsequent reviews (Bird et al., 2014; Slade et al., 2012b; Stuart et al., 2017; Van Weeghel et al., 2019). Stuart et al. (2017, pp. 300–301) also identified four elements of recovery, which were not covered by CHIME:

1. acknowledgement of "difficulties" in the recovery process,

2. "therapeutic input", including therapeutic relationships and medication,

3. "acceptance [of limitations] and mindful awareness" of the present, and

4. recovery conceptualised, by some, as a "return to normality".

Findings from Van Weeghel et al.'s (2019) review supported Stuart et al.'s (2017) inclusion of difficulties as part of the recovery process, highlighting the need to balance CHIME's focus on positive processes with an acknowledgement of the challenges. While not included in CHIME, Leamy et al. (2011, p. 447) did identify "recovery as a struggle" as part of the recovery journey.

Slade et al. (2012b) published an extension of Leamy et al.'s (2011) study validating the CHIME framework and identifying a strong emphasis on strengths and collaboration in

Table 2-1

Reviews of conceptualisation of recovery and common themes

Ellison et al. 2018	Leamy et al. 2011[1] Bird et al. 2014[2] Slade et al. 2012[3] Stuart 2017[4] Van Weeghal et al. 2019[5]	Jacob et al. 2017	Stickley & Wright 2011a[6]& b[7]
	Connectedness[1, 2, 3, 4, 5] Therapeutic Input[4]		Therapeutic Relationships[7]
Hope	Hope[1, 2, 3, 4, 5]	Future focus	Hope & Optimism[6] Hope for Individual[7]
Person-centre1 Self-direction	Identity[1, 2, 3, 4, 5]	Transformation of self/sense of self	Individual Identity & narrative[6]
Purpose	Meaning[1, 2, 3, 4, 5]	Having meaning in life; Engaging in meaningful activities	Meaning of Life[6] Activities promoting recovery[6]
Empowerment1	Empowerment[1, 2, 3, 4, 5]	Self-control	Historical, social & political critique[7]
	Difficulties3 & Trauma[4]		
	Acceptance & mindful awareness[3]	Self-acceptance; Inner Wellbeing	
	Returning to, or desiring, normality[3]	Cure-orientation; Return to pre-illness/ absence of symptoms	
		Recovery impossible	
Individualised & non-linear; many pathways	Individual/unique[1]; Non-linear[1]; Multi-dimensional[1]; Active/gradual process[1, 3]; A Journey[1]; Stages[1]; A struggle[1]	Multi-dimensional	

Australia. This finding was consistent with the National Framework for Recovery-Oriented

Mental Health Services (Commonwealth of Australia, 2013a, p. 6), which focused on

strengths and collaborative relationships.

Bird et al. (2014) validated the CHIME in community-based mental health services,

demonstrating that the framework developed with people further along in their journey

(Leamy et al., 2011) was also applicable to consumers experiences earlier in their recovery

when they were accessing support through mental health services. However, Bird et al.

(2014, p. 650) identified additional issues at this early stage of recovery, including the need

for practical support, diagnosis and medication, and scepticism about recovery. There was

less emphasis on personal agency and developing new identities and more reflection on the

loss of identity and lifestyle.

Two reviews by Stickley and Wright (2011a; 2011b) systematically examined British

peer-reviewed articles and another using the grey literature, respectively. Their peer-reviewed

examination identified two themes consistent with Leamy et al. (2011), viz., hope and

optimism, and meaning to life. The second review (Stickley & Wright, 2011) highlighted the

concept of hope and individual identity, supporting Stuart et al.'s (2017) finding that

therapeutic relationships play an essential role in recovery. Leamy et al. (2011) identified a

related concept in CHIME, connectedness, which includes peer support, relationships and

being part of the community, but did not incorporate therapeutic input.

In their review of peer-reviewed literature, Jacob et al. (2017, p. 59) found that the

concept of recovery meant different things to different people, including either a

transformation to new meaning and purpose, consistent with personal recovery, or a cure

from mental illness, consistent with clinical recovery. These two perspectives were reflected

in the multifaceted nature of recovery that was also highlighted by other authors such as

Ellison et al. (2018), Leamy et al. (2011) and Slade et al. (2012).

Given that recovery was emerging as an idiosyncratic process, unique to each

individual (Ellison et al., 2018; Leamy et al., 2011), Slade et al. (2012b) posit that the

conceptualisation of recovery developed from systematic reviews should not be prescriptive,

as each person decides what is essential for their unique recovery journey. Furthermore, Leamy et al.'s (2011) systematic review indicated that recovery is a dynamic, non-linear process that progresses in stages, similar to Prochaska and DiClemente's (1982, pp. 282 - 283) five-stage, transtheoretical model of change, moving from pre-contemplation to contemplation, preparation, action and maintenance and growth. Similarly, (Andresen et al., (2006, p. 973) propose a five-stage model of recovery, encompassing moratorium, awareness, preparation, rebuilding and growth. Other studies, included in Leamy et al.'s (2010) systematic review, proposed staged model of recovery. However, there was a lack of agreement on the number of stages, suggesting that progressing through a set number of recovery stages may not each person's unique experience of living with mental health issues.

Another component of recovery identified by some reviews was the process of empowerment. Four reviews used the word empowerment (Ellison et al., 2018; Leamy et al., 2011; Slade et al., 2012b; Stuart et al., 2017), whereas other reviews talked about similar concepts, such as taking responsibility (Andresen et al., 2003) or self-control (Jacob et al., 2017). Stickley and Wright (2011) did not identify empowerment directly but discussed the concept of social justice. Given the different terminology used, it is unclear whether these reviews are tapping into the same or different concepts.   Two reviews also included self-acceptance as a recovery component (Jacob et al., 2017; Stuart et al., 2017).

While consumers were consulted in the reviews discussed above, the perspective of professionals conducting the studies and interpreting the findings was likely to influence the conceptualisation of recovery. There is a risk that the conceptualisation may present an overly positive picture of the recovery process, which does not reflect the experience of many consumers. For example, the CHIME conceptualisation of recovery represents dynamic and nonlinear processes (Leamy et al., 2011). However, the CHIME acronym represents only the

positive end of each process, described by connectedness, hope, identity, meaning and empowerment, which may not characterise the experience of many consumers. There is an alternative view that professionals have co-opted recovery (Recovery in the Bin, 2017; Morrow & Weisser, 2012). For example, Recovery in the Bin (2016) has developed the "Unrecovery Star" to demonstrate that professionals co-opted recovery and do not attend to the distress and difficulties experienced by people living with mental health issues. Also, most of the reviews of the conceptualisation of recovery, except Bird et al. (2014), were conducted with people living in the community who may not have been accessing mental health services to manage more acute or distressing symptoms.

In summary, there was considerable agreement between reviews of the conceptualisation of recovery. CHIME, composed of connectedness, hope, identity, meaning and empowermentwas the most validated conceptualisation of recovery in community setting (Leamy et al., 2011; Slade et al., 2012; Stuart et al., 2017; Van Weeghel et al., 2019). Bird et al.'s (2014) validation of recovery with mental health services consumers found that diagnosis and medication, associated with the medical model, were also crucial to their personal recovery. Two reviews (Stuart et al., 2017; Van Weeghel et al., 2019) identified that difficulties are part of recovery, and several studies discussed the multi-dimensional nature of recovery and how the journey is unique for each person (Ellison et al., 2018; Jacob et al., 2017; Leamy et al., 2011; Slade et al., 2012). Leamy et al. (2011) and Andresen et al., (2006) also proposed that recovery happens in stages. Understanding the conceptualisationof recovery, and the underlying recovery processes, is critical to understanding how professionals can support recovery through recovery-oriented practice. The next sections explore the guidance for recovery-oriented practice and the tensions between a recovery-oriented approach and the medical model.

2.4   Recovery-Oriented Practice Guidance

The National Framework for recovery-oriented practice (Commonwealth of Australia, 2013a, 2013b) outlines practice domains that reflect key capabilities for recovery-oriented practice, based on Le Boutillier et al.'s (2011, p. 1470) study which identified four parts: "promoting citizenship, organisational commitment, supporting personally defined recovery, and the working relationship". *The National Framework: Guide for Practitioners and Providers* (Commonwealth of Australia, 2013b) specifies that this approach to recovery-oriented practice needs to be adapted to each consumers' needs.

Other practice guidelines have informed practice in Australia, including Slade's (2013) guide for professionals '100 Ways to Support Recovery' and Mind Australia's (2017) 'Mind's approach to recovery-oriented practice'. (Slade, 2013) emphasises the importance of relationships in supporting recovery, including staff's role in encouraging peer support, listening to what consumers want and supporting other relationships. Slade (2013) talks about making recovery-oriented values explicit, embedding values into daily practice, and seeking feedback on performance.

Mind's approach (Mind Australia, 2017, p. 4) identifies six core principles for practice:

1. Supporting personal recovery and wellbeing.

2. Taking a person-centred approach to care planning.

3. Providing services informed by the evidence and a social model of health.

4. Build trusting relationships.

5. Ensuring practice is sensitive to the needs of families and carers.

6. Working in partnership and collaborating with other agencies.

While guidelines are useful, there is no ideal service or step-by-step guide to follow (Slade, 2013). In practice, professionals also need to balance the existing medical model's requirements with the recovery approach in hospital-based mental health services.

2.5   Recovery and the Medical Model

Recovery-oriented practice comes from a humanistic, person-centred approach, focusing upon personal meaning and growth, strengths, empowerment, and recognition of expertise by experience (Slade, 2013). Conversely, the medical model traditionally uses diagnosis, evidence-based interventions and professional knowledge to treat illness (Slade, 2013). Shah and Mountain (2007) posit that scientific evidence about what treatments work for specific conditions is at the core of the medical model, with practice changing as new evidence emerges. Other authors identify that the medical model has evolved from the 'old' biomedical model, based on biological determinates of disease, to the 'new' biopsychosocial medical model that takes into account biological, psychological and social factors impacting on mental health (Huda, 2019; Engel, 2012; Fuller, 2017). The 'old' medical model, with its the sole focus on biology, did not adequately explain the determinates of mental health issues. Despite the changes in the conceptualisation of the medical model, Read (2005) believes that the biopsychosocial model remains focused on biological determines of disease and medication interventions to generate profits for big pharmacology companies. Huda (2021) disputes Read's (2005) claim, indicating that this view does consider a multidisciplinary approach that incorporates psychological and social interventions in addition to medication.

While the debate continues around how to conceptualise the medical model in psychiatry, the differences between a recovery-oriented approach and the medical model, i.e., the biopsychosocial model, have been the subject of much discussion in the literature

which tries to answer the question: Are these two ways of working like "oil and water or oil and vinegar?" (Davidson et al., 2009, p. 323). Byrne et al. (2016, p. 217) describe the two models as "world's colliding", viewing the medical model as a significant barrier to the development of recovery-oriented practice. However, other authors (Davidson et al., 2009; Ham, 2009; Mountain & Shah, 2008; Williams et al., 2013) envisage integrating the best from both worlds to provide evidence-based and person-centred services. Mountain and Shah (2008, p. 244) describe an approach where health professionals "attend to the person and to the illness" thus incorporating a recovery approach and the medical model. Similarly, Barber (2012, p. 278) points out that "becoming recovery-oriented does not mean abandoning medical knowledge". Rather recovery-oriented practice is about the process of working with people and reflects a shift in health services towards being more person-centred. Likewise, Huda (2021) contends that more than one model may be necessary to apply nomothetic knowledge from research and an understanding of individual needs.

The challenge in working in mental health services is that recovery-oriented practice has been implemented before the evidence base has been developed (Slade & Hayward, 2007). This situation presents a dilemma for professionals who must use evidence-based practice (Hoffmann, 2017) while simultaneously adopting a recovery-oriented approach (Commonwealth of Australia, 2013a; Houghton, 1982). An additional challenge is that professionals do not have access to measures to assess if interventions intended to support recovery are effective. Researchers have been developing recovery-oriented practice measures, but efforts are impeded by diverse conceptualisations of recovery (Williams et al., 2012). For example, Williams et al. (2012) could not identify any single measure that measured all of Leamy et al's 2011 CHIME processes, nor any other measures that demonstrated adequate reliability and sensitivity to change.

In conclusion, practice guidance documents advise the recovery approach, but there is no definitive guide as each person's recovery journey is unique. Also, until research catches up with changes in mental health policy, professionals are faced with a dilemma about how to support both clinical and personal recovery through the use of evidence-based interventions the National Framework for recovery-oriented practice (Commonwealth of Australia, 2013a).

The next section moves away from the general conceptualisation of recovery and recovery-oriented practice guidance to look at the role of hospital-based mental health services. (See Chapter 3 for further discussion of recovery and recovery-oriented practice in the context of hospital-based mental health services).

2.6   Hospital-based Mental Health Services

The research that informs this thesis took place in a private, hospital-based mental health service. In Australia, inpatient mental health services comprise 14% of specialised mental health facilities, with the remaining majority of services provided via community-based agencies (Australian Institute of Health and Welfare, 2019b). Private hospitals only account for 4% of inpatient mental health facilities (Australian Institute of Health and Welfare, 2019b), which equates to "32 stand-alone private psychiatric hospitals and 33 psychiatric units located in private general hospitals" (Australian Private Hospitals Association, Private Psychiatric Hospitals Data Reporting and Analysis Service, 2018, p. 5).

While both public and private hospitals see people presenting with a range of mental health disorders, they differ concerning the proportion of consumers with specific diagnoses. In 2016 to 2017, schizophrenia was the most common principal diagnosis (22.4%) followed by depression (11.9%) for inpatient admissions in public hospitals (Australian Institute of Health and Welfare, 2019a). During the same time in private hospitals, depression was the most common diagnosis for admissions (22.9%) with a diagnosis of schizophrenia only

accounting for a small percentage (2.5%) of all admissions (Australian Institute of Health and Welfare, 2019a).

Since deinstitutionalisation, admissions to hospital-based mental health services are limited to acute care where individuals are in extreme distress (Dewis & Harrison, 2008) or at risk to themselves or others (Bowers, 2005). The duration of an admission is usually brief (Waldemar et al., 2016), focusing on symptom remediation (Smith & Gridley, 2006; Waldemar et al., 2016). The average length of stay for mental health inpatients is 19 days in private hospitals (Australian Private Hospitals Association, Private Psychiatric Hospitals Data Reporting and Analysis Service, 2018) compared to 17 days in public hospitals (Australian Institute of Health and Welfare, 2018). Both public and private inpatient units are highly volatile environments where professionals are accountable for managing risks for acutely unwell consumers and staff are highly risk-averse (Chen et al., 2013). For those staff practising in inpatient facilities, high acuity and risk can mean that regular ward-procedures such as formal observation, i.e., regular checks to ensure consumer safety, are given priority over spending time for one-to-one engagement with consumers (Dodds & Bowles, 2001).

The two main modes of service delivery in private hospitals are inpatient services and day-programs. From 2016 to 2017, approximately 60% of patients received inpatient services only, with 20% of patients accessing both inpatient and day-patient services, and a further 20% accessing day-patient services only (Australian Private Hospitals Association, 2018). Private hospitals' treatments follow the *Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care* (Private Mental Health Alliance, 2015). These guidelines comply with national standards and state that "priority must be given to the most appropriate evidence-based, recovery-oriented, and cost-effective treatment options for each individual patient" (Private Mental Health Alliance, 2015, p. 7). This

statement is significant, as it demonstrates a commitment from private hospitals that both evidence-based and recovery-oriented practice are essential components of mental health care.

In addition to medical treatment, a significant component of private hospitals' interventions is group therapy offered to inpatient and day-patient admissions (Australian Private Hospitals Association, 2018). Compared to individual sessions, group programs are more cost-effective to facilitate (Tucker & Oei, 2007), produce equivalent clinical outcomes (Craigie & Nathan, 2009; Oei & Dingle, 2008; Söchting, 2014) in fewer sessions and with fewer dropouts (Hans & Hiller, 2013).

2.7   The Local Context

The site for the current study, Sunshine Clinic, is a 24 bed, psychiatric unit located in a private general hospital in regional Australia. The clinic was staffed by a multi-disciplinary team including consulting psychiatrists, mental health nurses, psychologists, an occupational therapist and other allied health professionals. Sunshine Clinic services included medical interventions and a suite of group therapy programs. The inpatient treatment program comprised two to three group sessions per day, including sessions on goal setting, understanding mental illness, recovery planning, therapy skills, mindfulness and a physical exercise program. Diversional activities such as art and card-making groups were also provided. The day-patient groups comprised a recovery program that took place one day per week over three months, and programs on managing anxiety, depression and bipolar disorder t took place one day per week over two months. The programs were facilitated by a multi-disciplinary team, including psychologists, occupational therapists, exercise physiologists, and mental health nurses. While staff had access to evidence-based treatment to support clinical recovery there was limited information on how to implement the recovery-oriented practice in this setting.

2.8   Chapter Summary

Over the last three decades, mental health reform in Australia has introduced a policy to support recovery-oriented practice ahead of the research-based evidence to support implementing a recovery approach (Slade & Hayward, 2007). This mismatch between policy and evidence has created tension for professionals between the provision of evidence-based practice, under the medical model, and a recovery approach (Davidson et al., 2009). While recovery-oriented practice guidance exists, it does not provide step-by-step instructions for implementation (Slade, 2013). Recovery is a unique journey for each person (Leamy et al., 2011) where no one approach fits all. This research was needed as implementing recovery-oriented practice in a hospital-based mental health service, defined by high acuity, short admissions (Chen et al., 2013), and a focus on risk management (Dodds & Bowles, 2001) is challenging. With private hospitals in Australia committed to providing both evidence-based and recovery-oriented services (Private Mental Health Alliance, 2015) this research provided an opportunity to improve the implementation of recovery-oriented practice in a private mental health service.

2.9   My Reflection: Identifying Gaps in Knowledge

When I started this research, I was interested in transitioning mental health policy about recovery into practice. As a mental health professional, I knew little about the mental health reform history that led to the requirement for recovery-oriented services. I saw little evidence of the recovery policies being applied to practice-as-usual, which was embedded in the medical model with expectations that interventions were evidence-based.

I was employed to facilitate group therapy programs on the inpatient ward and establish new group day programs. In setting up the programs, I became familiar with the national standards (Commonwealth of Australia, 2013a, 2013b) and started incorporating more recovery-oriented sessions in the group programs. However, I only found a small

number of guidance documents to inform practice, and I was surprised by the lack of research in hospital-based settings. I wondered if the conceptualisation of recovery and recovery-oriented programs developed in other settings would apply to hospital-based mental health services. Throughout this participatory research project and writing up the thesis, I came to understand recovery from consumers' perspectives at Sunshine Clinic and the broader literature. Together, these two elements changed my perception of recovery and what professionals can do to support consumer recovery during an inpatient admission. Literature Review.

Chapter 3. Literature Review

This chapter explores the three questions that inform our research about recovery and recovery-oriented practice in the context of admission to a hospital-based mental health service:

1. What is recovery?

2. What is recovery-oriented practice?

3. How can services implement recovery-oriented practice?

The questions are explored through three narrative, systematic reviews of the relevant literature. Section 2.2 provides a systematic review of the conceptualisation of recovery in inpatient settings. Section 2.3 to 2.4 report the findings of two systematic reviews; the first is of stakeholders' perceptions of recovery-oriented practice in hospital-based mental health services; and the second review explores the implementation of recovery-oriented practice in this setting. The chapter concludes with a summary and my reflection.

To complete the literature reviews included in this chapter, I completed a systematic search of the research in conjunction with two PhD supervisors (SB and WM). I designed and conducted the search strategy and reviewed all articles for inclusion. SB reviewed 5% of articles against the inclusion criteria to establish a 90% or higher concordance. WM acted as a mediator where SB and I did not reach an agreement. We all agreed on the selection of included studies. This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009).

"The search strategy included three databases, PsycINFO, MEDLINE and CINAHL Complete (see Figure 3-1) and two core concepts: the intervention (recovery) and the setting (hospital-based mental health services). I combined intervention and setting terms within the

group using the Boolean operator 'OR' and then combined each group (intervention and setting) with 'AND'. Included articles met the following criteria: qualitative, quantitative or mixed methods, in the English language, published between 2010–2019; completed in adult, hospital-based mental health services, but excluding residential care, accident and emergency departments, forensic mental health services and substance abuse or addiction services or informants from this setting, with a focus on professionals which included the peer workforce." (Lorien et al., 2020, p. 1036) Besides the database searches, a snowballing strategy (Greenhalgh & Peacock, 2005) was used to review or cite articles in the reference lists of included studies.

The initial search identified 1515 articles once duplicates were removed. After screening studies against inclusion criteria, 44 studies met all review requirements (see Figure 3-1). One study was excluded based on methodological concerns, leaving four studies on the conceptualisation of recovery, 12 studies on the perception of recovery-oriented practice, 27 studies on the implementation of recovery-oriented practice. I have published one article from the systematic review on implementation research (Lorien et al., 2020).

3.1   Conceptualisation of Recovery

While the research on the conceptualisation of recovery is extensive (see Chapter 2, Section 2.3), there is a lack of research in hospital-based mental health services. The systematic review of the research literature identified only four studies on the conceptualisation of recovery in inpatient mental health services (Aston & Coffey, 2012; Bredski et al., 2015; Eldal et al., 2019; Siu et al., 2012). Table 3-1 provides an overview of the design of included studies.

3.1.1   Findings

Aston and Coffey (2012) found that consumers and nurses had difficulty conceptualising recovery. Some participants equated recovery with a return to pre-illness functioning, which fits more with the concept of clinical recovery or cure (Davidson et al., 2006; Rossi et al., 2018). Some consumers did not think that the word 'recovery' made sense but could not identify a term that better described their diverse experiences (Aston & Coffey, 2012). Consistent with previous studies (Leamy et al., 2011; Stuart et al., 2017), participants described recovery as a journey, not a one-off event, and highlighted the importance of the therapeutic relationship (Aston & Coffey, 2012).

Bredski et al.'s (2015) study identified four major recovery themes from interviews with consumers: relationships, hope, agency and opportunity. Like Aston and Coffey's (2018) findings, positive relationships between professionals and consumers were associated with recovery. Bredski et al.'s (2015) study also identified that having family and friends' support during an admission helped recovery. Participants experienced both hope and hopelessness, with a more prolonged admission contributing to hopelessness. While hope was frequently identified in descriptions of recovery in previous reviews (Ellison et al., 2018; Leamy et al., 2011; Stickley & Wright, 2011a, 2011b), the flip-side encapsulating hopelessness was less prominent. Bredski et al.'s (2015) findings suggest that hopelessness may be more central to consumers' experiences than hope.

Agency and opportunity were the other two themes from Bredski et al. (2015). Agency described goal-directed behaviour and consumers' sense of control over their actions (Bredski et al., 2015). Agency is similar to other concepts identified in systematic reviews, such as self-control (Jacob et al., 2017), empowerment (Ellison et al., 2018; Leamy et al., 2011) and purpose (Ellison et al., 2018). Opportunity, in the context of inpatient admission,

Figure 3-1

Systematic review (2010–2019)

Databases: Medline, PsycINFO, CINAHL

Identification

Records identified through database searching July 2019 (n = 1973)

Additional records identified when search re-run January 2020 (n = 94)

Records after duplicates removed (n = 1515)

Screening

Records screened (n = 1515)

Records excluded (n = 1441)

Eligibility

Full-text articles assessed for eligibility (n = 152)

Full-text articles excluded, with reasons (n = 108)
20 = Not research, QI[1] study or Service Evaluation
5 = Not primary studies
15 = Not hospital based mental health service
68 = Not implementation ROP, conceptualisation or perception of ROP

Included

Studies assessed for quality (n = 44)

Records excluded (n = 1)

Implementation of ROP[2] (n=27)

Conceptualisation of Recovery (n=4)

Perception of ROP[2] (n =12)

Research (n=16)

QI[1] Studies (n=11)

QI[1] = Quality Improvement; ROP[2] = Recovery-Oriented Practice

Flowchart adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009)

Table 3-1

Conceptualisation studies

Study	Why	What/How	Who	Where	Design
Aston & Coffey, 2012	To examine what recovery means to consumers & mental health nurses	2 Focus groups (Consumers; MHN)	N = 11; Consumers N = 6; MHN N = 5	Informants with experience of Inpatient services, UK.	Qualitative
Bredski et al., 2015	To present consumers perceptive of recovery facilitators	Semi-structured interviews	N = 31 Consumers	4 wards, hospital rehabilitation service, UK.	Qualitative
Eldal et al., 2019	To provide a deeper understanding of the lived experience of recovery	Interviews	N = 14 Consumers	3 MH Units, Norway	Qualitative
Sui et al., 2012	To measure the importance of the different elements of recovery	Questionnaire: REAQ-PV[1]	N = 154; Consumers N = 101; Professionals N = 53	2 wards, Psychiatric hospital, Hong Kong	Quantitative

REAQ-PV[1] = Recovery Elements Assessment Questionnaire—Patient Version

referred to the environmental resources on the ward (Bredski et al., 2015). While previous conceptualisations of recovery refer to meaningful activities (Jacob et al., 2017), environmental resources have not been specifically identified. However, other inpatient studies have demonstrated the relevance of the ward environment to recovery, including the physical environment (Ahern et al., 2016; Donald et al., 2015; Urbanoski et al., 2013) and safety (Fletcher et al., 2019; Pelletier, 2015; Phoenix, 2013; Polacek et al., 2015).

Eldal et al. (2019) identified two themes to understand recovery. The first theme reflected the need for consumers to have their self-identity recognised and supported,

including being treated as a whole person rather than a diagnostic term or to be infantilised as a child. Consumers reported that some interactions with professionals were holistic and supportive of their recovery and others were not. The concept of self-identity was consistent with previous reviews indicating that developing a new identity is necessary for recovery (Leamy et al., 2011; Stickley & Wright, 2011b).

The second theme concerned consumers' ambivalence between two concepts: 1) needing physical and emotional closeness, and 2) needing to distance themselves from others (Eldal et al., 2019). Many participants identified helpful characteristics, including professionals having a genuine interest in them and the capacity to make consumers feel valued. However, participants also saw some professionals as dominant, or distant and uncaring, leading consumers to withdraw socially. Participants' experience in Eldal et al. (2019) reinforces the evidence from previous studies that having a strong therapeutic alliance is critical to recovery (Stickley & Wright, 2011b; Stuart et al., 2017).

In Siu et al.'s (2012) study, a high percentage of consumers endorsed having meaning in life (91%) and hope (86%) as important to recovery. These findings are consistent with previous research (Ellison et al., 2018; Jacob, 2015; Leamy et al., 2011; Stickley & Wright, 2011a), suggesting that these components are universal recovery elements, regardless of the context. The third concept highly endorsed by participants in Siu et al. (2012), stated that general health and wellbeing (85%) are similar to inner-wellbeing identified by Jacob (2015).

Professionals in Siu et al.'s (2012) study also rated the importance of elements of recovery, endorsing positive relationships (100%), followed by hope, basic needs and assistance when in need (all at 98%). While positive relationships were important for consumers, the proportion of endorsement (79%) was less than for professionals. Another difference was concerning the importance of peer support. Only 18% of consumers indicated

that peer support was significant compared to 96% of professionals. Siu et al. (2012) speculate that a negative symptom of schizophrenia, i.e., social withdrawal, may impact this finding. However, positive relationships were rated as important to consumers recovery (79%), so it may be that the nature of the connection, i.e., positive relationships, is relevant more so than with whom the relationship is.

3.1.2   Summary

While the four studies' results appear to be widely disparate, it may be likened to four blind persons trying to define an elephant with each describing only a small part of the whole animal. This incongruence may reflect the multi-dimensional nature of recovery and each person's unique journey (Ellison et al., 2018; Jacob et al., 2017; Leamy et al., 2011). The differences may also reflect each study's different culture and settings (see Table 3-1). Moreover, the findings appear to reflect a participant's uncertainty about the term 'recovery' (Aston & Coffey, 2012), having a greater focus on challenges, such as hopelessness (Bredski et al., 2015) and ambivalence about relationships with professionals (Eldal et al., 2019).

Despite the difference between the studies, the relevance of therapeutic relationships was evident across all studies (see Figure 3-2) and was consistent with the findings from previous reviews (Ellison et al., 2018; Jacob, 2015; Leamy et al., 2011; Stickley & Wright, 2011a). Two of the four studies incorporated the concept of hope (Bredski et al., 2015; Siu et al., 2012). The studies also picked up on other elements of CHIME (Leamy et al., 2011), including identity (Eldal et al., 2019), meaning in life (Siu et al., 2012) and empowerment through agency and opportunity (Bredski et al., 2015). However, recovery appeared to be experienced as a dichotomy between extremes (see Figure 3-2). For instance, while relationships were important to recovery, consumers experienced closeness or distance (Eldal et al., 2019). Similarly, hopelessness was shared more than hope (Bredski et al., 2015),

and consumers experienced being treated like either a whole person or a diagnosis (Eldal et al., 2019). As the conceptualisation of recovery becomes clearer, the challenge for mental health services is working out how to translate that understanding into practice (Hungerford & Fox, 2014).

3.2   Recovery-Oriented Practice Perception

Twelve studies were identified across five countries on the perception of recovery-oriented practice in inpatient mental health services (see Table 3-2). Four studies focused on consumer perception, three studies on professionals' views, and five studies included a range of stakeholders' perspectives. Of the studies that included professionals, 50% were with mental health nurses, and 50% had a range of professionals, with the majority being mental health nurses. All studies took place in inpatient mental health services or with informants from this setting. No studies took place in hospital day programs, and neither were peer support workers identified as participants.

Due to the studies' diverse designs, a narrative synthesis was used to understand how stakeholders perceived recovery-oriented practice was being implemented in inpatient settings (Campbell et al., 2018). The findings of included studies are presented under the following headings: consumers, professionals, and stakeholders.

We used the Quality Assessment Tool for Studies with Diverse Designs (QATSDD) (Sirriyeh et al., 2012) to understand studies' strengths and weaknesses as recommended by Fenton et al. (2015) and *Criteria 1. 'Theoretical Framework'* was adapted to ensure that recovery-oriented practice concerning personal recovery was the primary focus. All studies provided recovery-oriented practice descriptions or referenced relevant articles and policy documents. All quantitative studies provided reliability statistics for measures used but limited evidence of validity. The qualitative studies lacked rigour, with some studies not

including a measure of rigour (Chen et al., 2013; Coffey et al., 2019) and others providing

only one measure, e.g., more than one researcher determining themes, member-checking or

Figure 3-2

Inpatient recovery processes mapped on to CHIME

References: [1]Ashton & Coffey, 2021; [2]Bredski et al., 2014; [3]Eldal et al., 2018; [4]Wei-Man Sui
et al., 2021.

reflexivity (Cleary et al., 2013; Gwinner & Ward, 2015; Hyde et al., 2015; Waldemar et al.,

2018, 2019). Most studies comprised a small sample size (see Table 3-2), noting this as a

limitation to the findings' generalisations. Only one study (Coffey et al., 2019) mentioned

consumer involvement in the design. Overall, the quality of included studies' was acceptable,

and none were excluded based on quality.

3.2.1   Consumers

Two studies (Hyde et al., 2015; Waldemar et al., 2018) explored consumer perception of recovery-oriented practice. Hyde et al. (2015) identified three ways in which services could support recovery, including listening to consumers, enabling peer support and including families. Consumers in Waldemar et al.'s (2018) study identified how they experienced care after efforts to transform an inpatient service to a recovery-oriented approach. The themes reflected limited evidence of change in practice. Consumers reported feeling accepted and protected and having company but longing for dialogue. They also described being "in the dark", confused and uninformed, feeling like they were being "observed and assessed" by staff, having "limited choice and influence" concerning their treatment which was "centred on medication" (Waldemar et al., 2018, p. 1180).

The two quantitative studies evaluated recovery-oriented outcomes for consumers (Chang et al., 2018; Jaeger et al., 2015). Chang et al. (2018) examined the relationship between recovery-oriented practice measured by the Recovery Self-Assessment—Revised (RSA-R) (O'Connell et al., 2005) and consumer recovery, measured by the Recovery Assessment Scale (RAS) (Giffort et al., 1995). The findings indicate that three domains of the RSA-R, life goals vs symptom management, individually tailored support, and diversity of treatment options, were associated with an overall recovery improvement, as were three specific RAS subscales: willingness to ask for help, goal and success orientation, and reliance on others (Chang et al., 2018, p 707).

Jaeger et al. (2015) examined consumers' perspectives before and after changes to recovery-oriented practice being implemented. Consumers attitudes towards recovery, measured by the Recovery Attitudes Questionnaire (RAQ) (Borkin et al., 2000) increased on two aspects after implementation of changes: all consumers with serious mental illness can

work towards recovery, and recovery is possible (Jaeger et al., 2015, p. 192). Conversely, consumer ratings on two aspects decreased after the implementation: to recover requires faith, and people differ in how they recover from mental illness (Jaeger et al., 2015, p. 192). These findings suggest an increased belief that recovery is possible and that faith alone is not sufficient for recovery. The lower score in relation to people recovering in different ways was contrary to previous research conceptualising recovery as a unique journey (Leamy et al., 2011). One explanation for this finding may be that the organisational changes were insufficient to embed services tailored to individual needs. This explanation is consistent with Waldemar et al.'s (2018) findings that indicated little change to practice despite targeted interventions.

3.2.2   Professionals

Four qualitative studies used semi-structured interviews (Cleary et al., 2013) or focus groups (Gwinner & Ward, 2015; McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014) to find out what professionals identified as recovery--orientation practice. A fifth study employed quantitative methodology using the Recovery Self-Assessment (RSA) (O'Connell et al., 2005) to assess the recovery orientation.

Nurses in Cleary et al.'s (2013) study identified three themes relating to their perceptions of recovery-oriented practice. The first theme reflected a holistic view of recovery, incorporating social factors and living well. However, more than half the participants reported that recovery-oriented practice was not embedded in inpatient settings. The second theme reflected the idea of humanistic service provision, including concepts of working with the whole person and developing a therapeutic relationship. The third theme addressed the practical realities of supporting consumers' recovery, with attention to medication, education, goal setting, discharge planning, developing relationships and

Table 3-2

Perception of recovery-oriented practice study design

Study	Why	What/How/When	Who (Response Rate)	Where	Design
Consumers					
Chang et al., 2018	To examine the association RO services domains with recovery outcomes	Measures: RSA-R[1]; RAS[2]/Survey via face-to-face interviews/2012	N = 36 Consumers	State psychiatric hospital, USA	Quantitative
Hyde et al., 2015	To explore consumer experience of inpatient care	In-depth semi-structured interviews	N = 8 Consumers	Acute inpatient facility, Australia	Qualitative
Jadger et al., 2014	To evaluate consumer perspectives before & after changes (Conjoint treatment planning, ↓time spent on reports & RO mental health training)	Recovery measure*: RAQ[3]/2011–2012	2 Different samples: N = 63 (38%); Consumers; N = 34 before; N = 29 after	University Hospital of Psychiatry, Switzerland	Quantitative
Waldemar et al., 2018	To explore whether RO efforts are reflected in the inpatient experience	Semi-structured interviews	N = 14 Consumers	2 Mental health inpatient wards, psychiatric hospital Denmark	Qualitative

Study	Why	What/How/When	Who (Response Rate)	Where	Design
Professionals					
Cleary et al., 2013	To ask MHN‡ how they incorporate recovery into their practice	Semi-structured Interviews/October 2010	N = 21 MHN‡	NSW MHN‡ Summit, Australia	Qualitative
Gwinner & Ward, 2015	To identify RO practice in Psychiatric Intensive Care Units (PICU)	Focus Group 1 (FG1); Literature search; Focus Group 2 (FG2)	N = 57 MHN‡; N = 12 FG1; N = 45 FG2	2 hospitals, PICU§, Australia	Qualitative
McKenna et al., 2014	To ask MHN‡ to describe current RO practice	In-depth focus groups at each service/July–Sept 2013	N = 46 MHN‡	5 acute inpatient services, Australia	Qualitative
McKenna et al., 2014	To ask MHN‡ to describe current RO practice	In-depth focus group interviews at each service	N = 12 MHN‡	3 older-adult acute inpatient settings, Australia	Qualitative
Key Stakeholders					
Tsai et al., 2010	To compare recovery-orientation in Hospital vs. Community Settings	Recovery Measure*: RSA[2]	N = 1,380; N = 729 (63.4%) Professionals inpatient; N = 181 (78.7%) Professionals community	3 state hospitals; 4 community mental health centers	Quantitative
Chen et al., 2013	To identify recovery competencies for inpatient mental health service	Literature review & key informant interviews; Competence modeling	N = 21 MHN‡; N = 3 Consumers; N = 3 Family; N = 9 Other professionals with inpatient experience	3 mental health sites (1 Community; 2 inpatient), Canada	Qualitative

Study	Why	What/How/When	Who (Response Rate)	Where	Design
Coffey et al., 2019	To identify factors that facilitate or hinder recovery-focused care	Recovery measure*: RSA[2] & case studies/interviews with mental health professionals, consumers & carers	Surveys: N = 619; N = 301 Consumer; N = 290 Professionals; N = 28 Carers Interviews N = 76; N = 36 Consumers; N = 31 Professionals; N = 9 Carers	19 mental health wards in six sites, England & Wales	Mixed methods
Waldemar et al., 2019	To understand what takes place in Interactions between consumers & mental health staff[‡]	Observation of practice/Nov 2014–Jan 2015	The researcher conducted observations for 21 days, 84hrs	2 mental health Inpatient wards, psychiatric hospital, Denmark	Qualitative

Notes: MHN[‡] = Mental Health Nurses; RO[¶] = Recovery-Oriented; PICU[§] = Psychiatric Intensive Care Unit;* Reporting selected measures specific to recovery.

Measures: RSA-R[1] = Recovery Self-Assessment—Revised (O'Connell et al., 2005); RAS[2] = Recovery Assessment Scale (Giffort et al., 1995);

RAQ = Recovery Attitudes Questionnaire (Borkin et al., 2000).

goal setting, discharge planning, developing relationships and practical aspects of daily living.

Two similar studies by McKenna and colleagues (McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014) identified pragmatic ways nurses reported implementing recovery-oriented practice with adults and older-adults (respectively) in acute care settings. Both studies identified practical ways that nurses spoke about operationalising recovery-oriented care domains described in national policy (State of Victoria, 2011). Like Cleary et al. (2013), the findings indicate that while nurses have a clear perception of recovery-oriented care, the current structure and culture within mental health services hamper implementation. These findings suggest that nurses may not be the decision-makers who can implement change or that implementing change is more challenging than talking the talk, especially when there are competing priorities.

Gwinner and Ward (2015) also identified nurses' perspectives on recovery-oriented practice, in a Psychiatric Intensive Care Unit (PICU). A PICU is a locked, intensive treatment unit for consumers experiencing acute psychiatric distress (Ward & Gwinner, 2015). The findings indicate that recovery-oriented practice is possible, even within an intensive care setting. Nurses identified four recovery-oriented practice attributes applicable in this context (Gwinner & Ward, 2015, p.108). The first attribute, storytelling, encapsulated the reciprocal relationship between a consumer and nurse through listening and talking. The second attribute, safeguarding, described the need for nurses to ensure the consumer's safety when they are likely to be anxious and fearful. The third attribute, treatment, focused on medication, psychotherapy, structure and routine to support clinical and personal recovery. The fourth attribute, responsibility, balanced the need to respect and value the individual to

manage collective risks and unpredictable behaviours. Gwinner and Ward's (2015) findings

provide a guide to negotiating complex issues in an acute setting while supporting recovery.

The final study (Tsai & Salyers, 2010) compared the recovery-orientation of

professionals working in hospital settings to community settings. Participants included a

diverse range of professionals such as social workers, nurses, psychologists and psychiatrists,

who completed the RSA (O'Connell et al., 2005). The results indicated that professionals in

inpatient settings scored significantly lower on the RSA than professionals in community

settings, meaning that their practice was less recovery-oriented. Furthermore, very few

hospital-based participants reported that the services actively supported recovery-oriented

practice by involving consumers in decision making or building connections with the

community. Although unknown at this point is due to the dearth of research, it may be that

staff in this setting only see consumers when they are acutely unwell, so they may be less

likely to believe the evidence for recovery, which may be more apparent post-discharge.

Several studies provided evidence that professionals understand what they can do to

support personal recovery in this context (Cleary et al., 2013; Gwinner & Ward, 2015;

McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014).

However, changes to practice can be impeded by organisational structure and culture

designed to support clinical recovery under the medical model(McKenna, Furness, Dhital,

Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014; Tsai & Salyers, 2010).

Therefore, for practice to become more oriented towards personal recovery, professionals in

leadership positions need to champion this change.

3.2.3   Stakeholders

Three studies incorporated the views of multiple stakeholders, including consumers,

professionals, and family/carers. Each study took a different approach to learning about

recovery-oriented practice. Chen et al.'s (2013) study identified recovery competencies for professionals. Coffey et al. (2019) identified factors that help and hinder recovery from consumers and professionals' perspectives. Lastly, Waldemar et al. (2019) used ethnographic observational research to assess recovery-oriented interactions between professionals and consumers.

Chen et al. (2013) identified competencies for recovery-oriented practice in inpatient mental health services. These competencies focused on: 1) easing tensions at an environmental, consumer and professional level; 2) ensuring that professionals were working collaboratively with consumers to provide individually tailored services; 3) fostering a positive recovery, diminishing stigma, and facilitating self-help groups for consumers, and 4) supporting consumers to connect to community support and resources, post-discharge (Chen et al., 2013).

Coffey et al. (2019) used standardised measures of recovery and therapeutic relationships and case studies involving interviews with professionals, consumers, and carers across 19 mental health wards (see Table 3-3). The study highlighted some differences between consumers and professionals concerning their perception of recovery-oriented care. For consumers, high ratings of recovery-oriented care correlated with high quality of care and therapeutic relationships. For professionals, the ratings for recovery-oriented care varied across mental health wards. Nevertheless, professionals consistently rated the quality of therapeutic relationships higher than consumers. The qualitative data from interviews also revealed differences in the perception of collaboration. Professionals' perceptions of collaboration being part of routine care contrasted with mixed experiences of collaboration reported by consumers. Another difference was that professionals were more attuned to managing risk, whereas consumers were less focused on safety issues. Having limited carer

participation was a limitation of the study. However, those carers who were interviewed provided positive accounts of care by professionals.

In the last study, Waldemar et al. (2019) reported interactions between professionals and consumers in two mental health wards. Analysis of the observations revealed four sub-themes under the theme of 'as-if collaboration': negotiation on limited terms, competing demands, inconsistent guidance and postponed decisions, and controlling and condescending communication (Waldemar et al., 2019, p. 324). The findings indicated that while staff were seen to be collaborating with consumers, the researchers observed that the power balance was not equal. Professionals tended to define the problem and take responsibility for the solution. The observations support the premise that recovery is more rhetoric than reality in inpatient settings (Waldemar et al., 2019).

3.2.4   Summary

These studies provide valuable insights into recovery-oriented practice in inpatient settings. To make sense of the findings about the conceptualisation of recovery, I mapped the central concepts identified to the CHIME acronym (see Figure 3-3). Connectedness and empowerment were the most salient processes of personal recovery in hospital-based mental health services. Connectedness and collaboration were vital to recovery. While professionals recognised the importance of listening to consumers and developing therapeutic relationships, having time to engage meaningfully with consumers was a challenge. Also, inpatient services were less likely to build community connections than community-based services. However, fostering relationships with peers, family, and community was identified as part of recovery-oriented practice. Connectedness and collaboration were vital to recovery.

Figure 3-3

Recovery-oriented practice mapped onto CHIME

References: [1]Chang et al. 2018; [2]Hyde et al. 2015; [3]Jadger et al. 2014; [4]Waldemar et al. 2018; [5]Cleary et al. 2013; [6]Gwinner & Ward, 2015; [7]McKenna et al. 2014a; [8]McKenna et al. 2014b; [9]Tsai et al. 2010; [10]Chen et al. 2013; [11]Coffey et al. 2019; [12]Waldermar et al. 2019.

There were three aspects of empowerment that studies identified:

1. Collaboration. Professionals talked about being collaborative, but consumers experienced having limited choice and influence. (Waldemar et al., 2019)

2. Safety. Two studies identified that professionals had responsibility for safety (Coffey et al., 2019; Gwinner & Ward, 2015). Professionals felt that they had to

manage the tension between managing risks and respecting the consumers'

preferences (Gwinner & Ward, 2015).

3. Interventions. Professionals discussed the importance of providing diverse

treatment options to support personal and clinical recovery but acknowledged that

medication was the primary treatment in an inpatient setting.

The concept of identity was recognised concerning treating the whole person and individually tailoring services to support personal growth. Hope and meaning in life were only afforded brief mentions in a hospital admission context with the exacerbation of symptoms associated with hopelessness (Bredski et al., 2015). Assisting consumers with the practical tasks of daily living and ensuring that the environment was safe and that nurturing was an additional recovery element was identified by Chen et al. (2013) in the inpatient environment.

The findings collectively indicate that professionals can identify practical ways to implement recovery-oriented practice (Cleary et al., 2013; Gwinner & Ward, 2015; McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014). However, professionals over-estimate how collaborative their interactions are with consumers (Coffey et al., 2019; Waldemar et al., 2019). Several studies also demonstrated that inpatient services have not actively changed to be recovery-oriented (Jaeger et al., 2015; Tsai & Salyers, 2010; Waldemar et al., 2018). For this transition to be successful, changes to organisational structures and culture will be required (McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014).

When services are more recovery-oriented, consumers report better recovery outcomes (Chang et al., 2018) and recovery competencies have been developed to support workforce education (Chen et al., 2013). The next section goes beyond understanding what

recovery-oriented practice is to how hospital-based mental health services implement recovery-oriented practice.

3.3   Recovery-Oriented Practice Implementation Research

This section reviews how hospital-based mental health services have implemented recovery-oriented practice, bringing together emerging international research over the last decade. A systematic search identified 16 research studies in the review (see Table 3-3). The studies included were from 11 countries. The quality of the included research was measured by QATSDD (Sirriyeh et al., 2012). The design of the included studies comprised qualitative, quantitative, and mixed methods. One research study was excluded due to methodological concerns.

All studies provided either a definition of recovery or referenced relevant government policy. While there was some variance in definitions of recovery across studies, all descriptions indicated that the focus of each study was on supporting personal, rather than clinical, recovery. The included studies took place in hospital-based mental health services. Most studies took place in acute inpatient units. However, one study included a hospital out-patient unit (Fontaine et al., 2019), and another included inpatient and day-patient services at a hospital (O'Keeffe et al., 2016). Most studies had a small to moderate number of participants which limited the findings' generalisability (see Table 3-3). The most critical problem was that only two of the 16 studies showed consumer involvement in implementing or evaluating recovery-oriented interventions (Kidd et al., 2014; Zuaboni et al., 2017).

The research on the implementation of recovery-oriented practice includes a systematic review that I published in conjunction with my PhD supervisors (Lorien et al., 2020). While this was a joint publication, I was responsible for conducting the systematic review, interpreting the analysis and drafting the manuscript. We all contributed to the study's conceptualisation and design, revising the manuscripts and the intellectual content.

Sections 3.4.1. to 3.4.4. provide an excerpt from the findings and discussion of the review (Lorien et al., 2020) under the headings of staff training, consumer programs, models of care, and discussion.

3.3.1   Staff training

Several of the included studies evaluated staff training interventions that were intended to increase recovery oriented practice (see Table 3-3). Most included studies used more than one recovery measure, including recovery knowledge, attitudes towards recovery and recovery-orientation. Some studies evaluated related concepts, such as staff optimism (Tsai et al., 2010) and attitudes toward people with psychosis (Chang et al., 2014). Most studies that assessed staff recovery knowledge demonstrated an increase in staff recovery knowledge after training. Three studies (Hornik-Lurie et al., 2018; Kidd et al., 2014; Okamoto & Tanigaki, 2018) found higher total scores on the Recovery Knowledge Inventory (RKI) (Bedregal et al., 2006) in the intervention group after the intervention, and on at least one subscale [II] which is nonlinearity of the recovery process. Likewise, all three studies found no change in subscale [IV] which is expectations regarding recovery. A fourth study (Chen et al., 2014) reported an increase in the total RKI score for participants who completed self--paced, online training, but no significant improvement for participants who completed two modules of group-learning. While participants who completed the two group-learning modules rated the program highly, the attrition rate was 46%

The results were inconsistent for staff attitudes towards recovery across training interventions. Hornik-Lurie et al. (2018) found significantly higher recovery attitudes in the IMR intervention group than the control group, indicating a better understanding of recovery and expectations regarding outcomes. In contrast, Okamoto and Tanigaki (2018) found no change in the experimental learning group from pre- to post-training. Similarly, Chang et al. (2014) found no difference in staff attitudes to consumers and Tsai et al. (2010) found no

change in optimism for consumers' before and after CT-R training, regardless of the type of training attended, i.e., specific/practical or general/inspirational. However, staff who attended more training were higher in optimism (Tsai et al., 2010).

Results for changes to recovery-oriented practice varied depending on the type of training completed. Hornik-Lurie et al. (2018) found that staff who attended IMR training scored significantly higher on self-assessed recovery-orientation post-training than the control group. Similarly, Tsai et al. (2010) observed that staff who had participated in specific/practical training increased significantly in self-assessed recovery-orientation. In contrast, there was no change for participants who attended general/inspirational training or no training. Zuaboni et al. (2017) found no significant staff recovery-orientation changes from pre to post REFOCUS training (Bird et al., 2011) as assessed by staff or consumers, There was no significant difference in recovery-orientation between the intervention and control wards (Zuaboni et al., 2017). Similarly, Kidd et al. (2014) found no change to self-assessed recovery-orientation from pre- to post-participation in the series of consumer presentations.

Three training studies incorporated qualitative data, including staff interviews (Hornik-Lurie et al., 2018), focus groups (Kidd et al., 2014) and written feedback following their learning experience (Okamoto & Tanigaki, 2018). Hornik-Lurie et al. (2018) found that participants identified the benefits and challenges of the IMR intervention. Benefits included participants developing a greater interest in, and an understanding of consumers, and a focus on person-centred care. Problems, to implementation of learning, included needing more training and supervision and not knowing how to support recovery when consumers were acutely unwell. Two themes were identified through staff focus groups following the consumer presentations in Kidd et al.'s (2014) study. The first theme centred on the .

Table 3-3

Research design characteristics

Study	Name/Why	What/How/Recovery Measures*	Who (Attrition)	Where	Design
Staff Training					
Chang et al. (2014)	To investigate the feasibility of Cognitive Therapy—Recovery (CT-R[1]) training	CT-R[1] Face-to-face group sessions: 2 hrs/wk x 4 wks	MHS[‡] N = 29	Acute psychiatric inpatient unit; USA	Quantitative Pre/posttest
Chen et al. (2014)	To describe the development of a recovery education program	Self-paced learning (SPL)/Interactive DVD/ns Group-learning (GL) Face-to-face: 3 sessions/wk x 6 wks	MHS[‡] SPL N = 26 (3); GL N = 7	3 psychiatric inpatient units; Canada	Quantitative SPL pre/posttest; GL post
Hornik-Lurie et al. (2018)	To examine the influence Illness Management and Recovery (IMR)/training on MHS attitudes/practice	IMR Face-to-face group sessions: 1 hr/wk x 1 to 11 mths RAQ-7[3]; RKI[2]; RSA-R[4]; Interviews	Exp[§]N = 37; Control N = 35; Interviews N = 15	Mental health center; Israel	Mixed methods Posttest
Kidd et al. (2014)	To assess the impact of consumer narratives on the recovery	A series of talks (N = 58) to MHS[‡] by 12 former consumers Face-to-face group sessions: Biweekly x 12 mths/RSA[5]; RKI[2] Themes	MHS[‡] N = 90. Completed Surveys: Control N = 22 (pre); N = 38 (post) Exp[§] N = 37 (pre); N = 22 (post)	6 inpatient units, psychiatric treatment facility; Canada	Mixed methods Controlled trial Pre/posttest

Study	Name/Why	What/How/Recovery Measures*	Who (Attrition)	Where	Design
Okamoto & Tanigaki (2018)	To implement an experience-based program to increase understanding of recover	Lectures, observations & group Face-to-face lectures, assertive community, treatment, staff visits and group work sessions: 3 days Interviews; RKI[2]; RAQ-7[3]; Reflections	Nurses N = 9	6 hospitals with psychiatric wards; Japan	Mixed Methods Pre/posttest
Tsai et al. (2010)	To examine the types of recovery-oriented trainings on subsequent changes in staff recovery attitudes	3 interventions: Specific/practical training; general/inspirational training or no training How ns Over a 1 yr period & duration ns RSA[5]	MHS[‡] Specific/practical N = 45; General/inspirational N = 126; No training N = 13	2 State hospitals; USA	Quantitative Observational, controlled, Pre/posttest
Zuaboni et al. (2017)	To determine whether recovery interventions yield positive outcomes	RO MHS team meetings, Stakeholder feedback, MHS[‡] education (REFOCUS/ Motivational Interviewing), Consumer group program, peer support & ↑ consumer engagement in treatment planning Face-to-face group sessions: 5 x ½ day sessions for consumers RSA-D[6] (German Translation)	Nurses Intervention N= 43 (5); Control =19 (10) Consumer intervention N = 73 (8); Control N = 29 (15)	2 psychiatric hospitals; Switzerland	Quantitative Controlled trial, Pre/posttest

Study	Name/Why	What/How/Recovery Measures*	Who (Attrition)	Where	Design
Consumer Program					
Bartholomew & Zechner (2014)	To address low IMR program attendance	Workgroup, Consumer survey and 6 x consumer face-to-face focus groups IMR group program for consumers: 11 x 45 min modules	Consumers archival data N = 1186 (38)	State psychiatric hospital; USA	Quantitative: Correlational. Hrs of IMR attendance; Length of community tenure post-discharge
Fontaine et al. (2019)	To understand the effectiveness of an occupational therapist (OT) led transitional service (MORE)	Face-to-face group sessions in skill development and mindfulness & individualised OT sessions: 2 x 90 min group sessions/wk x 9 wks	Consumers N = 126 (60)	Psychiatric Out-patient Department; Canada	Mixed methods: Pre/posttest; 1:1 interview Program questionnaire
Lin et al. (2013)	To evaluate the feasibility and effects of an IMR program adapted for individuals with schizophrenia	Face-to-face IMR group sessions: 2 x 90 min/wk x 3 wks	Consumers Exp[§] N = 48; Control N = 49	6 psychiatric hospital wards; 2 general hospital psychiatric wards; Taiwan	Quantitative: RCT pre/posttest KI[7]
O'Keeffe et al. (2016)	To evaluate the effect of Wellness Recovery Action Plan (WRAP) on personal recovery*	Face-to-face WRAP group workshop: 2 days	Consumers Exp[§] N = 18 (4); Control N = 18 (3)	Psychiatric hospital and out-patient service; Ireland	Quantitative: RCT[¶] pre/posttest; 6 mth follow-up (Exp only) MHRM[8]; MHRS[9]

Study	Name/Why	What/How/Recovery Measures*	Who (Attrition)	Where	Design
Models of Care					
Dawson et al. (2019)	To explore the introduction of Open Dialogue (OD)	OD training for MHS[‡] Face-to-face group sessions: 5 x 1 hr pre-workshops & 5 days training Ethnographic field observations: Over 18 mths (190 hrs)	MHS[‡] Observed N = 33; 1:1 Interviews or focus group N = 18	Private inpatient unit for young adults; Australia	Qualitative. Impact of OD on practice; Staff experience of OD
Gandi & Wait (2010)	To ascertain how Partnership-in-Coping impacts on recovery	Partnership-in-Coping Exp biophysiological, cognitive–emotional, and social–environmental component. The control group had only the biophysiological component Face-to-face Individual and group sessions: 3 mths MHRM[8]	Consumer Exp[§] N = 28; Control N = 49	Neuro-psychiatric hospital; Nigeria	Quantitative: Double blind RCT[¶] Posttest
Hinton et al. (2014)	To determine whether Culturally Sensitive Client-Oriented Care Planning changed the quality of care for Indigenous clients	Senior MHS, cultural security training, face-to-face group: 1.5 days MHS[‡] Yarning about mental health training face-to-face group: 1 day Consumer AIMhi group sessions to develop individual care plans, stay strong plans Face-to-face group: 1 hr Number of times Consumer social history mentioned in the file; AIMhi care plan	Senior MHS[‡] N = 10; MHS[‡] N = 21	Inpatient psychiatric unit; Australia	Action Research; File audit Number of times consumer social history mentioned in the file; AIMhi care plan

Study	Name/Why	What/How/Recovery Measures*	Who (Attrition)	Where	Design
Kalisova et al. (2018)	To assess the effect of the System of Unit Psychiatric Rehabilitation (SUPR) on the quality of care	MHS[‡] supervision in SUPR Teleconferences and via email: 6 mths MHS[‡] training to assess needs and implement rehabilitation approach Face-to-face group: 3 days Implementation: Over 2 yrs	MHS[‡] N = 14	14 long-term psychiatric hospital wards; Czech Republic	Quantitative: Pre/posttest
Sellin et al. (2019)	To explore and evaluate how Recovery-Oriented Care Approach (ROCA) was experienced by a suicidal patient in a context of close relatives and nurses	Planned and spontaneous conversations between nurses consumers and relatives supported by the ROCA guide Face-to-face: 10 wks	Consumers N = 1; Relative N = 1; Nurses N = 3	Psychiatric clinic; Sweden	Mixed Methods: Single case study. Pre/posttest

Notes: Adapted from the TIDier Checklist (Hoffman et al., 2014).

Note: The outcomes from the interventions, i.e., how well are discussed in the text.

MHS[‡] = Mental health staff; RCT[¶] = Randomised controlled trial; Exp[§] = Experimental group ; ns = Not specified;.

Duration: hr = hour; wk = week; min = minute; mths = months; yr = year.

Measures: CT-R[1] Chang and Farash, unpublished text (2010), cited in Chang et al. (2014); RKI[2] Bedregal et al. (2006); RAQ-7[3] Borkin et al. (2000); RSA-R[4] O'Connell et al. (2007); RSA[5] O'Connell et al. (2005); RSA-D[6] cited in Zuaboni et al. (2017); KI[7] Mueser (2005); MHRH[8] Young & Bullock (2003); MHRS[9] MacKeith & Burns (2010).

development of hope in recovery and the second theme focused on implications of recovery

for staff practice. Nurses in Okamoto and Tanigaki's (2018) study identified several areas of

learning from their experience: awareness of the consumers' need to live in their community,

valuing the consumers' wishes and becoming more familiar with their lifestyle. Overall, the

qualitative data suggest that the training increased staff understanding of consumers and

person-centred care. Kidd et al.'s (2014) study also highlighted a change in staff attitudes

towards recovery after listening to the personal stories of consumers.

3.3.2   Consumer programs

Four studies evaluated the impact of implementing programs intended to support the

personal recovery of consumers accessing hospital mental health services (see Table 3-3).

Allied health or nursing staff facilitated all consumer programs. There was no evidence of

collaboration with consumers and no instances of programs facilitated by the peer workforce.

Two studies implemented the IMR group programs (Bartholomew & Zechner, 2014;

Lin et al., 2013) previously shown to be effective in community-based settings (Mueser et al.,

2006; Salyers et al., 2011). IMR uses psychoeducation, Cognitive Behavioural Therapy and

motivational strategies to support services users to achieve their recovery goals

(Bartholomew & Zechner, 2014). O'Keeffe et al. (2016) had health professionals implement

a RCT of the Wellness Recovery Action Plan (WRAP) (Copeland, 1997). WRAP is delivered

by consumers to assist them in taking responsibility for their wellbeing (Copeland, 1997);

however, in O'Keeffe et al.'s (2016) study, WRAP was facilitated by health professionals.

Fontaine et al. (2019) assessed the efficacy of the Mood Disorders Occupational

Rehabilitation and Education (MORE) program to support consumers to transition from

hospital to community-based services. MORE comprised occupational therapy lead group

sessions on life skills, mindfulness, and individual consultations focused on personal goals

and awareness of community resources (Fontaine et al., 2019).

All consumer programs provided adequate detail to enable replication of the studies,

such as references to standardised programs clearly stating modifications (Bartholomew &

Zechner, 2014; Lin et al., 2013; O'Keeffe et al., 2016) or descriptions of the components of

the program (Fontaine et al., 2019). The duration of the consumer programs varied widely.

The group programs ranged from a two-days (O'Keeffe et al., 2016) to several weeks

(Bartholomew & Zechner, 2014; Lin et al., 2013) to a couple of months (Fontaine et al.,

2019).

The measures used to assess outcomes varied across studies (see Table 3-3). Three of

the four studies used a combination of clinical and personal recovery measures (Fontaine

et al., 2019; Lin et al., 2013; O'Keeffe et al., 2016). Recovery measures included the Mental

Health Recovery Measure (Young & Bullock, 2003), the Mental Health Recovery Star

(MHRS) (MacKeith & Burns, 2010) and the Knowledge of Illness Management Scale (KI)

(Lin et al., 2013). Two studies used a quality of life measure (Fontaine et al., 2019; O'Keeffe

et al., 2016) and one study (Bartholomew & Zechner, 2014) used a service indicator of

recovery, i.e., length of time in the community before re-admission.

The results of the studies implementing IMR demonstrated an increase in the range of

recovery measures by participants. In Lin et al.'s (2013) study, those who participated in the

IMR group improved significantly more than the control group in both clinical and personal

recovery. Similarly, in Bartholomew and Zechner's (2014) study there was a positive

correlation between hours of IMR participation and reduced risk of re-admission, i.e., longer

community tenure. These findings were consistent with Fontane et al.'s (2019) conclusion

that the MORE program significantly increased the quality of life scores and reduced clinical

symptoms. Conversely, the results for WRAP (O'Keeffe et al., 2016) delivered by staff failed to demonstrate improvements in personal recovery, quality of life or clinical recovery.

3.3.3   Models of care

Five studies implemented models of care to support recovery within hospital-based mental health services (see Table 3-3). The approaches employed in these studies were diverse including ethnographic field research (Dawson et al., 2019); action research using a file audit to assess change (Hinton et al., 2014); quasi-experimental pre/posttest design (Kalisova et al., 2018); a double blind RCT (Gandi & Wai, 2010) and a single case study (Sellin et al., 2019). Limitations in quantitative designs included having no pre-intervention measures and a small sample size (Gandi & Wai, 2010), no control group (Kalisova et al., 2018) and a file audit which may have been limited by the quality of records (Hinton et al., 2014). Dawson et al.'s (2019) ethnographic field study provided good triangulation of data between observations of practice and staff interviews. Hinton et al. (2014) was the only study to include stakeholder involvement in the design explicitly; however, they did not indicate consumer involvement.

The characteristics of the models of care implemented, varied across studies. Three studies (Dawson et al., 2019; Gandi & Wai, 2010; Sellin et al., 2019) applied models of care based on a relational conceptualisation of recovery: Open Dialogue (Olson et al., 2014), Partnerships-in-Coping (Shanley et al., 2003) and ROCA (Sellin et al., 2018). Relational recovery reflects the ideology that humans are interdependent and the social context defines the experience (Price-Robertson et al., 2017). Open Dialogue is an approach to care based on listening to all voices in the network (Olson et al., 2014). Partnership-in-Coping combines a recovery-oriented approach with the use of the therapeutic alliance to support consumers to develop biophysiological, cognitive-emotional, social and emotional coping strategies

(Shanley et al., 2003). ROCA is an approach to working with people experiencing suicidal ideation, which focuses on their recovery process rather than monitoring behaviour (Sellin et al., 2018).

The other two models of care focused on culturally appropriate care planning (Hinton et al., 2014) and psychosocial rehabilitation (Kalisova et al., 2018). Hinton et al. (2014) implemented a model of care planning that was adapted to support Indigenous consumers, including cultural security training for staff and developing culturally appropriate care plans with consumers. While the focus was on cultural sensitivity, the relational recovery played an integral role in Hinton et al.'s (2014) approach with file audits identifying the social history and family issues in care plans. Kalisova et al. (2018) implemented the SUPR program, which included the development of individual care plans, meaningful activities targeting individual needs, consumer participation in their treatment and active contact with the community. In both Hinton et al. (2014) and Kalisova et al. (2018), the focus was on developing meaningful personal care plans based on individual needs.

The duration of models of care targeting individual services users was three months (Gandi & Wai, 2010; Sellin et al., 2019). Service-wide models of care took place over a longer duration, from 18 months to four years (Dawson et al., 2019; Hinton et al., 2014; Kalisova et al., 2018). These longer-term studies involved the gradual roll-out of training, supervision and changes to practice over time. Dawson et al. (2019) commenced the intervention with staff training followed by formal changes to work processes, including monthly supervision for staff and networks meetings for consumers. Similarly, Hinton et al. (2014) commenced with training for senior staff followed by training for other staff before implementing sessions with consumers. In Kalisova et al.'s (2018) study across multiple hospitals, staff were trained for 12 months before the implementation of SUPR.

The outcomes for models of care indicated that adapting the existing model of care, rather than advocating for a radical change, may be more viable in practice. Dawson et al. (2019) found that the conflict in priorities between Open Dialogue and the biomedical model did not allow for changes to practice-as-usual. Likewise, Sellin et al. (2019) found that ROCA enabled a suicidal consumer to talk about his experience and to ask for support as required. However, this approach is radically different from the current practice of regularly checking on consumers who are at risk and would be challenging to implement in a culture where safety is paramount. Conversely, Gandi and Wai (2010) found that Partnership-in-Coping, which combined biomedical treatment with cognitive-emotional, social and environmental coping, resulted in significantly better personal recovery than biomedical intervention alone. Similarly, Hinton et al. (2014) found that adapting care planning to be more culturally appropriate when associated with an increase in reporting social history and cultural factors for Indigenous consumers as well as a reduction in Indigenous services users readmitted within 28 days of discharge. Kalisova et al. (2018) also used an approach that adapted practice to individual care planning, finding a significant increase in quality of care scores from before to after the implementation SUPR as rated by unit managers.

3.3.4   Discussion

This review brings together international research on the implementation of recovery-oriented practice in hospital-based mental health services. While none of the included studies utilised a specific implementation framework, the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Rycroft-Malone, 2004) will guide the discussion of the enablers and barriers to implementation. The PARIHS framework posits that successful implementation incorporates three elements: evidence

drawn from research and experience, contextual factors within the service that support

change, and effective facilitation of the intervention (Rycroft-Malone, 2004).

The findings indicate that recovery-oriented practice can become a reality in

hospital-based mental health services. Several elements are required to change from a

medical to a recovery-oriented model of care. Consistent with the PARIHS framework, these

elements include knowing the evidence for recovery, cultural change to more optimistic

attitudes about recovery, and facilitation of a multi-modal approach that incorporates staff

training, and consumer programs and changes to care planning processes. Also, models of

care that incorporate aspects of medical practice and relational recovery are more likely to be

more successful than models that require a radical change in practice.

The findings of this review indicate that training increases recovery knowledge (Chen

et al., 2014; Hornik-Lurie et al., 2018; Kidd et al., 2014; Okamoto & Tanigaki, 2018) and

staff who are more optimistic about recovery attend more training (Tsai et al., 2010).

However, it is unclear whether the training itself or other factors yet to be identified,

contributed to the outcomes (Hornik-Lurie et al., 2018). Finding from two controlled trials

(Kidd et al., 2014; Zuaboni et al., 2017) that training made no difference to recovery-oriented

practice, supports the premise that other factors, such as staff optimism, may be integral to

recovery implementation. Also, the type of training maybe of importance with a significant

increase in recovery-orientation for staff who attended specific/practical training, but not for

staff who attended general/inspirational training (Tsai et al., 2010).

In regards to consumer programs, IMR was an effective intervention in hospital-based

services (Bartholomew & Zechner, 2014; Lin et al., 2013) even with a shorter duration than

recommended in previous fidelity studies (Substance Abuse and Mental Health Services

Administration, 2009). While IMR was shortened to several weeks it nevertheless yielded

positive outcomes for consumers, whereas a two-day WRAP workshop did not lead to

significant changes (O'Keeffe et al., 2016). This finding was contrary to studies of WRAP in

community settings (Cook et al., 2012; Jonikas et al., 2013) suggesting that a longer duration

may be required when acuity is of symptoms is higher, or the program is more effective when

delivered by consumers. Besides the implementation of inpatient programs, Fontaine et al.

(2019) demonstrated that a hospital-based day program could be useful in supporting

consumers to transition from hospital to community-based recovery. This transitional

approach is vital to having a holistic approach to recovery across settings and could provide a

viable alternative to the current residential step-up or step-down services (Queensland

Government, 2019).

An important finding was that the models of care studies showed the benefits of

harnessing the collective power of staff training, consumer programs and changes to care

planning processes, to increase recovery-oriented practice. Two studies (Hinton et al., 2014;

Kalisova et al., 2018) illustrated how taking a whole system approach, incorporating staff

training and development of individual care plans resulted in more recovery-oriented

outcomes.

If recovery-oriented interventions are to translate into changes in practice, several

barriers need addressing, including consumer involvement, staff attitudes towards recovery

and expanding organisational priorities to include processes that support relational recovery,

i.e., making time to talk with consumers. Training alone was not sufficient to change staff

attitudes towards recovery. However, in one study where consumers shared their personal

recovery stories, staff hope in recovery increased (Kidd et al., 2014). Staff working in

hospital-based mental health services see consumers when they are in crisis. Therefore,

having consumers share their stories of recovery post-discharge, may be pivotal in changing

staff attitudes to be more optimistic about recovery for consumers.

A final barrier was the embedded, medical model and organisational priorities focused on maintaining safety and clinical treatment, compared with person-centred, recovery-oriented practice. Several studies facilitated the implementation of relational approaches to recovery-oriented care (Dawson et al., 2019; Gandi & Wai, 2010; Sellin et al., 2019) including active collaboration between the consumer and their support network. Unlike the medical model, they advocate for a flat, relational structure where all stakeholders have a voice, rather than a hierarchical structure where professionals are the experts and consumers are recipients of care. Without support from senior staff and management, the desire of a team to become more recovery-oriented in their practice is likely to remain aspirational (Dawson et al., 2019). However, rather than the biomedical and recovery models being incompatible, they may be stronger together, using the biomedical interventions combined with a more holistic, relational approach (Gandi & Wai, 2010).

Overall, the included studies indicate that the implementation of recovery-oriented practice is feasible, albeit challenging in hospital-based mental health services. Multi-modal strategies, including a combination of staff training, consumer programs and changes to care planning processes (Dawson et al., 2019; Gandi & Wai, 2010; Hinton et al., 2014; Sellin et al., 2019) contribute to building a culture that supports recovery. However, without organisations prioritising personal recovery, new models of care will not translate to a service-wide change in practice (Dawson et al., 2019). Future interventions will need to target key decision-makers, such as psychiatrists and hospital administrators, and be developed collaboratively with consumers. (Lorien et al., 2020)[1].

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[1] This is the end of the excerpt from Lorien et al. (2020). This excerpt has been edited to align with the style of this thesis. Selected terms have been adapted for consistency, i.e., service user replaced with consumer.

The research studies provide a guide to building blocks for implementing recovery-oriented practice in hospital-based mental health services. Figure 3-4 depicts the elements essential to the transformation of practice, drawn from the reviews. Ideally, projects will have a committee or working group, including consumers, to oversee the implementation with clear goals and organisational support. All aspects of recovery-oriented practice, design, implementation and review, must involve consumers, consistent with the mantra "nothing about us without us" (National Mental Health Commission, 2012, p. 9). The next step involves initial recovery-oriented practice training for all staff, followed by changes to practice to incorporate recovery-oriented practice. The defining features of recovery-oriented practice are collaborative care with the consumer and involvement of other key stakeholders, i.e., carers/family and peers. This process recognises that recovery does not happen in isolation but in the context of supportive relationships. Other recovery-oriented tasks include introducing recovery-oriented programs for consumers, and recovery-oriented discharge planning, which includes linking the consumer to support in the community. Finally, recovery outcome measures need to be added to the existing clinical and service-level measures, including feedback from consumers on their own recovery and perceived recovery-orientation of professionals and the service.

3.4 Quality Improvement Studies

This section reports the findings from the quality improvement studies. There were three types of quality improvement projects: staff training, consumer programs and comprehensive programs comprising various strategies. Each approach is reviewed, and the collective findings are discussed. While the included studies measure a range of outcomes, including personal recovery, clinical and service indicators, personal recovery is the focus of this review.

3.4.1   Staff training

Only one study reported a stand-alone staff training intervention (see Table 3-4). Repique et al. (2016) assessed staff recovery knowledge before and after staff watched a one-hour online webinar on mental health recovery (Substance Abuse and Mental Health Services Administration, 2010, cited in Repique et al., 2016) and found that recovery knowledge of nurses did not change. The authors indicated that staff knowledge at baseline was moderate to high, so may have reached a ceiling on some subscales of the RKI (Bedregal et al., 2006). An alternative explanation for the findings may be that a one-hour online webinar is insufficient to change recovery knowledge.

3.4.2   Consumer programs

Six studies reported implementing different recovery-oriented programs for consumers (see Table 3-4). Most studies involved improving the provision of group-based programs. Passley-Clarke (2018) implemented the IMR; Mueser et al. (2006) and Christoforou et al. (2018) piloted a ward-based recovery group; Frost et al. (2017) implemented the Integrated Recovery-oriented Model (IRM) and Synovec (2015) evaluated a recovery-oriented occupational therapy service. The remaining two studies implemented strategies to improve recovery-oriented discharge planning. (Kisely et al., 2017; Taylor et al., 2016).

The findings across studies demonstrated some positive service-level outcomes following the implementation of recovery interventions. Passley-Clarke (2018) observed that the readmittance rate for consumers' participants in the IMR program was 5%, which was a decrease compared to the usual re-admission rates. Similarly, Taylor et al. (2016) found that the intervention group were 2.44 times less likely to be readmitted than the control group. These findings suggest that increasing support for personal recovery may positively impact

clinical recovery, with less need for re-admission due to acute symptoms.

Frost et al. (2017) assessed consumers' recovery against the MHRS domains (MacKeith & Burns, 2010). The finding shows improvements across several MHRS subscales, including symptom management and functioning social connection and self-belief. Similarly, feedback in Synovec's (2015) study indicated that occupational therapy services supported recovery. The most beneficial compoments were learning positive coping strategies, long-term goals and establishing supports. Participants in Christoforou et al.'s (2018) group reported a good understanding of the content and increased knowledge about recovery and wellness levels. Kisely et al.'s (2017) study identified that Motivational Aftercare Planning (MAP) recovery plans on the intervention ward improved significantly in identifying triggers, compared to no change on the control wards. However, there was no measure of whether improving care plans contributed to changes in actual care delivered or recovery outcomes for consumers. Therefore, it is unclear whether increased professionals' recovery knowledge led to better recovery outcomes for consumers.

3.4.3   Summary

The QI studies' findings indicate that recovery-oriented practice becoming part of practice-as-usual requires a holistic approach, from having recovery embedded in organisational policy to using a multi-modal approach to implement staff training and consumer interventions. These findings are consistent with Lorien et al. (2020),, which determined that implementing an integrated approach was more successful than stand-alone initiatives. While the QI studies included in the current review lack research rigour, they highlight the importance of working with organisational processes, from establishing recovery committees to staff training, the inclusion of peer specialists and consumers.

Table 3-4

Quality improvement study design characteristics

Study	Why	What/How/How much	Who	Where	Design/Measures
Staff Training					
Repique et al. (2016)	To increase recovery knowledge through online training (& reduce the use of restraints)	Recovery-oriented training: Online webinar provided by SAMHSA[1]; 1 hr	Nurses: N = 42 Pre N = 42; Post N = 32; Focus Group N = 4	8 Inpatient units, private psychiatric hospital; USA	Mixed methods. Pre-post design/RKI[2]; Focus group feedback
Consumer Programs					
Christoforou et al. (2018)	To test the acceptability of a new ward-based recovery group	Psychologically informed recovery group: psychoeducation, recovery stories, hope, wellbeing, self-belief & supports; 4 x 1 hr weekly sessions	Consumers N = 22	2 psychosis inpatient wards; UK	Retrospective evaluation/Interviews
Frost et al. (2017)	To provide an overview of 6 wk recovery program	IRM[3] program based on the MHRS[4]: identifying consumers[†] priorities, individual interventions, consumers[†] & family/carers groups & community connection; 6 wks	MHRS[3] Consumers & MHS[‡] N = 94; HoNOS MHS[‡] N = 82	Sub-acute Intermediate Stay Mental Health Unit; Australia	Prospective pre-post design/MHRS[3]; HoNOS[5]; Re-admission
Kisely et al. (2017)	To evaluate using MAP[x] in discharge planning	MAP[x]: motivational interviewing & advanced directives	Recovery Plans N = 297; Exp[§] N = 100; Control N = 197; Interviews N = 20	3 acute psychiatric wards in two hospitals; Australia	Mixed Methods: Pre-post survey; Interviews Recovery Plans; Interviews

Study	Why	What/How/How much	Who	Where	Design/Measures
Passley-Clarke (2018)	To reduce readmissions, assess MHS[‡] recovery knowledge & evaluate Consumers quality of life	IMR4 groups: psychoeducation, managing medication, relapse prevention, social supports & coping skills. 2–3/wk x 3 mth	N = 218. MHS[‡] N = 2; Consumers N = 216	2 inpatient psychiatric units at psychiatric hospital; USA	Pre-post design/MOS-SF[6]; RSA-RN[7]
Synovec (2015)	To identify effectiveness of an Occupational Therapy (OT) recovery program	OT recovery program: fostering empowerment, occupational engagement, life skills training & QoL management, communication skills & consumers goals	Consumers N=52	Inpatient psychiatric unit; USA	Post-intervention Survey Qualitative Survey
Taylor et al. (2016)	To use ROP to increase engagement in aftercare & reduce readmissions	Recovery-focused care management bridging strategy: identifying barriers to recovery post-discharge, crisis planning, safety & strategies to transition to the community; 10–20 min interview	Consumers N = 195; Intervention N = 87; Control N = 108	Inpatient units at a psychiatric hospital; USA	2-group design. Intervention: interview + TAU[p]; Control. Service use; Re-admission
Comprehensive Implementation					
Ash et al. (2015)	To describe the implementation of ROP	ROP initiatives: collaborative care planning, comfort room, debriefing after coercive interventions, carer consultant, restraint & seclusion review committee, & having consumers[†] exit interviews; 3 yrs	Consumers N = 63 (75%)	Closed psychiatric intensive care unit; Australia	Mixed Methods. Pre-post design; interviews Seclusion rates; Conumer Interviews

Study	Why	What/How/How much	Who	Where	Design/Measures
Koval et al. (2016)	To describe the Implementation ROP & Its Impact on Re-admission	ROP: recovery committee, increased recovery programing, staff training & creating a recovery worksheet for consumers to share with community providers post-discharge; 3 yrs	NS[β]	Inpatient unit, Veterans Health Affairs (VHA) Center; USA	Pre-post design Readmissions pre & 3 yrs post-intervention
McDonagh et al. (2019)	To describe an ongoing quality improvement implementation of recovery services	Partnership for Wellness Recovery Program: recovery committee, MHS education, peer MHS[‡] & recovery-oriented curriculum for consumers[†] (4-6 hrs/day); 2 yrs	NS[β]	Acute inpatient unit, VHA Center; USA	Post-group survey. consumers[†] Quality survey; re-admission
Zuehlke et al. (2016)	To determine whether recovery interventions would yield positive outcomes	Recovery-Oriented Model of Care: MHS[‡] recovery education, recovery-oriented group programing, collaborative treatment planning & inclusion of peer MHS[‡]; 12 mths	N= 379; Consumers N = 352; MHS[‡] N = 27	Acute psychiatric inpatient unit, VHA Center; USA	Pre-post design No. restraints/seclusions; Re-admission; MHS[‡] satisfaction

Notes: Abbreviations: MHS[‡] = Mental health staff; TAU[ᵖ] = Treatment-as-usual;; NS = Not specified[β].

Outcomes: → = No Change; ↓ = Decrease; ↑ = Increase; ↑ * = Significant increase; * = Significant.

References: SAMHSA[1] Substance Abuse and Mental Health Services Administration, 2010; RKI[1] Bedregal et al., 2006; IRM[3] Frost et al., 2017a; MHRS[4] MacKeith & Burns, 2010; HoNOS[5]; Wing et al., 1998; MOS-SF[6] Ware & Shelbourne, 1992; RSA-RN[7] McLoughlin & Fitzpatrick, 2008.

interventions. Having peer specialists recognised as essential team members was an omission identified in previous research

3.5 Chapter Summary

This review provided a partial answer from research concerning three questions: What is recovery in hospital-based mental health services? What is recovery-oriented practice? And how do services implement recovery-oriented practice? The findings support the CHIME conceptualisation of recovery (Leamy et al., 2011). However, the evidence suggests that, consumers have mixed experiences of connection, experience more hopelessness than hope, and have limited power over decision making in the context of an inpatient admission.

In a parallel process, recovery-oriented practice reflects the support needed for personal recovery. Professionals aim to work collaboratively with consumers to build therapeutic relationships and connectedness; to hold hope for recovery when consumers may be hopeless; to tailor services to the individual; to focus on re-establishing meaning through life goals; and empower consumers to be involved in decision making.
However, in endeavouring to be recovery-oriented, professionals face competing priorities, such as taking responsibility for safety while respecting consumers' choices and having limited time to talk and build connections due to other priorities. For consumers, it appears that the vision of recovery-oriented practice is more rhetoric than reality in this setting, with collaboration being on limited terms and the power residing with professionals (Waldemar et al., 2019).

The challenge is understanding how services can transform their practice to be more recovery-oriented when the existing risk management and responsibility culture prevails (Coffey et al., 2019; Gwinner & Ward, 2015). The implementation studies suggest that the

changes need to be systemic and implemented over time. The more successful

implementation strategies used multiple approaches, such as staff training, consumer

Figure 3-4

Implementation of recovery-oriented practice

Staff Training to understand recovery and recovery-oriented practice	Practice changes: Collaborative, person centred care Inclusion of carers, family, peers	Recovery oriented interventions for Consumers: Group Programs Discharge Planning

Oversight by key stakeholders, including consumers and carers

programs and putting recovery planning into routine practice. However, most studies did not

include consumers in their design and implementation. Changes in practice are likely to

remain rhetoric without re-balancing priorities to relational care and genuine collaboration

with consumers (Waldemar et al., 2019). It is not sufficient for staff to change programs or

tasks without service-level changes to enable recovery as part of routine practice. Further

research is required to better understand the conceptualisation of recovery during a hospital

admission and how services can become more recovery-oriented in this setting.

Besides shining a light on the recovery experience in hospital-based settings, this

literature review identified several gaps in the literature explored throughout this thesis.

The first gap is that we have little knowledge about recovery during an inpatient admission.

The limited findings suggest that consumers' experiences do not reflect the positive domains

of CHIME, but rather, more of the difficulties, including disconnection and hopelessness

(Bredski et al., 2015; Eldal et al., 2019). Further research is required to understand recovery

in this context.

The second gap is that our knowledge about recovery-oriented practice in hospital-based mental health services is limited. While the findings suggest that mental health professionals can conceptualise how to support recovery (Cleary et al., 2013; Gwinner & Ward, 2015; McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014), consumers see little change from practice-as-usual (Coffey et al., 2019; Waldemar et al., 2019). Also, some aspects that professionals think are important to recovery, such as positive relationships and peer support, may not be as important to consumers during a hospital admission (Sui et al., 2012). Further research is needed to understand what aspects of recovery are critical to consumers during an inpatient admissions, so staff are better informed about how to support their recoveryThe third gap is knowing how to embed long-term practice changes that incorporate recovery-oriented care in hospital-based mental health services. The interventions to date appear to have limited impact in changing the organisational culture from the medical model to a recovery-oriented approach (Dawson et al., 2019; McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014; Sellin et al., 2019). These findings suggest that cultural change requires a whole system approach and professionals in leadership positions to advocate for recovery-oriented practice.

A fourth gap was the lack of diversity in approaches to implementating recovery-oriented practice in hospital settings, with staff training, group programs for consumers and changes to the model of care being the focus of research and quality improvement studies. The search strategy for the systematic reviews only included studies that explicitly focused on recovery implementation. Therefore, other studies that covered some aspect of practice that was recovery-oriented may have been omitted. For example, approaches that could support recovery-oriented practice include peer support (Davidson et al., 2012), the introduction of recovery narratives (Llewellyn-Beardsley et al., 2019), shared decision

making (Duncan et al., 2010), e-mental health resources (Reynolds et al., 2015), advanced

directives (Zelle et al., 2015), strengths models (Chopra et al., 2009), and mental health

trialogues (Slade et al., 2014). While there is no common language used to identify recovery-

oriented practice, it is difficult to ascertain whether there is a lack of research on recovery

implementation in hospital-based mental health services or if the studies are difficult to

identify.

A limitation of the systematic review was the small number of studies identified and

the diversity of settings, which meant that one study's findings might have limited

generalisability to another setting. However, this limitation suggests that future research

needs to focus on implementation developed with, and tailored to, the local context.

This thesis explores the gaps identified in this review, specifically the

conceptualisation of recovery and recovery-oriented practice in a hospital-based mental

health service. Using a Participatory Health Research approach also addresses the need to

tailor interventions to the local setting, including all key stakeholders, and taking a whole

system approach.

3.6   My Reflection: Down the Rabbit Hole

Doing a literature review can be like going down the rabbit hole in Alice in

Wonderland. Like Alice, I felt like a stranger in a strange land when I started looking at

recovery literature. There was a multitude of definitions of recovery, opinions about

recovery-oriented practice and approaches to implementation. Unsure of which pathways to

follow, I decided to do an initial literature review to inform the research project that looked

broadly at recovery, recovery-oriented practice guidance and national standards for practice.

After we had analysed data from stakeholders, the direction of our study became clearer,

which led me to conducta systematic review of the research to help make sense of our

findings. I decided to focus on the research evidence from studies with consumers and professionals in hospital-based mental health services, rather than the myriad of opinion pieces which expressed the view of individual authors. Looking back, I can see how the initial literature review provided a broad scope that enabled us to commence the study. Then our findings narrow the focus and informed more specific research questions for the systematic review about recovery and implementing recovery-oriented practice in a hospital-based mental health service.

Chapter 4. Methodology

This chapter details the process of developing the research question and research project in collaboration with co-researchers. Section 4.1 describes Participatory Health Research and the philosophical beliefs and principles at the core of this research. Section 4.2 details the research partnership, including the knots, i.e., challenges experienced along the way and how we resolved them. Sections 4.3 to 4.6 cover the research questions, ethical approval, qualitative methodology, and ethical consideration in designing the project. Section 4.7 describes our approach to analysis and synthesis of the data. Section 4.8 reviews the trustworthiness and authenticity criteria used to measure the "goodness" of our research (Lincoln, Lynham, & Guba, 2011, p. 164) The chapter concludes with a summary and my reflection.

4.1   Participatory Health Research: Ontology, Epistemology and Axiology

This section describes what brought me to Participatory Health Research (PHR), the diversity of approaches in this paradigm, and the central ontology, epistemology and axiology that informed each step of the research process. I also outline the principles of Participatory Health Research that our co-researcher group adopted to guide our research.

When I began my research higher degree study, I was looking to do research collaboratively with mental health staff and consumers, congruent with recovery-oriented practice principles. While working at Sunshine Clinic, I experienced having an outsider, i.e., academic researcher, researching an intervention. In that instance, there was minimal input from staff(and no input from consumers on the study's design and limited feedback to inform practice post-research. The researcher obtained their PhD and a publication. However, when I read the article, the researcher's assumptions did not reflect my experience as an insider. I was disappointed and felt disempowered by the process. Given my own experience,

I wanted to research collaboratively and contribute to real practice changes at Sunshine Clinic. Also, I sought to conduct the study using a parallel process to how staff would work with consumers in the recovery approach. The National Standards for Mental Health Practice (Commonwealth of Australia, 2010) describes recovery-oriented practice principles encompassing working in respectful partnerships with people to empower them to make real choices based on their unique needs.

Participatory Health Research is research paradigm or approach, not a methodology, that incorporates a broad range of research traditions, including Action Research, Participatory Action Research, Cooperative Inquiry, and Community-Based Participatory Research (International Collaboration for Participatory Health Research, 2013; Springett, Wright & Roche, 2011). While there is great diversity between these traditions, there are commonalities in ontology and epistemology.

The ontology of the participatory paradigm is that reality is an integration of subjective and objective perspectives (Howell, 2015; Heron & Reason, 1997). Reality results from a creative interaction between the mind and the external world (Heron & Reason, 2000). Coghlan and Brydon-Miller (2014, p. 4) posit that reality in Participatory Health Research is "dynamic and changeable by human agency". Therefore, the research process itself can be "messy" (Abma et al., p. 37) with twists and unexpected turns along the way, as knowledge is co-created through the lived experience of the researchers. The expression 'building the plane while flying' aptly describes the process of bringing together subjective and objective perspectives as co-researcher work through iterative cycles of planning, action and reflection. (Stringer, 2014).

The core assumption of a participatory epistemology is that "participation on the part of those whose lives or work is the subject of the study fundamentally affects all aspects of

the research" (International Collaboration for Participatory Health Research, 2013., p. 5).

Knowledge is generated through co-creation by researchers who are both the researchers and

participants (Heron & Reason, 1997) or, in Coghlan and Brydon-Miller's (2014, p. 3) words,

the "knower(s) and the known". Research is conducted with, not on, people to guide action to

improve some aspect of their lives or experience (International Collaboration for

Participatory Health Research, 2013). This approach is consistent with Heron and Reason's

(1997, p.8) two principles of Co-operative Inquiry: epistemic and political participation.

Epistemic participation means propositional knowledge developed through the research is

grounded in co-researchers lived experience (i.e., experiential knowing). Political

participation emphasizes the central value of people who are subjects of the study also being

researchers, ensuring their rights to participate in all aspects of research about them. Having a

participatory epistemology is informs all decisions about the research (Peralta, 2017). In

Participatory Health Research, community members are actively involved in deciding on the

initial research question and methodology, analysing the data and disseminating the findings

(Minkler & Wallerstein, 2008).

Within Participatory Health Research, there is a considerable difference in the degree

of participation. Participatory "greenwash" is a term used by Abma et al. (2109, p.15) to

describe projects labelled as participatory but where the research is co-opted by external (i.e.,

outsider) interests. Further up the participatory continuum are projects where community

members (i.e., insiders) opinions are sought through consultation or co-operation, but

outsiders still control the research process (Cornwall, 2008). At the ideal end of the

participatory continuum are projects where insiders and outsiders collaborate as co-

researchers (i.e., co-learning) and projects owned and directed by insiders without outsider

input (Cornwall, 2008). Our research involved a co-learning partnership between me, an

academic researcher, and my co-researchers from the community of interest (i.e., staff

working at Sunshine Clinic).

While ontology and epistemology are about what constitutes truth, axiology considers values, asking in the question "what is intrinsically worthwhile?" (Heron & Reason, 1997, p. 10). In Participatory Health Research, the primary value of the research is participation, which is an end in itself (Abma et al., 2019; Given, 2012). The research goal is not to identify universal truth but to transform reality in the local community for the better through the co-creation of knowledge and action (International Collaboration for Participatory Health Research, 2013; Abma et al., 2019). Co-creation respects the fundamental right of people to be involved in the decisions that impact their lives (Heron & Reason, 1997). Furthermore, when people participate fully in the research process as co-researchers, their engagement and co-creation of knowledge leads to transformative action (Amba et al., 2019). What constitutes action may include observable changes at an individual or community level or changes to researchers' beliefs through reflection on their learning (Abma et al., 2019). Consequently, generalizability is not the objective; however, others may evaluate the level of similarity to different contexts (Winter, 2002).

An integral part of doing Participatory Health Research is critically reflecting on our learning and action, including how power impacts participation (International Collaboration for Participatory Health Research, 2013). As co-researchers who were predominantly professionals in a mental health care setting, we needed to be cognizant of the need to share power and give voice to consumers. As the academic researcher, I also needed to be mindful of ensuring equitable participation of all co-researchers. Therefore, each research process step was informed by a participatory epistemology and critical reflection on our roles in co-creating knowledge, consistent with the principles of Participatory Health Research (Israel et al., 2013).

In the current study, our research group decided to be guided by Israel et al.'s (2013, pp. 8–10) nine principles of Participatory Health Research (also known as Community-Based Participatory Research for Health) summarised below:

1. Acknowledging the community as a unit of identity.

2. Building on strengths and resources within the community.

3. Facilitating a collaborative, equitable partnership in all phases of the research.

4. Fostering co-learning and capacity building for all partners.

5. Integrating and balancing knowledge generation with the intervention of mutual benefit to all participants.

6. Focusing on relevance to the community involved and their immediate context.

7. Involving systems developed using a cyclic and iterative process.

8. Disseminating results to all partners, with partners engaged in the broader dissemination of results.

9. Commitment to a long-term process that is sustainable.

The Participatory Health Research principles listed above underpin the phases used in conducting the research project (see Figure 4-1). Consistent with Participatory Health Research, we formed the research partnership to conduct the study with all decisions made collaboratively and co-researchers actively participating in each phase of the project (Israel, Eng, Schulz, & Parker, 2013). The first phase involved the development of the research question. The second phase focused on deciding on the methodology and implementation of the research. The third phase encompassed analysis and making sense of the data. The fourth phase covered action planning, disseminating the findings, and reflecting on our learning through the partnership.

While the principles and phases may give the impression that the research is structured and follows an orderly process, the reality participatory, research is inherently "messy" (Abma et al., 2019, p. 37). No aspect of our research, including the research question and methodology, could be predetermined, as we collaboratively negotiated every phase. The study was located in the local community of interest, i.e., Sunshine Clinic, and was subject to the challenges of working in a dynamic and busy workplace. Throughout this chapter, I will acknowledge the knots that represent the challenges of doing participatory research and are also part of the fabric that holds the project together (Abma et al., 2019p. 16).

Figure 4-1

Phases of the research partnership

4.2   The Research Partnership

This section describes forming the research partnership and how we worked collaboratively throughout the research project. I will explore our partnership process, including the knots that arose and how we found ways to work through these challenges. The partnership with

co-researchers was central to participatory research and involved co-researchers equitably

sharing power and collaboratively developing knowledge in the local context (Abma, 2019;

Israel et al., 2013).

The research partnership was formed in the first two research meetings. Research

meetings three and four were used to co-design the methodology and prepare the ethics

application. Research meetings five and six were during the consultation phase, so they

involved discussion of implementation progress. Co-researchers analyzed findings in

research meetings seven through to ten. In Research Meeting 11, the co-researchers reviewed

and reflected on the research findings from the consultation with stakeholders. In the final

research meeting (Research Meeting 12), co-researchers developed an action plan to improve

recovery-oriented practice, based on what we had learned, and reflected on the research

process (See Appendix A, Table A-1 Research Meeting Schedule).

4.2.1 The researchers

When we commenced the research, our research group comprised eight staff members

(four nurses, two psychologists, an occupational therapist and a ward clerk), a volunteer

consumer advocate and myself as the external researcher. All co-researchers had worked in

Sunshine Clinic for several years, were Caucasian, with most of the group being female.

Our ages ranged from mid-twenties to mid-fifties. Some co-researchers had some personal

experience supporting someone with mental health issues in their personal life as well as

being professionals. While our research group lacked cultural diversity, it was representative

of staff working at Sunshine Clinic in terms of age, gender and ethnicity. Everyone in the

group was passionate about improving support for consumers at Sunshine Clinic. I had

worked with several group members previously when I worked at Sunshine Clinic. I had

known the consumer advocate for many years, initially as my son's teacher and as a participant in one of the first day programs I had facilitated at Sunshine Clinic.

The first knot I encountered was wanting to form a research partnership with professionals and consumers at Sunshine Clinic, but identifying the ethical issue of dual relationships (Hammond, 2010) with co-researchers also having a therapist-client relationship with consumers. To resolve this dilemma, I approached the group in whose practice I was interested, i.e., staff, to form a partnership and invited the volunteer consumer advocate, Lea, to participate. Lea had previously been a consumer but did not have any current therapeutic relationships with staff. Lea's involvement resolved the initial dilemma about involving professionals and consumers without breaching professional ethics.

4.2.2   The research question

To get approval to create a research partnership at Unity Hospital, I had to propose a research question explored by the partners. I consulted with the Nurse Unit Manager at Sunshine Clinic and my former colleagues on the Allied Health Team to derive at an initial research question. The knot was that all co-researchers were not involved in identifying and conceptualising the research from the outset. Once the partnership commenced, we negotiated the power-sharing relationship with each researcher to decide on the research question (Research Meeting 1) and how we would implement the project (Research Meetings 3 & 4). We intended that we would collectively consider options, make decisions and take action to enhance recovery-oriented practice, consistent with an emancipatory action research approach (Carr & Kemmis, 2009). Central to emancipatory action research is participation with all co-participants being equal and involved in the co-creation of knowledge (Ledwith, 2016). The aim is not simply to contribute to theory development but also to better the world through social action (Kemmis, 2010). In line with this broader aim of social action, we

reviewed the research question. We decided to keep the context of the original question, i.e., recovery-oriented practice in Sunshine Clinic. However, we amended the question to reflect the research group's perception that staff were already working in some recovery-oriented ways.

Once we agreed on the primary research question (Research Meeting 1), we collaboratively developed three secondary research questions to explore with other stakeholders to help us answer the primary research question (Research Meeting 3):

1. What is your understanding of recovery and recovery-oriented practice in mental health?

2. What are staff currently doing to support consumers with their recovery?

3. What more could staff and management do to enhance consumers' recovery?

Table 4-1

The research question

Question	
Initial	How can a hospital-based mental health service implement recovery-oriented practice?
Revised	How do we collaboratively enhance and deliver recovery-oriented practice at Sunshine Clinic?

4.2.3   Project approval

The third knot was threefold, viz., getting the project approved which required support from Unity Hospital Chief Executive Officer (CEO), having a supervisor affiliated with Ramsay Health, and ethics approvals by CQUniversity and Ramsay Health. My existing relationship with the CEO and the consultant psychiatrists was critical at this stage. Before submitting a proposal for ethics approval, the CEO provided a letter of support, and a

consultant psychiatrist agreed to be one of my supervisors for the project. Obtaining ethics approval was then a two-step process requiring ethics approval from CQUniversity Human Research Ethics Committee (HREC) (Reference No. 20680) and then from Ramsay Health HREC (Protocol No. 17/01).

4.2.4 Recruiting co-researchers

After ethics was approved and the CEO had read the research information sheet and completed the agency consent form (see Appendix A: Agency Consent Form) I commenced recruiting co-researchers. The agency consent form confirmed that participation or non-participation in the research project would not affect staff employment and provided anonymity for the hospital and participants in any subsequent publications. The CEO also agreed that staff could attend research meetings during work time.

The aim was to recruit co-researchers from each of the key stakeholder groups in Sunshine Clinic, including nurses, allied health staff, administration staff and the consumer advocate. The Nurse Unit Manager invited me to a staff meeting to ask for expressions of interest. Each staff member was given the research information sheet. All staff who expressed interest in participating were given an invitation to be a co-researcher and completed a consent form (see Appendix A: Co-Researcher Consent Form). Eight staff and the consumer advocate accepted the invitation and attended the first co-researcher meeting to form the partnership.

Our approach was consistent with Israel et al., (2013) who posited that regardless of who initiates a project, Participatory Health Research's process becomes collaborative and equitable in the decision making. We drew up a Partnership Agreement at the first research meeting (see Appendix A: Partnership Agreement) that clarified everyone's responsibilities. The agreement outlined our intention to uphold Participatory Health Research's values, attend and actively engage in partnership meetings, and speak up to say what we thought

while respecting differing perspectives. My co-researchers' consent to write up the research

as part of my PhD, was documented in the agreement. The agreement and our meeting

minutes formed part of the audit trail to document our group's discussion and decisions).

Consistent with a participatory action research approach, my role in the research

group was as a catalyst and facilitator of change. I worked with my co-researchers to develop

a 'community of inquiry' to explore our understanding of recovery-oriented practice at

Sunshine Clinic and actions to enhance practice (Pyett, Waples-Crowe, & Van Der Sterren,

2014; Stringer, 2014, p. 23).

4.2.5   Knowledge to inform the research

I completed an initial review of the literature to inform this research, focusing on

how mental health policy in Australia (Commonwealth of Australia, 2013a; 2013b) translates

into practice in hospital-based mental health services. Staff co-researchers added their

practice knowledge from working in Sunshine Clinic, and the consumer advocate shared her

lived experience of living well with mental health challenges. Together these diverse ways of

knowing (Heron & Reason, 2008) informed this research. We agreed that it was essential to

observe the basic principle of "nothing about us without us" (National Mental Health

Commission, 2012, p. 9), and listen to consumers' experiences at Sunshine Clinic if staff

practice was to be genuinely transformed by recovery principles (Happell, 2008). While our

research group primarily comprised professionals focused on improving our practice, we

could not do this research without the consumers who shared their lived experience and

having the consumer advocate co-researcher involved in every aspect of the project.

4.2.6   Key stakeholders

At the first reseach meeting, we unanimously agreed that the project was more likely

to succeed if we communicated regularly with the management team (including the CEO,

consultant psychiatrists and managers in the hospital) and the Consumer Reference

Committee (see Figure 4-2). We used the existing administrative processes to communicate with the respective groups. The Nurse Unit Manager communicated with the management team and the consumer advocate shared our project with the Consumer Reference Committee. Working in collaboration with key stakeholders was essential and reflected in the goals of the partnership, which included:

1. To answer the research question.

2. To consult with key stakeholders to answer the research question.

3. To action changes to enhance the delivery of recovery-oriented practice.

(see Appendix A: Partnership Agreement).

Figure 4-2

Relationship with key stakeholders

One of the knots for our research group was finding a suitable day and time for everyone to meet. Hospital management ensured that all co-researchers on staff were rostered to be at work on the day of the first meeting and had time off from their usual duties attend our first half-day meetings. At the first research meeting, we agreed on a regular one-hour

meeting on Thursdays at 2.30 pm approximately every six weeks over the next 18 months (see Appendix A: Table A-1 Research Meeting Schedule.) The meeting was after the allied health staff had finished facilitating groups for the day and before the nurses finished the day shift. However, not all staff co-researchers worked the morning shift on the meeting day or sometimes prioritised other tasks on the ward. As a co-researcher group, we addressed this challenge pragmatically, agreeing that if someone could not attend a meeting, they would contribute to the agenda, read the minutes and email the group to contribute.

We met 12 times during the project, and all other communication between our co-researcher group was via email. At the second research meeting, we also considered other communication options, e.g., communicating using a secure online website; however, we found that email was the best option as the agency limited internet access.

Another knot was attrition from the research group when three co-researchers left the service for other employment. After the initial meeting, one co-researcher left the service, another departed mid-project, and one left before the final meeting. Another co-researcher was frequently unavailable due to rostering or other duties but kept in touch via email. One of the co-researchers who left was the Nurse Unit Manager. Fortunately, one of the nurse co-researchers stepped up into the Nurse Unit Manager role, so our research group continued to have a manager as a co-researcher. While the number of staff attending meetings fluctuated, seven co-researchers were actively involved in the project from start to finish (see Appendix A: Table A-1 Research Meeting Schedule).

4.3   Ethics Approval and Considerations

At the third and fourth research meetings, our co-researcher group collaboratively designed the study methodology and prepared the ethics applications for CQUniversity and Ramsay Health HREC committees. All co-researchers were co-signatories to the ethics

application as were my three supervisors (two from CQUniversity and a consultant

psychiatrist at Unity Hospital). To ensure that key stakeholders had the opportunity to

provide input, the Nurse Unit Manager presented our plan to the management team. The

consumer advocate did likewise to Consumer Reference Committee. CQUniversity HREC

(Reference No. 20680) and Ramsay Health HREC (Protocol No. 17/44) approved the study

to be implemented from 14 August 2017 to 31 March 2019. (see Section 1.4 for further

ethical considerations for this study).

Researchers are ethically required to conduct research in a way that minimizes

participants' risks and respects their privacy (Bloomberg & Volpe, 2018). Ethical

considerations were crucial for our study involving a vulnerable population, i.e., people

experiencing increased mental illness symptoms during a hospital admission, and hospital

staff who shared their perspectives on practice in their workplace. Section 4.3.1 will provide

an overview of ethical considerations in researching a vulnerable population, based on the

principles of "autonomy, beneficence, non-maleficence, and justice" (Tee and Lathlean,

2004, p. 537). Sections 4.3.2 to 4.3.5 then cover our practical approach to gaining informed

consent, anonymity and confidentially for participants.

4.3.1 Ethical issues in researching a vulnerable population

In researching with people during an inpatient admission, we were conscious of

maintaining the balance between autonomy and protecting participants from harm (Tee &

Lathleam, 2004). To support participant autonomy, we developed a transparent process for

consent (see Section 4.3.2). We emphasised that participants could withdraw at any time and

identified who they could talk to if they experienced any negative impacts from participating.

The consumer advocate and I were mindful that the discussion could trigger an unwanted

emotional response in the focus groups. In this case, a participant may need to leave the

group to check in with staff. We planned the focus groups to run for only one hour to reduce any negative impacts on participants who may have had difficulty participating for a longer duration due to fatigue, concentration problems or other mental health issues (see Section 4.4.3).

In planning our engagement with consumer participants, we considered the principles of beneficence and non-maleficence (Tee and Lathleam, 2004). In addition to outlining risks in the project information sheets (see Appendix B), we discussed potential risks and ways to minimise disruption to the ward with the Nurse Unit Manager. For example, our focus groups were timed not to conflict with other activities or clinical interventions. In the focus groups, we took the time to build rapport with participants and listen to their stories before asking our research questions (see Section 4.4.3). We were aware that participants' distress could be triggered by talking about challenges they or others had experienced. Therefore, we encouraged participants only to contribute what they were comfortable sharing and check-in with ward staff if they become distressed. Part of our role as group facilitators also involved advising staff if we noticed that anyone appeared to be distressed during the group. During the focus groups, there were no instances of consumers reporting being distressed or seeing that someone was visibly distressed.

To promote the final principle of promoting justice (Tee and Lathleam, 2004), we were open and transparent about our research processes in the information provided to potential participants (see Appendix B: Information Sheets). We requested that staff, who were not co-researchers, check that participants understood the information and could provide informed consent. We reiterated the research information at the beginning of the focus groups, including the right to withdraw at any time and how to make a complaint. At co-researcher meetings, we were open and transparent in our communication about how our

attitudes, assumptions and roles impacted the research. However, these discussions were

brief, given the limited time to meet. I gave all co-researchers a journal and encouraged them

to reflect on our project between meetings. Only the consumer advocate and I regularly used

our journals across the project. I discussed my reflections with one of my supervisors (WM),

including how my insights interacted with the research process. Exerts from my journal are

included throughout this thesis.

4.3.2 Informed consent

All participants read an information sheet describing the research and provided

written consent to participate in the study (see Appendix B: Information Sheets and Consent

Forms). The information sheet articulated the purpose of the research, the procedure, benefits

and risks, the right to withdraw at any time and who to contact about any concerns or

complaints. The consent form also included a statement to confirm that participation or non-

participation in the research study would not affect the person's admission at Sunshine

Clinic. An additional step was required to ensure that inpatients could give informed consent

to participate in the research. For the inpatient focus groups, a nurse, who was not a

co-researcher, completed a 'consumer capacity to provide consent' form for each participant

(see Appendix B: Consumer Capacity to Consent Form). By signing the form, the nurse

indicated that the participant understood the details in the Information Sheet about the

research's purpose, appreciated the risks and benefits of participating, and had made an

informed choice to participate.

4.3.3   Anonymity

At the third research meeting, we agreed that providing anonymity for the research

participants was an essential consideration in completing this research. The study did not

identifying individual participants or the hospital. Pseudonyms were used instead of the name

of participants or the hospital and mental health service. We took the additional step of the consumer advocate and me, as non-staff members, completing all the consultations and de-identifying the transcriptions before sharing these with our research group. Similarly, when reporting feedback from the co-researcher group to the Mental Health Advisory Committee and the Consumer Reference Committee, we summarised group decisions without identifying who said what.

4.3.4 Confidentiality

As the academic co-researcher it was my responsibility to confidentially store completed consent forms participants details and audio recordings from the consultations and research group meetings. These records were saved electronically on a password protected CQUniversity computer and backed-up on CQUniversity OneDrive. Each participant was assigned a unique pseudonym in the transcriptions available to co-researchers in this thesis and articles for publication.

4.4 Qualitative Methodology

This section provides a rationale for the qualitative methodology chosen by co-researchers, an overview of the research design, research sample and data collection methods. The academic researcher cannot pre-determine the methodology in participatory research, but must be co-designed with co-researchers (Abma, 2019; Bourke, 2009).

At the third research meeting, we chose to use qualitative data collection methods, including interviews, focus groups and a qualitative online survey. Qualitative methods were appropriate to make sense of the meaning that key stakeholders brought to the research question. The focus groups provided a natural environment, familiar to consumers, to communicate with researchers in a relaxed and flexible format to explore their research question perspectives (Bloomberg & Volpe, 2018). The interviews with managers and

consultant psychiatrists aimed to capture their recovery-oriented practice views while

maintaining anonymity. The online survey provided all staff at Unity Hospital the

opportunity to contribute to the research in line with the value of maximising participation

(Abma et al., 2019). The goal was to obtain comprehensive, richly-descriptive findings that

reflected insiders' perspectives (Merriam, 2015) (see Section 1.3 for discussion of each data

collection method).

4.4.1   Research sample

The research site, Sunshine Clinic, comprised a 24-bed inpatient mental health unit

and a day-patient program based in a small, 66-bed, private hospital in regional Australia.

The day-patient program ran one day each week over three months. The hospital had two

other general wards and provided a range of out-patient services. The hospital's managers

were primarily nurses, including three Nurse Unit Managers. Five psychiatrists had

consulting rights at Sunshine Clinic and were part of the Mental Health Advisory Committee

that managed the clinic.

We used purposeful heterogeneity sampling to select the study participants

(Bloomberg & Volpe, 2018). My co-researchers represented a cross-section of the

stakeholder groups within Sunshine Clinic, i.e., four nurses, including a Nurse Unit Manager,

three allied health staff, administrative staff and a consumer advocate. At the third research

meeting, our research group discussed wanting to ensure that all stakeholders within the

clinic, i.e., staff including managers, consumers and carers, had the opportunity to participate

in the study. We also wanted to extend participation to staff working in all parts of Unity

Hospital. The rationale for including staff and managers who did not regularly work in

Sunshine Clinic was pragmatic and theoretical. Other staff sometimes worked at Sunshine

Clinic, and managers made decisions about providing care across the hospital. Also, staff

were on the continuum between emic (insiders) and etic (outsiders) and would contribute insights to our collective understanding of the research question (Hoare, Buetow, Mills, & Francis, 2013). Consumer participants were either current inpatients or day-patients accessing services at Sunshine Clinic.

Seventeen consumers participated in the study, including the consumer advocate: ten male and seven females. Ten consumers were inpatients at the time of the study, and six were day-patients. Consumers who were inpatients participated in Focus Group 1 and 3. One consumer, Myles, participated in both inpatient focus groups. Consumers who had participated in day programs participated in Focus Group 2 and 4.

Most day-patient participants had previously had an inpatient admission. While we did not ask participants about their diagnosis or demographic details, we found that most participants were eager to tell us about the experiences that led to their admission. Many of the participants had experienced mental health issues over several decades. Most people agreed to participate in the study as they wanted to help other consumers with their recovery.

Seventeen hospital staff participated in the anonymous online survey, including six staff who regularly worked in Sunshine Clinic and 11 staff from other hospital sections. Fifteen staff respondents identified as clinical staff, one identified as non-clinical (admin/auxiliary/other) and one did not indicate their role. Some managers may have participated in the online staff survey in addition to individual interviews as the survey was sent to all staff to complete anonymously. Therefore, up to five participants could have been counted twice.

While we did not have access to staffing numbers, based on state nurse to patient ratios (Queensland Health, 2016) the hospital would have employed approximately 60

full-time equivalent nurses. Also, five allied health staff were employed across the hospital (two psychologists, two occupational therapists and a pharmacist), administration staff, auxiliary staff, i.e., cleaners, cooks and maintenance staff, managers and human resource staff. All treating doctors were private practitioners with consulting rights at the hospital.

Seven managers, including two consulting psychiatrists, also participated in the study. Three of the managers (one nurse and two psychiatrists) worked in Sunshine Clinic full-time, and the other managers worked in different sections of Unity Hospital. Several managers who did not regularly work in Sunshine Clinic said they had limited knowledge about recovery and recovery-oriented practice and did not know what they could contribute to the research. However, they had worked with patients on other wards who were experiencing mental health issues and had personal experience in supporting a family member who had experienced mental health issues. The two psychiatrists who participated in the study had an existing interest in recovery-oriented practice.

No carers responded to the invitation to participate in the study. Not having carers involved in the study presents a significant gap in our research as they are an important stakeholder group. Engagement with carers is discussed further in the findings and actions arising from this study.

4.4.2 Data collection methods

At the third research meeting, we decided to use multiple data collection methods with different stakeholders to obtain an in-depth understanding of the research questions. This data triangulation strategy, i.e., by seeking numerous perspectives, added to the rigour of the research (Creswell & Poth, 2016). Another advantage of having multiple data sources was the data's increased credibility (Davidson et al., 2005). This phase comprised focus groups with consumers, semi-structured individual interviews with managers and an online staff

survey (see Appendix B: Table B-1 Consultation Schedule). The data collection design provided participants with the opportunity to confidentially share their perspectives on recovery and recovery-oriented practice at Sunshine Clinic. In the following sections each of the data collection methods will be described, along with the number of participants who took part in each consultation type, i.e., focus groups, interviews and survey.

4.4.3   Focus groups

Focus groups are useful for collecting in-depth data from a group of people who have something in common (Bloor, Frankland, Thomas, & Robson, 2001; Green & Thorogood, 2009). Focus groups work best when participants feel comfortable, respected and can voice their perspectives (Krueger & Casey, 2015). Focus groups also provide a forum for participants to share their collective knowledge, learn from each other through discussion and promote participant ownership of the project (Kamberelis & Dimitriadis, 2005). Therefore, we decided that focus groups would be an appropriate method to collect data from consumers.

The consumer advocate and I collaboratively planned the focus groups so that participants would be safe, comfortable, engaged and had their confidentiality protected. Our primary concern was that consumer participants, who had a dual relationship with staff co-researchers as consumer/clinician and participant/researcher, could participate knowing that staff co-researchers would not know who said what in the focus groups. To achieve this end, the consumer advocate and I conducted the focus groups. We de-identified and collated the data across focus groups before sharing this information with our co-researchers to complete that thematic analysis.

It was imperative to have the consumer advocate co-facilitate the focus groups with me so that participants would feel comfortable during discussions. To prepare for the focus

groups, the consumer advocate and I met to plan our approach, following the guidelines provided by Krueger and Casey (2015) and using our practical knowledge of the local setting. For instance, we knew we needed to listen to participants lived experiences of mental health challenges before asking our research questions. We also thought it might help participants share their experiences if the consumer advocate shared some of her own stories. This strategy worked well, with all participants actively engaging in the discussion.

In the focus groups, the consumer advocate had an active role in discussing the experience of recovery and recovery-oriented practice with consumer participants. My role was not as an expert but as a resource person who helped facilitate the process as recommended by Stringer (2014). I advised participants of my role and explained that I had previously worked on the ward. Some participants had met me during a previous admission, but that had been at least two years before the time of facilitating the groups. I followed the advice given by Herr and Anderson (2015) to disclose this pre-existing relationship to participants and actively develop equitable relationships with all participant groups. Some participants also knew the consumer advocate when they were visited during their admissions or from a prior group day program.

We facilitated separate groups for inpatients and day-patients. We held the inpatient focus groups in the ward and the day-patient focus groups in the day program area. This strategy ensured that participants were in a familiar environment, with other participants they already knew, and that staff were available should someone needed assistance. All consumers could participate in a focus group if they could provide informed consent (see Section 1.3.1).

To protect participants' privacy, we de-identified the transcripts before sharing the de-identified feedback with staff co-researchers. The focus groups were audio-recorded with the informed consent of participants, from which I transcribed the recordings verbatim.

Four focus groups took place between August and November 2017, two inpatient groups and two day-patient groups, with a total of 16 participants. We offered participants an individual interview or participation in a focus group. No consumers took up the option of a separate interview. In addition to consumers, we invited carers to attend a focus group or have individual interviews. We offered carers the opportunity of participating in focus groups on four occasions, advising patients at the ward meeting and placing information noticeboards in the ward. No carers attended.

We conducted sufficient focus groups to reach saturation. Consistent with Bowen's (2015) description, saturation was the point that we agreed, as co-researchers, that additional data collection was unlikely to provide any new insights. We arrived at this decision by reviewing the transcripts and identifying the same themes emerging from each focus group. We used the terminology of saturation pragmatically, recognising that other terms, such as "information power" may better represent our decision about when to stop data collection based on sufficient meaning being generated (Braun & Clarke, 2021, p210).

4.4.4 Interviews

Interviews are a common approach in qualitative research to obtain an in-depth understanding of the phenomenon of interest (Bloomberg & Volpe, 2018). We agreed that the interviews would need to be anonymous and conducted by an external person for managers to feel comfortable participating. All managers and consultant psychiatrists received an invitation to participate in an individual discussion for the research project. I met with managers in their offices at Unity Hospital and the consultant psychiatrists in their private

consulting room. The individual interviews took place between November 2017 and February 2018 at times that suited each participant. The duration of the meetings was approximately 15–20 minutes, although some interviews took up to half an hour. Traditionally interviews that more time (Irvine, 2011); however, the short duration was because it was challenging for managers to make time in their busy schedules to participate. Our co-researcher group felt that it was preferable to include managers, even if the interviews were short, than not to have them participate at all. The disadvantage was that the interviews may not have been as indepth as possible with more time. Conversely, the one advantage was all the managers who participated had worked with me previously. Hence, they were comfortable sharing their perspectives and gave their full attention to answering the research questions in the time available.

Given that the pool of manager participants was small and well known to all co-researchers, an integral part of their ability to honestly share their perspectives was that we assured them that their participation would be confidential and de-identified. The interviews were audio-recorded with participants' informed consent and transcribed by me. I advised participants that I would not share with my co-researchers who said what in the one-on-one interviews. The process was that, before communicating with my co-researchers, I de-identified the transcripts and collated them so that the co-researchers could not identify the participant based on the date or location of the interview. Seven managers, including five senior nurses and two consultant psychiatrists, participated in the research.

4.4.5 Online survey

At the third research meeting, we decided to include hospital personnel from other wards inUnity Hospital and Sunshine Clinic in the research. The rationale for this decision was that staff co-researchers felt that some staff from other wards had a limited

understanding of recovery, and this impacted practice when they did an occasional shift in

Sunshine Clinic. We chose to use an online survey as this was the most effective way to

reach all staff. Consistent with qualitative research methodology, the survey included open-

ended questions to capture staff perspectives on the phenomenon of interest (Bloomberg &

Volpe, 2018). The staff survey (see Appendix B: Staff Survey: Recovery-Oriented Practice at

Unity Hospital) was emailed out to all staff and was available from November 2017 to

January 2018. The survey contained information about the research and informed consent.

The survey included the following two optional items that would identify participants by role

and local in Unity Hospital:

- At which location do you usually work (Sunshine Clinic or other location at Unity

  Hospital)?

- What is your job role? (Clinical - Nurse or Allied Health or

  Non-clinical - Administration/Axillary or other).

The staff survey took 5–10 minutes to complete. Four staff worked in Sunshine Clinic

and 11 in other hospital sections. All participants identified as clinical staff, i.e., nursing or

allied health.

The challenge for the staff survey was that, while the hospital sent the survey link to

staff via email, most staff did not have access to a work email. Therefore to participate, staff

needed to complete the survey in their personal time. This may have contributed to a low

response rate, along with some staff sharing with co-researchers that they did not complete

the survey as their knowledge about recovery was limited.

4.5   Data Analysis and Synthesis Methods

When conceptualising this project, one of my supervisors (BM) suggested doing a

grounded theory study. However, finding a methodology that provided meaningful data while

maximising co-researchers' participation was challenging. Participatory action research aims
to better understand the phenomena of interest, i.e., recovery-oriented practice in Sunshine
Clinic, to inform action (Dick, 2014). The data needed to be meaningful and credible to the
participants, i.e., co-researchers involved in the project (Abma et al., 2019). Furthermore, the
analysis method needed to be co-designed and completed collaboratively with co-researchers
(Abma, 2019; Bourke, 2009). The focus of analysis in participatory research is on developing
knowledge with insiders who have insights and lived experiences of the community of
interest. The positivist belief in "total objectivity" (Varpio et al., 2017, p. 42) is not relevant
in participatory research, where the objective is not to reach an objective truth but to
understand the phenomenon of interest and take action in the local context (Abma, 2019).

Therefore, at the third research meeting, we chose the inductive thematic analysis
method (Guest, MacQueen, & Namey, 2011). This analysis method allowed us to identify
themes from our stakeholders' consultations and was relatively simple, empowering all co-
researchers to participate in the data analysis.

We used Flicker and Nixon's (2015) DEPICT model (see Table 4-2) for the thematic
analysis. Participation of all co-researchers' deepened and enriched the meaning-making and
allowed for member-checking as the group comprised members of each stakeholder group.
At research meetings seven to ten, the research group collectively explored and analysed
themes identified in the implementation phase and made sense of the data. To prepare for the
analysis, I reviewed the audio recordings and transcribed them verbatim. At the research
meetings, we coded that data into themes.

Coding was a process of collaboratively organising the codes into themes, and
identifying the relationships between them. A code was the label attached to a quote or short
sequence of the text from the transcribed consultations with stakeholders. A theme was a

categorisation used to identify a major element of analysis. After we had sorted the initial

themes, we grouped them under meta-themes that described the major unit of analysis, i.e.,

conceptualisation of recovery, relational recovery, and recovery-oriented practice. Then, due

to the complexity of the data, we identified sub-themes within each theme that represented a

distinct element of analysis within the theme. For example, within the meta-theme

'recovery' , the theme 'different pathways' consisted of three sub-themes identified: 'not one

size fits all', 'the recovery track' and 'back to where we were'.

Table 4-2

DEPICT steps

Step	Academic Researcher	All Co-Researchers	Questions
Dynamic Reading	Review all codes from stakeholders and sort into themes with Consumer Advocate.	In pairs, review a subset of codes from stakeholders and sort into themes.	What are the themes?
Engaged Development of Themes	Develop preliminary themes.	Come to consensus around a preliminary themes	Do we have the right themes?
Participatory Coding	Review and sort all codes under themes.	Provide feedback on themes.	Which codes fit into each theme?
Inclusive Reviewing & Summarising of themes	Develop theme summaries.	Review category summaries.	What are the main ideas? Does this fit with the perception of stakeholders?
Collaborative Analysing	Create a figure that illustrates the findings.	Collaboratively make sense of data and come to a consensus on new understandings.	What were our most important findings?
Translating	Collate the research findings.	Develop a plan for sharing research findings with stakeholders.	Who needs to know what? How do they need to hear it?

Adapted from Flicker & Nixon (2015).

The knot was that it was not feasible to check identified themes with the focus group, individual interviews, or online survey participants. By the time we had completed the consultation and were doing the analysis, consumer participants had been discharged from the service; managers availability became limited, and the staff survey was anonymous. However, it was possible to do member-checking with co-researchers from the identified participant groups. This process was consistent with Davidson et al.'s (2014) recommendations to involve other participants, i.e., the co-researchers review of the findings from the previous participants and their comments on their credibility. When there were any differences in the themes identified by co-researchers, we listened to the perspectives of the co-researchers that were part of the same group as participants whose responses we were reviewing, i.e., consumers or professionals, before collaboratively deciding on the final themes.

The challenge for data analysis was how to make the process collaborative so that all co-researchers had the opportunity to be actively involved. Staff co-researchers' capacity was limited to the one-hour research meetings held every six weeks. I initially used NVivo (QSR International, 2106) to sort themes, but none of my co-researchers had access to NVivo. Therefore, I proposed a paper-based method that could be completed over several research meetings and involve all co-researchers. My time-poor co-researchers agreed to collaboratively sort the feedback from the two stakeholder groups (consumers and professionals) into themes over four successive meetings (Research Meetings 7, 8, 9 & 10). At the meetings, staff co-researchers worked in pairs to sort themes. The consumer advocate and I met between meetings to sort the themes and compare them with those identified by our co-researchers. Where we identified differences in identified themes we would discuss this in the subsequent meeting until we all agreed on the final themes. The process of having the data sorted by at least two pairs of reviewers was to reduce the impact of individual

assumptions or bias on interpretations (Kidd & Parshall, 2000). We recognised that in participatory research, it is the co-construction of knowledge that is central (Abma, 2019). Hence, our main objective in having multiple coders was to incorporate the perspectives of all co-researchers. The other reason for working in pairs was that co-researchers preferred working together to discuss their thinking with another co-researcher as they worked through the process.

We initially sorted themes from the consumer focus groups, then from the interviews and survey with professionals. We tried to understand the data by examining the responses to each of the research questions, then across all questions as we noticed similarities. Once we had all the data from consumers and professionals, we saw considerable overlap in themes. Wedecided to combine the data from both stakeholder groups to arrive at the final themes (see Figure 4-3—Process to Develop Themes).

To prepare the sorting data, I numbered and typed quotes, i.e., each comment made by participants in the consultation, under each of the three research questions. Then I printed the quotes out on coloured paper, i.e., one colour per research question. I cut the paper into strips containing one quote per strip. I made two complete sets of printed strips containing all the quotes. The consumer advocate and I sorted one set into themes and likewise, our co-researchers sorted the other set. I compared the two sets of themes by putting them into a table. The first column contained the themes and quotes that the consumer advocate and I had agreed on, and the second column repeated the process for the other co-researchers. The third column proposed themes, based on a combination of the other two columns, for discussion at the next meeting (see Appendix C: Thematic Analysis Development, Tables C-1 to C-8). I noted where the same quotes were grouped together, but that the name of the theme was different, e.g., discharge support vs care planning, or where sub-themes could be put together,

e.g., isolation and lack of support. I emailed the tables to co-researchers to review, and we

discussed the proposed themes at the subsequent meeting. Where there were different

perspectives, we reached a consensus by discussing our ideas and listening to the views most

Figure 4-3

Process to develop themes

aligned to each stakeholder group who raised the theme. For example, for consumers, we

prioritised the consumer advocate's perspective, and we listened to the view of staff co-

researchers. Once we reached a consensus on the themes, I drew up a document containing

the meta-themes, themes and sub-themes, along with representative quotes and a one-page

summary (see Appendix C: Summary of Themes). The summary document used the exact

wording of the research participants to ensure it reflected their perspective and they could

recognise their voices in the narrative (Stringer, 2014).

4.6 Trustworthiness and Authenticity

Trustworthiness and authenticity measure qualitative research's "goodness", i.e.,

rigour and validity, or quality (Lincoln et al., 2011, p. 164). Trustworthiness comprises

credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985).

Authenticity is the extent to which the research is meaningful and useful (Guba & Lincoln,

Table 4-3

Quality assurance strategies

Strategy	Credibility	Dependability	Confirmability	Transferability	Authenticity
Audit trail		x	x		
Data collection					
Prolonged Engagement	x				x
Audio recording & verbatim transcription			x		x
Triangulation	x	x			
Saturation of data	x			x	
Member-checking	x	x			
Data coding/analysis					
Intercoder reliability	x		x		
Triangulation (investigator)	x	x	x		
Presentation of findings					
Thick, vivid descriptions	x			x	

Table adapted from Nurse Key (2017)

4.6.1 Credibility

Credibility refers to whether the researchers accurately reflect the participants' perceptions of the phenomena of interest (Cope, 2014). Techniques for assessing credibility include prolonged engagement, triangulation, negative case analysis, member-checking and reflexivity (Amankwaa, 2016).

To enage with the community of interest, i.e., consumers and staff at Sunshine Clinic, and genuinely build relationships, Stringer (2014) as well as Herr & Anderson (2015) wrote of the importance of a prolonged period of engagement. The research project took 18 months from inception and dissemination of findings to allow our research group time to develop a comprehensive understanding of recovery from stakeholders' perspective. While the formal research partnership stopped at this point, staff co-researchers continued implementing the project's actions.

Traditionally, triangulation is a positivist research tool used to gather multiple sources of information to identify an objective truth (Varpio, 2017). However, in our participatory research project we use triangulation for another purpose. We used triangulation of data from multiple sources, i.e., consumers, staff and managers, to develop a rich appreciation for diverse perspectives and to deepen our knowledge of the phenomena of interest (Denzin, 2011; Flick, 2006). Triangulation was used again in the analysis with multiple co-researchers analysing the data to identify the themes. We did this by having co-researchers aligned with each stakeholder group, i.e., consumers, staff, manager, share their perspectives in group discussion. Our objective was not to arrive at one shared meaning but to understand the data from diverse perspectives. For example, making sense of how does each group conceptualised recovery, including areas of converage or diverigence.

From a positivist perspective, member checking is used to verify the data with participations to correct errors and minimise misinterpretation. However, in participatory research, knowledge is co-constructed by the participants and researchers (Varpio, 2017). While we could not member check with participants from stakeholder consultations, we did check with co-researchers from each stakeholder group to understand their perspectives on the data. When we decided on what codes to group under themes and the theme names, we listened to the view of researcher/s from the relevant stakeholder group. For example, when we identified consumer themes, we preferred the consumer advocate's perspective on the themes and names. We also compared the final themes with the codes, i.e., quotes from participants who contributed to each theme, to check that our interpretation was consistent with what the participants said. .

Unlike traditional research, where the academic researcher aims to be as unobtrusive as possible, Stringer (2014) recommends as the academic researcher in a participatory action research project, should be actively involved in the process. Therefore, it was vital for me to be cognisant of my biases and acknowledge that my perspective was influenced by group affiliation (Kidd, Kenny, & McKinstry, 2014). In this case I was a clinical psychologist who previously worked at Sunshine Clinic. So while I was ostensibly an outsider, I had some insider knowledge from previous experience and connections with my co-researchers. I was also an outsider in the consumer focus groups, as I do not have any lived experience of mental health challenges. Consistent with Stringer's (2014) participatory action research process, I kept a reflective journal to record my learning across the project and the thesis (Stringer, 2014). Exerts from my journal are included at the end of each chapter. Consumer, clinician and manager co-researchers were also encouraged to keep a reflective journal to record their reflections, ideas, insights and analyses of the process (Rice & Ezzy, 2005).

In our research meetings, we would periodically share our reflections on the research process and findings.

4.6.2 Dependability

Dependability refers to data consistency and stability, similar to the quantitative criteria of reliability (Bloomberg & Volpe, 2018). The research demonstrates dependability by having a clear audit trail of critical decisions and procedures so another researcher could replicate the study with similar participants and conditions (Cope, 2014; Stringer, 2014). The research group meeting minutes provide an audit trail of co-researchers decisions. We provided a de-identified summary of meeting minutes to the Mental Health Advisory Committee to keep them informed of our progress. The ethics application to CQUniversity and Ramsay Health for consultation with stakeholders explained the rationale and procedures we followed to collect the data. The audit trail for data analysis comprised the audio recordings, verbatim transcriptions, and tables showing the progressive coding and triangulation of themes to represent the data. The methodology's description should also be sufficient for another mental health service to judge whether it is relevant to their context or to repeat the study in their context (Stringer, 2014).

4.6.3 Confirmability

Confirmability refers to demonstrating that the conclusions represented the participants' perspective, not the researchers' view or biases (Cope, 2014). In participatory action research, the researchers are also participants (Abma et al., 2019), therefore, the data will reflect their views. Ongoing reflexivity throughout the project is necessary for researchers to demonstrate their cognisance of the impact of their perspectives on the research (Bloomberg & Volpe, 2018). A summary of co-researchers' reflections is documented in each of the thematic chapters (Chapters 5 to 7) and summarised in the

concluding chapter (Chapter 8). In reporting the findings of our study, I have used quotes from the consultation which shows the data sources that contributed to the development of specific themes (Cope, 2014).

4.6.4   Transferability

While our focus was on the local context of Sunshine Clinic, transferability requires a sufficiently detailed description of the phenomena of interest so that one can evaluate if the findings are transferable to another setting (Amankwaa, 2016). A "thick description" provides a rich understanding of the participants' experiences and the meaning that researchers make of these experiences (Ponterotto, 2006, pp. 540–541). I have provided an in-depth description of the participants, context, and findings of our study, and verbatim quotes that reflect the context, participants' voices, and the meaning our research group made based on our findings.

4.6.5   Authenticity

Authenticity has no equivalent measure in positivist research. It is a measure of meaningfulness or usefulness of the inquiry, resulting in social change (Guba & Lincoln, 1989). Shannon and Hambacher (2014, p. 2) describe five criteria for assessing the authenticity of research, including:

a.   fairness, i.e., the researchers show a range of participants' viewpoints,

b.   ontological authenticity, i.e., the degree to which participants become aware of the complexity of the social context,

c.   educative authenticity, i.e. the degree to which participants learn from other viewpoints,

d.   catalytic authenticity, i.e., were participants motivated to take action, and

e. tactical authenticity, i.e., did the process lead to a redistribution of power amongst stakeholders.

Our research project strove for authenticity by including multiple perspectives in the inquiry process and incorporating our learning into a plan for action. We gained insight into the social situation's complexity by hearing the feedback from stakeholders who had different experiences and perspectives. Staff co-researchers were empowered to act, with management support, to enhance recovery-oriented practice in their workplace.

4.7   Chapter Summary

In summary, this chapter describes the approach and methodology used to implement our research project. The approach used was participatory action research, specifically Participatory Health Research. The methods comprised purposeful sampling, including consumer focus groups, an online survey for staff, and managers' interviews. Inductive thematic analysis was used to collaborative analyse and make meaning of the data. Finally, the quality of the study was assessed using measures of credibility, dependability, confirmability, transferability, and authenticity.

4.8   My Reflection: Finding My Voice

The process of doing this Participatory Health Research was simultaneously challenging and rewarding. I loved the process of researching with my co-researchers and collaborating on all aspects of the project. This aspect was a comfortable fit for me, having previously facilitated a range of groups where I needed to bring together people from diverse backgrounds to work together on community issues. However, while I was passionate about ensuring that stakeholders had a voice, I was uncomfortable with having my voice in the research. Having formally done quantitative styles of research, I was accustomed to being an observer or facilitator but not an active participant. While I enjoyed advocating for recovery

and joining in the discussion, I was conscious of honouring the voices of my co-researchers and other participants over my own. I learned that my voice had to be part of the participatory process for our research to be genuinely collaborative. Also, through writing the thesis, I realised that my voice, expressed through critical analysis and commentary, was essential to contributing to the literature. Becoming more critical in my thinking represented a significant shift for me, from initially accepting previous research and narratives about recovery and related practice at face value to actively looking for alternative interpretations and perspectives.

Chapter 5. Conceptualisation of Recovery

This chapter presents the findings on the first meta-theme: conceptualisation of recovery. The conceptualisation of recovery developed in this chapter informs the understanding of recovery-oriented practice addressed in subsequent chapters. The conceptualisation is based on consumers' perceptions, as recovery is experienced by people with lived experience of mental illness, not something that professionals do (Slade, 2013). Professionals' perspective is included to see if their views align with that of the consumers'. Table 5-1 provides an overview of the themes and sub-themes under the meta-theme 'conceptualisation of recovery'. (See Appendix C: Thematic Analysis, Tables C-9 for number and percentage of participants endorsing each category).

Table 5-1

Research meta-themes, themes and sub-themes

Meta-Theme	Theme	Sub-Themes
Conceptualisation of Recovery	Different Pathways	Not One Size Fits All
		Recovery Track
		Back to Where We Were
	Challenges	It's Not Easy
		Ups and Downs
		Hopelessness and Distress
		Isolation and Lack of Support
	Living Well	Everyday Living
		Hope and Acceptance
		Self-Efficacy
	I Don't Know	

Section 5.1 covers the theme 'different pathways' which recognises that recovery is an individualised journey, with different pathways to living well in recovery. Section 5.2 presents the theme 'challenges' that details the difficulties in recovery, including

acknowledging recovery is not easy, that the journey consists of ups and downs, and that many people experience hopelessness and distress, and isolation and lack of support. Section 5.3 covers the theme 'living well', which focuses on people wanting to get back to everyday living, hope for the future and self-efficacy. Section 5.4 provides an analysis and synthesis of the conceptualisation recovery. The chapter concludes with a summary of the findings, co-researchers' reflections and actions, and my reflection.

Pseudonyms are used for co-researchers and participants in this study. Quotes from consumers are referenced using the focus group they attended, e.g., Myles, Focus Group 1. In the focus groups, the consumer advocate and I noticed that when one person shared their experience, other participants were likely to contribute similar experiences or indicate agreement by saying 'yes' or nodding. In presenting responses under each theme for the thesis, I have tried to include comments representing the conversations on that theme across focus groups. Quotes from professionals indicate if they worked in Sunshine Clinic, e.g., Drew, Sunshine Clinic, or another Unity Hospital section, e.g., Ashley, Unity Hospital. Quotes from co-researchers show the relevant research meeting, e.g., Kim, Research Meeting 11. Managers have pseudonyms starting with 'R', e.g., Rylee, Ricki, Rob, to differentiate this group from other professionals.

5.1   Different Pathways

Three sub-themes were identified under the theme 'different pathways': 'not one cap fits all', 'the recovery track' and 'getting back to where we were'. Each sub-theme will be presented, followed by a summary of the findings for 'different pathways'.

5.1.1   Not one size fits all

'Not one size fits all' describes the unique experience of recovery for each person. Three consumers articulated this aspect of recovery.

There is not one cap fits all. Everything is so individual. (Jack, Focus Group 1)

It's an individual journey. (Lea, Focus Group 4)

No one size fits all. (Emma, Focus Group 4)

Some professionals also spoke about recovery being personalised to each individual.

It [*Recovery*] *should be tailored for the individual.* (Ricki, Sunshine Clinic)

Everyone is an individual, and I don't know that you can have a blanket approach [*to recovery*]. (Rylee, Sunshine Clinic)

Care plan, for instance, [*the template*] *is the same, but the needs of each patient are very, very different.* (Rob, Unity Hospital)

Recovery for each person is going to be very individualised. (Rhys, Unity Hospital)

In reviewing the feedback from the consultation with participants, our research group agreed that recovery was very individualised, so they needed to individualise their approach to supporting people.

5.1.2 The recovery track

Some consumers conceptualised the recovery journey as developing a new way of living, with some ongoing symptoms, 'the recovery track'. Approximately one-quarter of consumers and one-third of professionals talked about the recovery track concept. Several consumers, who had lived with mental health challenges for many years, reflected on their experience of being on the recovery track.

My belief is that you can't ever be cured. The rest of our lives we're on a recovery track. I'd dearly like to go back to when I was carefree, and you know, go back

20 years, but that's not going to happen. You have to be able to live with what you're

got and make the best of it. (Kevin, Focus Group 2)

Earlier on with my diagnosis I used to think, I'm going to get well; I'm going to be

symptom free and whatever medication I'm on is going to sustain me … but you

realise very quickly that that isn't the case. It's a growing thing and a changing thing

all of the time. I think that for me it's accepting that. You live with the disorder that

you have and learn strategies and ways of dealing with it. (Emma, Focus Group 4)

People think you are going to get well. [*In*] *medical recovery, you get an illness; you*

recover, and off you go again whereas you are never cured. It is always with you, but

you can still live a good life. (Lea, Research Meeting 11)

Likewise, Sunshine Clinic professionals described recovery as a journey or process

rather than an end-point or cure.

Recovery in mental health is a journey. I believe it is an ongoing process and

development of learnt skills and strategies designed to help manage and improve the

individual's mental state. (Drew, Sunshine Clinic*)*

Recovery I wouldn't consider to be clinical recovery. Clinical recovery would be

seeing remission and no symptoms and cure. With mental illness, there has to be an

understanding that this is a journey and process. For some, it may be far less side

effects and still having a level of illness. It's about your journey and quality of life and

being collaborative in that process. Not about cure. (Rylee, Sunshine Clinic)

Other consumers associated their recovery track with having a quality of life rather

than a cure. For example, Jenny (Focus Group 3) said, "*I'm looking for a better quality of*

life." Professionals reflected a similar view. Ashley (Unity Hospital) commented, "*I suppose*

it's about assisting someone to have a quality of life that they can have alongside their illness" and Drew (Sunshine Clinic) said, "*It's all about quality of life.*"

At Research Meeting 11, we thought that life could still be good on the recovery track even if a cure was not possible.

> *You can't undo what's happened. You allow them to move forward, to recognise there is still good in the changed person, the person they are now. [Rather than] getting back to this magically set point of where I was before I became unwell.* (Chris)

> *We take a different path. You might have been on this road, but now you have to go down this [other] road, [and that's] not necessarily a bad thing.* (Charlie)

5.1.3   Back to where we were

A few consumers talked about getting back to where they were before the onset of mental health problems. However, there was a recognition that this desire was not wholly possible.

> *Wasn't it basically that we were trying to get back to where we were? As close as we could to where we were happy or close to being to that stage, that liveable state.* (Myles, Focus Group 1)

> *To actually be recovered, I need to get back into the workforce, I guess. I haven't worked in a couple of years.* [Leonie: so getting back to where you used to be?] *Yes, or anywhere that resembles that.* (Ben, Focus Group 3)

One professional also talked about recovery as a "*return to their normal lifestyle.*" (Sam, Unity Hospital)

5.1.4 Summary

In summary, the theme 'different pathways' recognised that recovery is an individualised journey. Most consumers talked about being on 'the recovery track', which was about adjusting to a new future where life could still be good, albeit different. Some consumers also spoke about getting 'back to where we were', which was about resuming everyday activities while accepting that not everything would be the same as before their illness. Professionals in Sunshine Clinic, including co-researchers, shared a similar conceptualisation of recovery to consumers, seeing recovery as unique to each person.

5.2 Challenges

Most consumers talked extensively about recovery challenges, with many comments about this issue. This finding contrasted with professionals who focused primarily on the positive aspects of recovery. In each focus group, challenges were described as a core part of consumers' lived experiences of recovery. As other consumers discussed this issue, consumers who did not speak directly about challenges indicated verbal or non-verbal agreement, e.g., saying 'yes' or nodding There were four sub-themes identified under challenges: 'It's not easy', 'ups and downs', 'hopelessness and distress', and 'isolation and lack of support'.

5.2.1 Ups and downs

Over half the consumer participants talked about the ups and downs of their experiences. The ups and downs reflected the experience of cycling between living well and experiencing mental health challenges.

> *I had a few ups and downs recently … I've been going really good until I've had these last couple of episodes … Sort of crashed down and thought, 'what the hell?'.* (Lance, Focus Group 2)

You kind of feel well and you let … things creep up on you … and before you know it, you are really not well again. (Emma, Focus Group 4)

There's good days and bad. (Lea, Focus Group 2) *… I have what's called 'blue sky days'. The sky is blue, the sun is shining, and everything is easy.* (Lea, Focus Group 1)

I've had depression … around that time when I was admitted. Then it came back to me a month ago, and I had to go in again. (John, Focus Group 2)

Two professionals also reflected on the up and down nature of the recovery journey.

It's an up and down journey. (Rylee, Sunshine Clinic)

Recovery … is not a static one-off. It is indeed a recovery and relapse, good days and bad days and growing from strengths. (Ashley, Unity Hospital)

5.2.2   It's not easy

Almost half of the consumers talked about how difficult recovery was and how hard they worked to stay well. Consumers struggled with having the agency to do everyday things that they knew would be beneficial.

I've worked very hard … It's not easy. (Lea, Focus Group 2)

You drag yourself up. (Lance, Focus Group 2)

I think it's good to dream, and the dream is to going back to being great at everything. For me, that is something that's going to be … really hard to get to. (Kevin, Focus Group 2)

It's been so hard … even simple things. (Ben, Focus Group 3)

The last four, five weeks I haven't even been able to [*work*] *... been really struggling.* (Trevor, Focus Group 3)

I just can't get off the couch ... even though I know it's going to benefit me. It's just really difficult to do. (Emma, Focus Group 4)

5.2.3   Hopelessness and distress

Over half of consumers spoke about their hopelessness and distress associated with mental illness symptoms describing the loss of hope.

It's a bitter pill. Everything's against you. You lose all hope. (Jenny, Focus Group 3)

When I'm depressed ... everything just seems meaningless ... I think it just takes away the hope ... It's like you can't see forward because there is a wall there. (Ben, Focus Group 3)

Every day is the same. There is no hope. There's nothing to look forward to. (Emma, Focus Group 4)

I was going across the bridge the other day and [*thought*] *it would just be better if I jumped over the side.* (Lance, Focus Group 2)

Consumers also described how the symptoms of mental illness were distressing mentally and physically.

When my thoughts are running wild, my whole body is tense, stomach is knotted, and you just feel like rubbish hey. When I'm bad it's a real battle just to get through the day. I don't want the night to come because that just means another day is coming along ... At the end I said, 'I can't do this anymore, I'm going to go and get a rope'. Of course, I ended up in hospital that day. (Jack, Focus Group 1)

I had a nervous breakdown and was off work for about seven months … I have, over the years, suffered from depression … anxiety and OCD and wouldn't wish that on anyone. (Lance, Focus Group 2)

This all goes into the one big spiral. Once you start [*thinking*] *negative, you lose sleep, you lose everything.* (Doug, Focus Group 3)

Brain just goes into overdrive and just starts spinning things around and out of control, and you just can't think straight. (Trevor, Focus Group 3)

5.2.4   Isolation and lack of support

Two-thirds of consumers talked about how, in the community, they often experienced isolation and lack of support. In Focus Group 1, Jack and Myles spoke about their experiences.

You feel so alone. Because you think you are the only one that's ever had that, and it's all concentrated on you. When I'm bad, I go within myself, I don't annoy anybody, I tend to be almost in a cupboard. (Jack)

For the last eight weeks and I really dug myself a deep hole and just totally isolated myself from family, from external family … I sort of just went into a ball and wanted to escape. (Myles)

In Focus Group 4, Emma and Lea talked about similar challenges. Lea said, "*The hardest part for me is that feeling of being alone.*" Emma added, "*I don't connect with people … I stay with my door locked, and I stay at home … Life is just vanilla.*" The concept of life being 'vanilla' came up in a day program group I had facilitated several years prior, in which Lea and Emma were participants. The group had come up with the term 'vanilla' to

describe how mental illness takes away the joy of everyday living, leaving life bland and lacking meaning.

Consumers spoke about having difficulty talking about their experiences to people who would not understand, which added to their sense of isolation.

Someone outside … doesn't have a clue. (Doug, Focus Group 3)

Sometimes it's hard to talk to family … I've got a daughter … and son … and I have never spoken a word to them about it. (Kevin, Focus Group 2)

There is only two in my family, myself and my brother … We used to ring each other, and I told him I was coming to this [*day program*] *and he said 'You'll end up as silly as they are.' I've hardly heard from him since.* (John Focus Group 2)

Other consumers discussed the challenges of getting help in the community when they are not unwell enough to be in the hospital.

I find that when you are in that stage, where you are not critical, and you are not good … You don't see people often, but when you see them you put on the smile … And then you go home, and you fall in a heap. But they wouldn't admit you to hospital for that … so you are in no-man's land. (Emma, Focus Group 4)

When you are really sick, you can be in hospital, and you get looked after … When you are just struggling in that middle zone, you just have to pick yourself up all the time. It's hard. (Lea, Focus Group 4)

In Focus Group 1, Myles and Tom spoke about the lack of support available in regional communities.

There are no psychiatrists out there. That's why I'm here. (Myles)

It was just shocking. I went to see a psychiatrist once out there, and he said 'I won't be able to see you for another six weeks because I'm not back in town' ... You're just forgotten about out there ... That's why I came in here. (Tom)

Jack spoke about a protective factor for him that reduced his feeling of isolation.

I am fairly fortunate in one respect; I have a club and two or three really good friends who understand. I don't know if they understand the illness, but they understand that I'm not well. And they are prepared to sit down and talk to me. We don't talk about the illness, but we talk. (Jack. Focus Group 1)

At Research Meeting 11 we reflected on the challenges for consumers trying to access community services and constant changes that affect their support.

I'm not surprised with the [*comments on*] *community ... I have tried to keep up with community services, and they change constantly ... I don't think that's something we can change, but its so frustrating.* (Charlie).

Staff change as well ... It is hard. (Lea).

Kim and Charlie discussed how they help consumers cope with changes when they are back in the community, with the day-programs being central to this process.

Maybe that should be part of our focus, teaching people that there are services out there, but they are going to change, and how are you going to cope with that? (Charlie)

With the Relapse and Recovery Group [*day program*] *… when they* [*consumers*] *are missing supports, they … ask us to problem solve … Not just us; they can ask the other co-patients too.* (Kim)

It's like [*the day program group*] *is the consistent set point even though there are lots of changes elsewhere.* (Charlie)

5.2.5   Summary

Challenges were a significant part of recovery for consumers in the context of admission to Sunshine Clinic, but rarely mentioned by professionals. Consumers spoke about cycling between coping well and episodes of ill health, how hard they worked to stay well, their feelings of hopelessness and distress, and the isolation and lack of support in the community. Some consumers also talked about how mental illness takes away the joy of everyday living. Our research group acknowledged the difficulties in accessing support in the community, identifying that changes in services and staff as impacting the support provided.

5.3   Living Well

Almost two-thirds of consumers spoke about the concept of living well, which is the opposite of experiencing challenges. Living well reflects the conceptualisation of recovery, described by consumers as "the right to lead fulfilling lives, and to pursue our own choices about how we live and about the support we accept, regardless of whether we are experiencing symptoms" (Mental Health Commission of New South Wales, 2014, p. 9). Connectedness, hope, identity, meaning, and empowerment (CHIME; Leamy et al., 2011) are the processes most often used to describe the concept of living well in recovery. We identified three sub-themes for living well: everyday living, hope and acceptance and self-efficacy.

5.3.1 Everyday living

Some consumers wanted to get back to everyday living where they could participate in normal activities. 'Everyday living' was similar to the theme 'back to where we were', with consumers wanting to get back to doing the basics that most of us take for granted.

To be able to do your everyday things. (Emma, Focus Group 4)

Being able to do things, shower, make meals stuff like that, without feeling like they are big things, struggles … Being able to work … Trying to sort out my basics of coping with life in general. (Myles, Focus Group 3)

It would be lovely to be able to control my moods or keep it in the comfortable zone where you can go out and have coffee with friends and do a day's work. (Trevor, Focus Group 3)

Recovery to me is … where you can get on with your life and you can do most things, without the burden of the disorder … without having to think twice about it … Recovery to me is where you think you can manage most things in your life. (Olivia, Focus Group 4)

When I'm well, I can get up, the day is bright, whether it's raining or not, I'm feeling bright and I can go and do the things I want to do. (Jack, Focus Group 1)

Our research group (Research Meeting 11) reflected on what the theme of everyday living meant for consumers. Chris described everyday living as "*sitting in that level of wellness where you can do everyday things. … You can engage with your family and friends.*" Kim added, "*where you are not missing out.*"

5.3.2   Hope and acceptance

About one-quarter of consumers spoke about hope and acceptance as part of their recovery compared to almost two-thirds who spoke about hopelessness and distress. Surmising that hope and hopelessness are part of the same continuum, then most consumers discussed some aspect of hope including the three consumers who spoke about their experience of hope and hopelessness. For example, Ben (Focus Group 3) discussed how his depression "*takes away hope,*" but he also needed "*something to look forward to.*"

Other consumers spoke about self-acceptance, which was an aspiration or hope for the future rather than what their current experience represented.

> *I have to accept that I've got this disease. That I have to somehow learn to love myself with it … I've got to learn how to love myself, as I am, not how I'd like to be.* (Jenny, Focus Group 1)

> *Learning not to beat the crap out of yourself over being different. Just accepting yourself.* (Myles, Focus Group 1)

Staff co-researchers (Research Meeting 11) reflected on hope in recovery and their experience talking with consumers about hope.

> *We get this term hope a lot in 'focus for the day'* [*group*]. *Focus for the day is about doing something you can achieve in one day.* (Charlie)

> *The hope in one day, looking at … little things you can do each day to rebuild that hope … If you are still unwell, hope can be really hard to reach* (Chris)

> *The fact that they have got themselves out of bed and come to group, says to me that you hope for something to be different to where you are right now.* (Kim)

5.3.3   Self-efficacy

Approximately half of all consumers spoke about self-efficacy as being part of their recovery, whereas only a few professionals talked about this concept. Self-efficacy described consumers' confidence in being in control of their recovery, being a similar concept to empowerment (Leamy et al., 2011). Some consumers talked broadly about taking responsibility for their recovery.

You have to be invested in your own recovery. You have to want to recover. (Josie, Focus Group 2)

Follow-through with doing the things you know you are meant to do to keep you well. It's being mindful to keep on top of routine. (Emma, Focus Group 4)

The psychologists can guide you but it's up to you to make the effort. It's up to the individual. If you want to get over it, you're going to have to do something yourself. (Kevin, Focus Group 2)

Other consumers provided examples of how they took control of their recovery.

I do a lot of voluntary work and that helps because it gives me structure to my week. (Lea, Focus Group 3)

I like hands-on work ... so, if I'm not doing the physical work, I am working on my computer ... It keeps [my] mind off what else is around, and I suppose I can regulate that ... so that's how I can pull myself up. (Jack, Focus Group 1)

I'm building a [mechanical device] ... to keep me busy. I like to keep my brain active. (John, Focus Group 2)

Professionals also talked about involving consumers in decision making and taking responsibility for their recovery, exemplified by Rylee's (Sunshine Clinic) comment, "*Engaging … with an individual in education and empowering them with ability to learn about their illness and triggers and how* [*they*] *can manage it*."

During Research Meeting 11, our research group recognised that when a consumer is acutely unwell in hospital, self-efficacy may involve taking "*small steps*" (Chris) to take responsibility for their recovery.

5.3.4 Summary

Living-well represents the positive components of recovery (the 'ups') at the other end of the spectrum to challenges (the 'downs') discussed in Section 5.2.1. Everyday living describes a return to doing normal activities, such as work, socialising, and the routine tasks of daily living. In the context of hospital admission, hope was an aspiration rather than the reality for most consumers who were experiencing hopelessness and distress (see Section 5.2.3). Self-acceptance was also aspirational, with consumers hoping for a future described by Jenny (Focus Group 1) as "*learn*[*ing*] *how to love myself, as I am*". As consumers progressed with their recovery, they spoke about self-efficacy, i.e., realising that they needed to take control of their recovery.

5.4 I Don't Know

While most Sunshine Clinic professionals shared a similar conceptualisation of recovery to consumers, responses from other Unity Hospital professionals indicated that they did not know what recovery was or provided vague answers.

I don't know that field of nursing. (Marley, Unity Hospital)

I have not heard this term before. (Erin, Unity Hospital)

Recovery may be that they are able to cope at a certain level, with certain strategies in place. (Rhys, Unity Hospital)

My knowledge on this subject is limited. (Quinn, Unity Hospital)

Staff co-researchers reflected that the findings for the 'I don't know' theme confirmed what they suspected, i.e., that some professionals who did not regularly work in Sunshine Clinic did not know what the term recovery meant.

Consistent with the 'I don't know' theme, two managers suggested recovery training would be useful.

I think there needs to be more focus on training the inexperienced staff in the terminology ... and knowing what it actually means. (Rhett, Unity Hospital)

Training and looking at what we can offer to keep up to date with concepts around recovery. (Rylee, Sunshine Clinic)

In summary, the 'I don't know' responses from some staff indicated a training need at Unity Hospital, which managers supported.

5.5   Analysis and Synthesis

The analysis and synthesis explore the extension of the CHIME conceptualisation to include the experiences from challenges to living well *in* recovery. Section 5.3.5. acknowledges the unique journey and living with some ongoing symptoms in recovery. Section 5.3.6 discusses the conceptualisation of recovery as a return to everyday living. Section 5.3.7 introduces the idea of recovery as a spectrum, building on the existing CHIME conceptualisation to be more holistic and inclusive of people's experience during hospital admission. Section 5.3.8. addresses ways to enhance staff knowledge about recovery.

5.5.1   Recovery as a unique journey

Our study's finding that recovery is an individual journey with different pathways is consistent with previous systematic reviews (Ellison et al., 2018; Leamy et al., 2011; Stuart et al., 2017). Similarly, Aston and Coffey (2012) identified an individual journey as part of recovery in an inpatient setting. The sub-theme, 'ups and downs' (see Section 5.2.1) reflected the non-linear nature of recovery identified in other conceptualisations (Jacob et al., 2017; Leamy et al., 2011). Consumers described how they could be travelling along well and then come crashing back down. They also spoke about experiencing hopeless and hope, isolation and connectedness, and being at different stages on each of the recovery processes of CHIME. For instance, connectedness and hope appeared to be critical early in admission. Empowerment increased as acute symptoms decreased and consumers could take more control of their recovery. Developing new identity and meaning was not as prominent but reflected the 'recovery track'.

5.5.2   Recovery as a return to everyday living

Consumers spoke about recovery in one of two ways:

'The recovery track' which represented a transformation to a new identity and meaning in life with mental illness; and

'To get back to where we were' represented a return to a "*liveable life*" (Myles, Focus Group 1) while acknowledging that a complete cure was not likely.

Our findings differed from previous research thatidentified consumers were either oriented towards recovery *in* or recovery *from* mental illness (Jacob et al., 2017). In our study, both 'the recovery track' and wanting to 'get back where we were' reflected different recovery aspects *in* mental illness (see Figure 5-1). Consumers spoke about being able to do everyday activities like "*to go out and have coffee with friends*" (Trevor, Focus Group 3),

"*being able to work*" (Myles, Focus Group 3) and being able to "*do most things, without the burden of the disorder*" (Olivia, Focus Group 4). Similar to Stuart et al.'s (2017, p. 301) finding that some people wanted a "*return to normality*", consumers in our study wanted to return to the normal activities of everyday living that most people take for granted.

Figure 5-1

Recovery pathways

The most validated conceptualisation of recovery, CHIME (Leamy et al., 2011) does not reflect the importance of a return to everyday living that was critical to consumers in the context of admission to a hospital-based mental health service. Therefore, our findings suggest that extending CHIME to include 'everyday living', i.e., CHIME-E, would better reflect consumers perception of recovery. The other CHIME processes, i.e., connectedness, hope, identity, meaning and empowerment, reflect the concept of living well but do not cover being able to do the practical tasks of everyday living (see Figure 5-2).

5.5.3   Recovery as a spectrum: From challenges to living well

Two opposite but complementary themes arose from the analysis: challenges and living well. The theme of 'challenges' aligned with the process of 'difficulties', were identified in previous reviews (Stuart et al., 2017; Van Weeghel et al., 2019). Challenges represented consumers' experiences at the opposite end of the spectrum to the positive processes of living well in recovery (CHIME; Leamy et al., 2011). Also, consumer accounts indicated that their

Figure 5-2

Recovery as a return to everyday living

Notes: FG = Focus Group

recovery journey had not been unidirectional, but instead moving between the 'ups and downs', i.e., see Section 5.2.1. This finding is consistent with research indicating that recovery is non-linear (Ellison et al., 2018; Leamy et al., 2011).

There were some CHIME processes that received limited attention from consumers in our study. Transformation to a new identity was only briefly commented on in relation to consumers accepting themselves as they are now (see Section 5.3.2) and being on 'the recovery track' (see Section 5.1.2; see Figure 5-3). Besides the limited exploration of a new identity, no one spoke specifically about finding new meaning. What they did talk about was getting back to everyday living and learning to live with mental illness. In the context of a hospital-based admission returning to daily living and other processes, such as connectedness, hope and empowerment, may be more critical when symptoms are acute. Given that inpatient stays are generally short and focused on reducing acute symptoms (Waldemar et al., 2016) rebuilding identity and finding new meaning in life may be more relevant to consumers post-discharge.

Hopelessness identified by consumers in our study was at the opposite end of the continuum to hope identified in CHIME (Leamy et al., 2011) (see Figure 5-4). Bredski et al.

Figure 5-3

Loss of hope in recovery

You lose all hope. Jenny FG3

Hopelessness

There is no hope. ... nothing to look forward to Emma FG4

Hope

Notes: FG = Focus Group

Figure 5-4

Developing a new identity in recovery

You lose everything
Doug FG3

I have to ... learn to love myself with it [mental illness] Jenny FG1

Loss of Identity

Identity

Accepting yourself Myles FG1

Notes: FG = Focus Group

(2015) also found that hopelessness rather than hope was the primary emotion experienced by consumers during an inpatient admission. Andresen et al. (2003, p. 591) describe the first stage of recovery, 'moratorium', which includes a sense of hopelessness and withdrawal from the world, and this fits with the experiences described by consumers in our study. While Leamy et al.'s (2011) systematic review confirmed that recovery happens in stages, there was a lack of consensus on the number of steps. It may be that the number of steps is less relevant than understanding that there is a progression from challenges to living well.

Another component of CHIME raised in all focus groups was connectedness. However, like hope, rather than living well, we heard about the challenges of disconnection, i.e., isolation and lack of support; (see Section 5.2.4.) Consumers could not talk about recovery without describing their challenges, including the isolation and lack of support in

the community. Consumers also spoke about the importance of their connectedness with

people who supported their recovery which is discussed in Chapter 6 under the meta-theme

of 'relational recovery', and how their initial experience was one of isolation and

disconnection (see Figure 5-5).

Figure 5-5

Experience of isolation and disconnection

Consumers also discussed concepts that we conceptualised as aligning with the

CHIME process of empowerment. While not as prominent as the continuums of

connectedness and hope, empowerment developed as consumers self-efficacy increased to

the point that they could take control of their recovery (see Section 5.3.3; Figure 5-6). A

similar concept to self-efficacy, agency was identified by Bredski et al. (2015) to describe

goal-directed behaviour that inpatients identified as part of their recovery.

While the individual processes may be a continuum, the concept of a spectrum may

better explain consumer experience across all recovery processes. A spectrum is used to

describe Autism Spectrum Disorders, "where the effects and severity of symptoms are

different for each person" (American Psychiatric Association, 2018). In relation to recovery,

the concept of a spectrum represents each person's unique recovery experience, reflecting

that a person may be at a different place on the continuum for each CHIME-E component at

any point in time. For example, during an inpatient admission, connectedness and hope are

Figure 5-6

Empowerment in recovery

Follow-through with doing the things… to keep you well
Emma FG4

You have to be invested in your own recovery Josie FG2

Disempowerment

Empowerment |Self-Efficacy

Notes: FG = Focus Groups

If you want to get over it, you're going to have to do something yourself Kevin FG2

likely to be the first processes to move along the continuum from the challenges,

i.e., isolation and hopelessness, towards living well, i.e., experiencing greater connectedness

and hope. As the consumer develops self-efficacy, disempowerment may move along the

continuum towards empowerment. Creating a new identity and meaning may follow later, as

the person recovers further post-discharge. Similarly, a return to participation in daily living

tasks will probably increase with a return to living to the community, consistent with the

concept of "living skills" in the Recovery Star (Mental Health Providers Forum and Triangle

Consulting, 2011, p 4.).

The spectrum represents the person's collective experience across each of the

CHIME-E continuums from challenges to living well. Where each person sits on the

spectrum is may change from day to day. Some days may be "*blue sky days … were*

everything is easy" (Lea, Focus Group 1), and other days may be more difficult. Figure 5-7

depicts the expanded conceptualisation of the recovery, CHIME-E, on a spectrum that spans

from challenges to living well.

Our conceptualisation of recovery includes positive and negative aspects of CHIME and the additional component of 'everyday living'. Our study highlighted that connectedness, hope, and empowerment are integral to recovery during an inpatient admission. Also, consumers were at the early stages of coming to terms with a new identity. Finding new meaning was not part of the conversation. Consumers talked about how 'it's not easy' (see Section 5.2.2) to do "*even simple things*" (Ben, Focus Group 3) and wanted to get back to everyday living. Developing new meaning may happen post-discharge from the hospital, but this recovery component seemed unattainable during a hospital admission. Figure 5-7 provides an example of recovery across the spectrum at a point in time for someone during an admission, being mindful that everyone's journey is unique and non-linear. The arrows are bi-directional to reflect the variable 'up and down' nature of recovery.

5.5.4   Understanding recovery

The findings indicate that staff thought that training was required, particularly for inexperienced professionals, to become more familiar with recovery. Previous studies indicate that staff training may increase staff knowledge of recovery (Chen et al., 2014; Hornik-Lurie et al., 2018; Kidd et al., 2014; Okamoto & Tanigaki, 2018). However, Tsai et al. (2010) found that the type of training may matter with staff who attended specific/practical training on recovery to increase their recovery-orientation, with no change for staff who attended general/inspirational training. It is also unclear whether the training itself or other factors contribute to increased recovery knowledge. For instance, one study found that staff who were more optimistic about recovery attend more training (Tsai et al., 2010). Furthermore, a previous review (Lorien et al., 2020) found that staff training, combined with recovery-oriented consumer programs and changes to care planning was more effective in supporting recovery in hospital-based mental health services than training alone.

Figure 5-7

Example of the spectrum of recovery during a hospital admission

5.6   Chapter Summary

The current study has expanded the understanding of recovery's conceptualisation for consumers in a hospital-based admission context. The main findings were that:

1. extending CHIME to included everyday living (i.e., CHIME-E) is more reflective of what inpatients want in recovery

2. the conceptualisation of recovery needs to incorporate the full spectrum of experiences across each of the CHIME-E continuums from challenges to living well

3. the concept of a spectrum better represents an individuals experience of recovery across each of the CHIME-E recovery processes at any point in time

4. connectedness and hope are the most salient recovery process during an inpatient admission

5. some staff have a limited understanding of the concept of personal recovery and may.

5.7   Summary of Co-Researchers' Reflections and Actions

In the research group, we reflected on the themes identified through the consultation process with consumers and professionals. Staff co-researchers considered the feedback related to what staff did to support recovery and how they could enhance their practice.

Different Pathways. We agreed that recovery is an individual journey where 'no one size fits all'. Therefore the staff need to take an individualised approach to care planning. Rob (Unity Hospital) identified that there was some evidence of an individualised approach to care reflected in care plans. Staff co-researchers discussed how they helped consumers see 'the recovery track' positively. In Research Meeting 11, Chris talked about encouraging consumers to "see the good in the changed person", and Charlie spoke about how consumers might take a "different path", but life could still be good.

Challenges. We recognised the challenges consumers faced, especially in the community trying to access support. While staff co-researchers did not feel they could change what happens in the community, they talked about how they could help consumers solve issues through the day-programs (discussed further in Chapter 7).

Living-Well. We reflected on the importance of consumers getting back to 'everyday living'. To support a return to everyday living, the staff implemented diversional activities on weekends during the project. Staff co-researchers tried to encourage consumers to do "*little things … each day to rebuild that hope*" and acknowledged that consumers might need to take " '*small steps' towards self-efficacy following an acute episode of illness"* (Chris, Research Meeting 11).

Understanding Recovery. Consistent with the 'I don't know' sub-theme in relation to staff knowledge about recovery, we agreed that there was a need to upskill staff around

"*What it* [*recovery*] *actually means*" (Rhett, Unity Hospital). Staff co-researchers shared the

finding and the identified training need with management.

5.8   My Reflection: New Understanding of Recovery

When we started this research, I thought our findings would be consistent with

previous recovery conceptualisation reviews. However, the results fundamentally changed

the way I understood recovery. Writing this chapter and re-reading the transcripts from the

consumer consultations allowed me to reflect on consumers' challenges. I felt privileged that

consumers shared their stories with us and a responsibility to tell their stories faithfully.

While I appreciated that CHIME represented the experiences people aspire to, it was essential

to acknowledge that isolation and loss of hope, identity, meaning, and personal control were

not part of many people's recovery experiences. In particular, the comment that "*life is*

vanilla" (Emma, Focus Group 4) resonated with me. Previously I had thought about the

impact of the distress of experiencing acute symptoms on living well but had not reflected on

how pervasive mental illness can be in taking away the joy of everyday living, leaving life as

bland and lacking meaning. Doing this research has given me a greater appreciation of the

experience of recovery from the perspective of consumers who participated in our study. It

also reminded me of the importance of listening to people with lived experience.

Chapter 6. Recovery-Oriented Practice: Relational Recovery

This chapter introduces the meta-theme 'recovery-oriented practice' and presents the theme's findings: relational recovery. Recovery-oriented practice is what mental professionals do to support consumers in their recovery (Slade, 2013). Recovery-oriented practice looks at how professionals can support recovery as conceptualised in Chapter 5. Understanding the recovery during a hospital admission expanded the conceptualisation of recovery to include the full spectrum of recovery experiences from challenges to living well. Three recovery processes, connectedness, hope and empowerment, were particularly relevant to consumers during their admission. Consumers also identified another recovery element: returning to everyday living after the disruption of an acute episode of mental illness.

The current study identified four themes under the meta-theme recovery-oriented practice: relational recovery and three themes related to interventions: group programs, medical treatment and recovery planning. The first theme relational recovery is explored in this chapter (see Table 6-1) and the other themes are explored in Chapter 7. Relational recovery encompasses professionals taking time to meaningfully engage with consumers (Hyde, Bowles, & Pawar, 2015; McKenna, Furness, Dhital, Ennis et al., 2014; McKenna, Furness, Dhital, & Ireland, 2014); developing therapeutic relationships (Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013; Coffey et al., 2019) and fostering the inclusion of family in care and peer support (Hyde et al., 2015).

Almost all consumers and most professionals talked about concepts that we conceptualised as aligning relational recovery, with extensive comments about this theme. The three sub-themes: professionals-consumer relationships, peer support and the inclusion of carers, are discussed in Sections 6.1 to 6.3. Section 6.4 provides analysis and synthesis of the findings. (see Appendix C, Table C-10 for number and percentage of participants

endorsing each category).The chapter concludes with a summary, co-researchers' reflections and actions and my reflection.

Table 6-1

Relational recovery theme and sub-themes

Meta-Theme	Theme	Sub-Themes
Recovery-Oriented Practice	Relational Recovery	Professional-Consumer Relationships
		Inclusion of Carers
		Peer Support

6.1   Professionals-Consumers Relationships

Initially, we had named this theme 'collaborative and supportive professionals.' However, for the thesis, I renamed this theme to the 'professionals-consumers relationships' to reflect a relationship where both parties participated, i.e., talking and listening to each other. Although talking to each other was central to this relationship, consumers and professionals focused on different aspects of the relationship. Consumers spoke about their connectedness with supportive professionals, and professionals talked about empowering consumers through collaborating in their care. Professionals also raised the concept of holding hope when consumers were experiencing hopelessness. The finding will be presented under the CHIME headings of connectedness, empowerment, and hope. During a hospital admission, more consumers identified supportive relationships with professionals helpful to their recovery than any interventions discussed in Chapter 7 (see Appendix C, Table C-10).

6.1.1 Connectedness

Consumers spoke about the positive and supportive relationship they had with the staff at Sunshine Clinic.

The staff here, I can't speak highly enough of the attention, and I'm going to say the love and care because they really understand. (Jack, Focus Group 1)

All the staff I've worked with I find very understanding, and I think they do a marvellous job. (Lance, Focus Group 2)

They [staff] are all about us. … They go above and beyond. (Doug, Focus Group 3)

One consumer commented on how all staff on the ward provided support.

Even goes down to environmental service or cleaning staff. They'll have a chat [with you] when they are working away. (Trevor, Focus Group 3)

Consumers specifically identified staff taking time to talk with them as being supportive of their recovery.

They [staff] take the time to talk to you. … They are never too busy to listen. (Jack, Focus Group 1)

Having people that listen to you and actually talk back to you, on the same level, same understanding. They do it well. (Kevin, Focus Group 3)

That's what I meant by listen, … actually hear what you are saying. (Jenny, Focus Group 3)

These conversations with staff were informal, everyday exchanges in the ward, primarily with the nursing staff. Participants also commented on the allied health professionals' contribution.

The psychologists are really good. … [They] talk more about the cognitive side of things. That's as important, if not more important, to your recovery than the actual

drugs. (Olivia, Focus Group 3)

The allied health staff have a really good input in terms of … the individual psychotherapy and the groups. (Rob, Unity Hospital)

While most consumers reported having a positive connection with staff, a few people spoke about having mixed experiences.

Some [staff] can go through the roles in sort of sterile, clinical way, and it doesn't achieve anything for anyone. (Ben, Focus Group 3)

I feel that certain staff have … more natural empathy than others. (Myles, Focus Group 3)

Only one consumer identified the need for professionals to have more time to talk. Josie (Focus Group 2) said, "*I think another psychologist would be great because they are so busy running groups [and] one-to-one sessions*". However, almost a quarter of professionals identified a lack of time to talk, with most staff experiencing tension between time to talk and other tasks.

On many occasions, not enough time to provide good quality therapy time due to poor staffing and [an] overabundance of red tape and paperwork. (Billie, Sunshine Clinic)

Paperwork, [such as] care plan, signing off daily checklist, falls risk, pressure area risk. Some could be rationalised and reduced to provide for face-to-face contact with clients. (Cody, Sunshine Clinic)

Staff time to sit and listen/talk with clients instead of endless reams of paperwork. (Logan, Unity Hospital)

Staff co-researchers reflected on the tensions between talking and other duties (Research Meeting 11). Chris commented, "*It's a common complaint … that we don't want to be doing paperwork; we want to be in there talking to people*".

One professional (Quinn, Unity Hospital) talked about "*improving staffing levels*". However, one of the managers (Rob, Unity Hospital) said that "*It comes back to time and resources … We are a business. There are only so many hours in a day and only so many staff*". There was also recognition from professionals that to achieve changes to the ward practices required leadership. Rylee (Sunshine Clinic) said, "*You have to lead that kind of collaborative culture on the ward from the top.*"

Our research group reflected on the comment about new staff learning how to have conversations with consumers. In Research Meeting 11, Chris said, "*Newer practitioners are anxious anyway. [In] medical ward you can kill somebody, if you are not careful enough, literally. Maybe [they think] I could kill somebody in there [Sunshine Clinic] too with my words?*" We noted that generalist nurses tended to do medical tasks and rely on the mental health nurses to deal with emotional distress. Chris gave an example of what a generalist nurse might say: "*I'll do the medication, blood pressure, ECG … and sign off the care plan. You can deal with the feelings.*" However, there was an agreement in the research group that generalist nurses did indeed have the skills to work with distressed patients.

6.1.2 Empowerment

While consumers spoke about their connectedness with staff, professionals focused on empowering consumers through collaborative practice. However, the relationship was still at the heart of the interactions, and the process was the same, i.e., taking time to talk and listen. The interactions reported by staff ranged from professionals managing consumers to consulting with consumers and working in partnership.

It is a fairly harmonious team that communicates and collaborates well together for that goal of recovery-based management **of** [*emphasis added*] *patients.* (Rhys, Unity Hospital).

To be patient-focused and involve them in the process. ... Staff may feel that they are intuitively doing that now. But when one looks at it, are we actively involving the client, relatives, carers, important others in the process. (Ricki, Sunshine Clinic)

The weekly meetings, … when a Nurse Unit Manager sits down … with patients. ... They [*the patients*] *do have a way of feeding back into how we do conduct the department* (Rhys, Unity Hospital).

It's about empowerment and joint management. ... There are still parts of medicine that are really paternal in how they deliver care. ... I'd much rather be collaborative about my care. I think it's really important for it to be involving what patients want and what they see as recovery. (Rylee, Sunshine Clinic)

This theme fits with the recovery component of empowerment. While staff aspire to be collaborative and encourage consumers to develop self-efficacy, the continuum reflects a range of professionals' approaches from anagement *of* to management *with* consumers.

6.1.3   Hope

The findings concerning consumers' experiences of hopelessness and hope were presented in Chapter 5 (see sections 5.2.3 and 5.3.2, respectively). A critical aspect of supportive relationships with consumers, from a staff perspective, was the capacity to hold hope for consumers when they were hopeless. This sentiment was summed up by Reagan (Sunshine Clinic) who said, "*We maintain that positive, hopeful, you will recover attitude.*" Our research group also discussed ways in which they try to foster hope. Chris (Research

Meeting 11) said, "*Often we'll say to people, you may not be feeling really hopeful right now, so we'll carry that hope for you until you are feeling better.*"

6.2   Peer Support

Some consumers and professionals commented on the informal peer support between consumers in the ward.

> *A lot of good stuff comes out of talking, just sharing stories. When you are with other people who are going through the same thing as you, you don't feel judged or different.* (Myles, Focus Group 3)

> *Patients will have their own spontaneous group. … They will appropriately get together and talk. … Good, therapeutic peer support.* (Reagan, Sunshine Clinic)

Reagan (Sunshine Clinic) also gave another example of this informal peer support professional, "*A lady that we had in … made an active effort to go and meet the newbies and let them know that 'I know you are terrified, but you're okay'.*"

While professionals at Sunshine Clinic encouraged informal peer support, they knew other inpatient mental health services did not share their perspective. Charlie (Research Meeting 11) said, "*Other facilities … say 'Go to group … but don't socialise with other people, don't make friends. Because you're here for your journey and a lot of people will take on other peoples' [issues].*" In the research group we questioned the value of discouraging peer support and discussed the benefits of informal support between people with lived experience. Kim (Research Meeting 11) said, "*We are so risk-averse? … We haven't been in their shoes. We don't have that experience. … There is so much value that comes from that shared experience.*"

Consumers who participated in our focus groups expressed a desire to help others in a similar situation to themselves. Josie (Focus Group 2) mentioned the value of research in particular, "*I wanted to be involved today … because I know the value of research.*" (Josie, Focus Group 2). Another consumer, Doug (Focus Group 3) commented on the value of having a consumer researcher co-facilitating the focus groups, "*Seeing you* [*Consumer Advocate*] *come up and do something like this gives us hope.*" Our research group also valued the Consumer Advocate's participation. Alex (Research Meeting 12) said, "[*Lea's*] *participation … added a lot of value … brought credibility to the project.*"

In addition to informal peer support on the ward, peer support was discussed in the group programs at Sunshine Clinic (See Chapter 7, Section 7.1).

6.3   Inclusion of Carers

Relational recovery is broader than the relationship consumers have with professionals and peers, extending to other relationships. This section focuses on carers in the context of inpatient admissions. The term 'carers' refers to family and support people who care for a consumer of mental health services (COAG, 2012).

Half of the consumers and a third of the professionals identified family members' as helping with recovery.

> "*My daughter is my rock … particularly in this episode. My first episode, once my wife understood what was going on, she was great. … Matter of fact she was the one that convinced me to go into hospital the first time.*" (Jack, Focus Group 1)

> "*I'm lost without* [*my partner*]*.*" (Jenny, Focus Group 2)

In Research Meeting 11 we discussed how various people might also provide support. Chris identified the "*person who drove them to the hospital or who helps them fill their scripts*." Kim added that a support person might also be their "*kids or neighbour*."

Both consumers and professionals indicated that they valued the inclusion of carers during a hospital admission.

> *It's good that* [*Sunshine Clinic*] *is such an inclusive place. It recognises that your family is just as important as other aspects.* (Olivia, Focus Group 4)

> *It is very much about collaborative care and listening and making sure they* [*the consumer and their family*] *feel very much involved in the delivery of care.* (Rylee, Sunshine Clinic)

> *They are the people that are going to carry them through.* (Charlie, Research Meeting 11)

The absence of carers' voices in the consultation process was a significant limitation of our study. No carers attended focus groups despite being invited to participate via flyers posted on the ward and provided to consumers to pass on to their carers. This lack of carer engagement mirrored Sunshine Clinic's difficulties with attendance at fortnightly carers support group meetings. Rob (Unity Hospital) said, "*I wish that* [*the carers group*] *was more utilised by carers*." In the research group we realised that one factor contributing to lack of carer participation was that consumers did not identify their family and friends as 'carers'. Charlie (Research Meeting 12) said, "*With our client group, they'll say 'I'm fully employed and … don't have a carer.'*"

Staff co-researchers reflected on how they could improve the identification of carers by asking consumers at admission, "*who are your important people? How do you want us to*

involve [*them*]*?"* (Chris, Research Meeting 12). We also discussed the use of alternative

terms that support people may use. Chris summed up our discussion, saying, "*I think*

rebranding to support crew or pit crew would be really good; ... acknowledging that not

everyone identifies as being a carer" (Research Meeting 12).

When professionals knew who the carers were, they made time to engage with them.

Rob (Unity Hospital) said, "*They* [*staff*] *will sit down and talk to the carers ... you can*

actually see where they [*staff*] *are engaging the carers ... where they are saying 'spoke to the*

husband about blah, blah, blah' ... in [*the care plans*]*."* Rylee (Sunshine Clinic) commented

that "*You always need to work with that patient and work with the families*" and

acknowledged that "*We try to see relatives, spouse or carers within that admission but that*

doesn't always happen."

6.4   Summary

The findings indicate the relationships that consumers have with professionals, peers,

and carers are at the core of their recovery in a hospital admission context. The findings for

each of these relationships is summarised in this section.

First, when consumers feel heard and understood by professionals, they identified that

this helped their recovery. Conversely, staff who lack empathy or connection with consumers

"[*don't*] *achieve anything for anybody*" (Ben, Focus Group 3) and Ben was reiterating that

they did not engage in a way that promoted recovery. In our study, consumers focused on

connectedness, while professionals discussed developing collaborative practice to empower

consumers, highlighting the different perspectives of consumers and professionals. Also, the

findings show that while staff aspired to collaboration, there was variability in practice, from

professionals making decisions for consumers to joint management with consumers.

Regardless of which component of recovery was the focus, i.e., connectedness or

empowerment, the mechanism supporting them was the same, viz., taking time to talk and listen to each other. Consumers talked about helpful conversations that took place informally in the ward and in therapy sessions. Professionals spoke about listening to consumer feedback at ward meetings and collaborating with consumers about their care. Also, the concept of professionals holding hope may be fundamental when consumers experience more hopelessness than hope in a hospital admission context. Overall, the recovery processes most important in the professional-consumer relationship were connectedness, empowerment and hope.

Second, the findings indicated that the naturally occurring peer support was fostered and valued by consumers and professionals at Sunshine Clinic. Staff co-researchers provided opportunities for consumers to share their experiences. Our research group agreed that hearing advice from peers who had "*been in their shoes*" (Kim, Research Meeting 11) was more powerful than hearing it from a professional.

Third, while staff endeavoured to include carers, it did not always happen in practise. In the research group, we reflected on the lack of carer participation, including that supporters may not identify as carers and might not have realised that the carer focus group (for the research) or carers group (part of practice-as-usual) was for them. Based on this insight, the staff co-researchers changed the carers group's name to the supporters' group and reported increased attendance.

6.5   Analysis and Synthesis

Our study found that Sunshine Clinic supported relational recovery through the relationship between professionals and consumers, fostering peer support and working towards the inclusion of carers. The findings identified five areas vital to recovery-oriented practice in a hospital-based mental health service: everyday conversations, training to talk,

collaboration, the inclusion of carers and holding hope. These areas of practice reflected the

recovery processes of connectedness, empowerment and hope. Each area will be discussed in

relation to the broader literature on recovery-oriented practice.

6.5.1   Everyday conversations

Our findings were consistent with previous studies indicating the central importance

of relationships to recovery during an inpatient admission (Cleary et al., 2013; Coffey et al.,

2019; Hyde et al., 2015; McKenna, Furness, Dhital, Ennis, et al., 2014; McKenna, Furness,

Dhital, & Ireland, 2014). Similarly, evidence about what works in therapy indicates that the

alliance (which comprises the relationship and agreement about goals) has a moderate

correlation with outcomes regardless of the intervention (Flückiger, Del Re, Wampold,

Symonds, & Horvath, 2012; Wampold, 2015). However, in our study, it was not the alliance

in the context of therapy that was central to recovery, but the everyday conversations with

professionals and other consumers. Everyday conversations represented informal

communication that was not part of therapy or case management. The communication content

was less important than the quality of the interaction; the sense that each party was "*on the

same level*" (Kevin, Focus Group 3) and consumers felt heard and understood.

The concept of 'everyday conversations' is like Cleary et al.'s (2012, p. 75) theme of

'ordinary communication' between a nurse and consumer, which entailed being person-

centred through showing interest, sharing information, and getting to know the person.

Similarly, Molin, Graneheim and Lindgren (2016, p. 9) identified 'ordinary relationships'

between staff and consumers as being as critical to recovery as medical treatment in the

context of an inpatient admission. Consumers also identified everyday conversations with

staff as beneficial (Bacha, Hanley, & Winter, 2020). Other research found that collaborative,

supportive relationships facilitated recovery, whereas paternalistic or coercive relationships

hindered recovery (Gilburt, Rose, & Slade, 2008; Mancini, Hardiman, & Lawson, 2005).

Having a good relationship with health professionals correlated with consumers having more

say in their treatment (Tobin, Chen, & Leathley, 2002) and better recovery outcomes

(Bredski et al., 2015). Consistent with previous research, our findings demonstrated that

connectedness with professionals, developed through ordinary, everyday conversations, was

seen as being supportive by consumers for their recovery.

Besides informal conversations between consumers and professionals, consumers

valued having discussions with others in the same situation, exemplified by Myle's (Focus

Group 3) statement, "*a lot of good stuff comes out of talking, just sharing stories*".

This finding was consistent with two studies that found that the benefits of peer support in

inpatient settings included companionship, and practical and emotional support (Bouchard,

Montreuil, & Gros, 2010; Galloway & Pistrang, 2018). In our study, professionals were

supportive of "*good, therapeutic peer support*" (Reagan Sunshine Clinic). However, this

finding was contrary to previous research indicating that staff were reluctant to encourage

informal peer interaction because of the high level of support consumers required and the risk

of negative consequences for the peer supporter's recovery (Galloway & Pistrang, 2018).

Due to being risk-averse, mental health services may limit the opportunity for peer support

(Shaw, 2014). Limiting peer support negates the the importance of lived experience. It also

removes support from the those who are receiving it and the benefits experienced by the

supporter in helping others (Bracke, Christiaens, & Verhaeghe, 2008; Faulkner & Basset,

2012).

Outside of the inpatient setting, the benefits of peer support to recovery are well

established (Davidson, Chinman, Sells, & Rowe, 2006; Faulkner & Basset, 2012;

Lawton-Smith, 2013; Repper & Carter, 2011; Solomon, 2004). However, most research on

peer support is focused on formal peer support roles (Galloway & Pistrang, 2018; Repper & Carter, 2011) not informal peer support. Similarly, there is a lack of study being conducted on formal peer support in inpatient settings. In our review of recovery-oriented practice in inpatient settings (see Chapter 3, Section 3.4) no studies focused on the peer workforce. These findings indicated a significant gap in research about the impact of informal and formal peer support in inpatient Mental Health Services.

The lack of research about formal peer support roles is unsurprising, given the lack of peer support roles in mental health services (Byrne, Happell, & Reid-Searl, 2016; Happell & Scholz, 2018; Holmes, Molloy, Beckett, Field, & Stratford, 2013). Advocates for peer support posit that creating paid peer support positions validates the expertise by lived experience that peer support workers provide (Happell & Scholz, 2018). However, this opinion was not raised in by consumers or professionals in the current study, who talked about the informal, naturally occurring peer-to-peer support that took place in the ward. Faulkner and Basset (2012) also suggest that having formal peer support roles may inadvertently decrease the value of informal peer-to-peer relationships between consumers accessing the service by promoting the peer worker as an expert.

The finding that the connection with peers was vital to groups' effectiveness is consistent with Yalom and Leszcz's (2005) concept of universality, i.e., similar experience or concerns, in group therapy. Furthermore, Kurtz (2015) stated that it is the sharing experience of recovery in recovery groups that inspire hope. Professionals contributed to consumers recovery by providing participants with the opportunity to share their lived experience in a supportive environment. Staff used a technique from evidence-based therapy, i.e., check-in, and applied it in a recovery-oriented way to foster the dialogue between consumers. Check-in

is a process where consumers share they between session experiences (Beck, 2020). This sharing increased consumers connectedness and hope in recovery.

The findings from our study are consistent with research identifying the tension between time to talk and other duties in inpatient settings (Gabrielsson, Savenstedt, & Olsson, 2016; McAndrew, Chambers, Nolan, Thomas, & Watts, 2014; Moreno-Poyato et al., 2016; Reid, Escott, & Isobel, 2018). Reid et al. (2018) found that consumers thought that nurses were too busy to have time to engage with them in collaborative care planning. Moreno-Poyato et al. (2016) found that both nurses and consumers identified lack of time as an obstacle to therapeutic relationships. Likewise, McAndrew et al. (2014) found that nurses spent excessive time on other activities and not enough time on engaging with consumers. Gabrielsson et al.'s (2016, p. 437) study of good mental health nursing in inpatient care identified the challenge of "having enough time" to be present and connect with consumers.

Protected Engagement Time (PET) (Edwards et al., 2008; Thomson & Hamilton, 2012) and Time Together (Molin, Graneheim, Ringnér, & Lindgren, 2019; Molin, Hällgren Graneheim, Ringnér, & Lindgren, 2020) are interventions developed to address the problem of not having enough time to talk. In Edwards et al.'s (2008) study, staff identified two times each week to prioritise nurse-consumer sessions. The feedback from consumers was mixed, with 60% of participants reporting it was useful or very useful. Edward et al. (2008) concluded that PET could help build engagement, but adequate supervision was required to support nurses to engage therapeutically with consumers. Thomson and Hamilton (2012) implemented a similar study, where they surveyed staff on two wards that had implemented PET. Group and one-to-one diversional activities were offered regularly and protected from disruption by other activities such as clinical intervention or having visitors. Most staff felt that having this time improved the relationships between nurses and consumers. However,

interference with clinical interventions, limited staffing and inconsistent consumer participation were identified as potential problems to implementation (Thomson & Hamilton, 2012). Most staff viewed the approach as essential to supporting consumer recovery, reducing risk, enhancing relationships between staff and consumers and improving consumer satisfaction with the service. Potential problems identified included intrusion on medical activities, insufficient staffing and inconsistent uptake by consumers (Thomson & Hamilton, 2012).

Time Together (Molin et al., 2019) was developed from the PET and the Tidal Model (Buchanan-Barker & Barker, 2004) which helps consumers to recover through telling their personal stories. Like PET, staff regularly scheduled protected time (one hour, five days each week) to engage with consumers in activities. Consumers reported that the intervention supported their recovery by increasing their hope through human interaction (Molin et al., 2019). Nurse participants described improved relationships between staff and consumers due to Time Together's participation (Molin et al., 2020).

The group programs at Sunshine Clinic ran on a similar concept to PET. Generally, the expectation was that consumers would attend the group program if they were well enough to participate, and other appointments and visitors were outside of group hours. Although this did not always happen in practice as sometimes a psychiatrist wanted to see their patients during this time. The Allied Health Team primarily facilitated the group programs with nurses doing a daily group check-in. Nurses had less time to talk with consumers and more responsibility for the day to day management on the inpatient ward, doing intakes, discharges, medication and hand-over between shifts. However, nurses often made time to talk with consumers in the evening, when it was quieter after the psychiatrists had finished

their late afternoon visits and the therapeutic groups had finished for the day. Consumers

particularly appreciated these informal conversations with staff (see Chapter 6, Section 6.1).

Another aspect of informal conversations raised in our study was that some staff

lacked the confidence to talk with consumers. A systematic review of the literature (Hartley,

Raphael, Lovell, & Berry, 2020) identified just eight studies on the therapeutic alliance topic

in mental health care settings. Most included studies had low methodological quality and

non-significant findings, i.e., the interventions did not significantly change the working

partnership between consumers and staff, or there was insufficient data to determine the

outcome. However, two studies demonstrated a significant therapeutic relationship change

following interventions (M. K. Byrne & Deane, 2011; Moreno-Poyato et al., 2018). The first

intervention comprised a three-day workshop for staff in a community-based service (M. K.

Byrne & Deane, 2011). The second intervention, in an inpatient setting, entailed regular

individual interactions between staff and consumers over 10 months (Moreno-Poyato et al.,

2018).

6.5.2   Continuum of collaboration

Recovery-oriented practice promotes a shift away from the medical model where

professionals are considered the experts, and towards an approach where professionals and

consumers collaborate drawing on their respective expertise from training and lived

experience (McCloughen, Gillies, & O'Brien, 2011; Slade, 2013). Sundet et al. (2020, p. 6)

identified three essential aspects of collaboration at the interpersonal level: 1) the person is at

the centre of care with services provided for, by and with the person, 2) the focus is on the

person's everyday life rather than psychopathology, and 3) a "pluralistic orientation" where a

diverse range of intervention options are available to suit the person's needs. Ness, Borg,

Semb and Karlsson (2014, p. 3) described the process of collaborating as "walking

alongside" the person, with the quality of the relationship being a core component to working together to support recovery.

Our findings indicated that at Sunshine Clinic, collaborative practice is on a continuum from the "*management of patients*" (Rhys Unity Hospital) to the consultation, e.g., ward meetings, and "*empowerment and joint management*" (Rylee, Sunshine Clinic). In relation to CHIME (Leamy et al., 2011) the collaborative practice supports consumer connectedness and empowerment. Higher levels of collaboration foster greater empowerment of the consumer to build their capacity to take responsibility for their recovery (Slade, 2013). During an admission when they are acutely unwell, consumers may have limited capacity to decide about their care (Mandarelli et al., 2014). Therefore, the balance of decision making may move from professional to consumer as the person's capacity to make decisions improves. Given that most admissions are short and designed to stabilise acute symptoms (Waldemar, Arnfred, Petersen, & Korsbek, 2016) by the time the person can collaborate fully in their care,they are ready to return to the community.

Another challenge for professionals, who are keen to embrace collaborative care, is that there is a lack of clarity around what this looks like in inpatient settings (McCloughen et al., 2011). Most of the emerging research on collaborative practice has been completed in community-based settings (Ness et al., 2014; Sundet et al., 2020). The experience of collaboration may also not be the same for professionals and consumers. McCloughen et al. (2011) found that nurses experienced collaboration as a mutual process, whereas consumers described the same collaboration process as often negative and challenging. Roper and Happell (2007) assert that what underlies the lack of effective collaboration is negative attitudes held by health professionals towards consumer participation. While most consumers in our study reported positive working relationships with staff, some had mixed experiences

similar to what was found in previous research findings (Coffey et al., 2019; Eldal et al., 2019; Gilburt et al., 2008; Mancini et al., 2005; Tobin et al., 2002). The findings suggest that consumers and professionals may have different attitudes towards, and experience of, consumer participation.

The World Health Organisation (2010) asserts that consumers and carers' empowerment need to extend beyond decision making about individual care to service provision and governance. To truly empower consumers and carers requires services to be accountable to consumers, to provide better access to information and resources, and to include consumers and carers in decision making at all levels (World Health Organization, 2010). Consumers had the opportunity to provide feedback on services at the ward meeting in Sunshine Clinic and on participation in Unity Hospital's Consumer Reference Committee to discuss hospital policy and procedures. However, from what I have observed, the consumer representatives' roles are to provide feedback on policy and procedures proposed by professionals rather than being active participants in the development of organisational governance. To move organisations towards more effective citizen participation, Ianniello, Iacuzzi, Fedele, and Brusati (2019) identified strategies to increase stakeholder engagement and effectiveness. These strategies reflected the complexities of developing a meaningful, long-term partnership, such as having a diversity of stakeholders represented, embedding participation in organisational practice with clear expectations and mechanisms to allow collaborative decision making and broad participation (Ianniello et al., 2019).

In a hospital-based mental health service, sharing power to balance the professional's duty of care towards the consumer and others and the consumer's preferences might be a reasonable approach (Gwinner & Ward, 2015). Seager (2015) states that medical management is the foundation of treatment for acute mental illness, followed by

recovery-focused interventions to support the person once the active symptoms dissipate. This approach aligns with Duckworth's (2015) view that it is imperative to maximise professional expertise and the consumer's lived experience when facing severe mental health challenges. In this respect, the medical model and recovery approach can be integrated to support the consumer better. It does not have to be "either/or" but "both/and" (Duckworth, 2015).

Collectively, consumers' responses reflected their experiences along a continuum from disconnectedness to connectedness, and staff responses ranging from management *of* to management *with* consumers, reflecting progression from disempowerment to empowerment (see Figure 6-3). Connectedness and empowerment appeared to be important aspects of collaborative practice that supported consumer recovery.

Figure 6-1

Continuum of collaboration through connectedness and empowerment

Notes: FG = Focus Group; UH = Unity Hospital; SC = Sunshine Clinic

6.5.3 Inclusion of carers

Our finding of limited inclusion of carers is consistent with previous research. While collaboration with carers is embedded in national policy (Commonwealth of Australia, 2013a; Department of Health, 2017) this has not translated into practise (Doody, Butler, Lyons, & Newman, 2017; Private Mental Health Consumers Network, 2010; Wilkinson & McAndrew, 2008). In previous studies, carers have felt excluded from care planning (Cree et al., 2015; Wilkinson & McAndrew, 2008; Wynaden & Orb, 2005). They also believed that their involvement was not valued by professionals (Jakobsen & Severinsson, 2006; Wainwright, Glentworth, Haddock, Bentley, & Lobban, 2015; Wilkinson & McAndrew, 2008). Wilkinson and McAndrew (2008) describe how the mental health crisis and the short-term nature of acute inpatient care also makes it challenging for carers to build effective working relationships with health professionals, even though they want to.

Several factors may have impacted engagement with carers in the current study. The original Nurse Unit Manager, who previously liaised with carers, left the service before the commencement of the consultation phase of the research. Carers tend to be more comfortable with the continuity of relationships with health professionals (Ewertzon, Andershed, Svensson, & Lützén, 2011) so this change may impact carer participation. Also, Giacco et al. (2017) indicate that it is preferable to have a whole team approach to supporting carers rather than having one primary contact. If this had been the case at Sunshine Clinic, carers might have remained more engaged with the service despite staff change.

Another significant problem for our study, and across mental health services, is difficulty in identifying carers. A comprehensive report on 'Identifying the Carer' (Private Mental Health Consumers Network, 2010) found that multiple factors contributed to the non-identification of carers: using the term 'carer', and confidentiality issues. Consistent with

our findings, consumers tend not to identify their family members as carers. Likewise, carers

tend not to identify themselves as carers but as partners or parents of a consumer (Private

Mental Health Consumers Network, 2010). Also, professionals sometimes find it challenging

to identify carers at admission due to the acuity of consumers' symptoms and their limited

capacity to provide consent (Giacco et al., 2017). However, carers play an essential role in

recovery and relapse prevention (Australian Health Ministers, 2008; Private Mental Health

Consumers Network, 2010) and they need to be involved as soon as possible after admission

(Giacco et al., 2017). Not providing support to carers during admission decreases the carer's

capacity to support their family member (Wynaden & Orb, 2005).

While carers were not involved in our research, our research group reflected upon

being more inclusive of Sunshine Clinic's carers and implemented practice changes. At Unity

Hospital during a Consumer Reference Committee (23/11/2018) staff reported that seven

carers attended the most recent carers group now rebranded as a 'supporters' group'. The

Nurse Unit Manager said that consumers are now actively encouraged to identify who their

support people are at admission and encourage these carers to attend the 'supporters' group'

offered fortnightly by one of the co-researchers on this project.

6.5.4   Holding hope

Holding hope is central to recovery (Bonney & Stickley, 2008; Schrank et al., 2012).

For people to recover they, and their support network, need to believe that recovery is

possible (Ahern & Fisher, 2001; Bonney & Stickley, 2008; Turner & Frak, 2001). Our

findings were consistent with previous research indicating that professionals being hopeful

for consumers when they feel hopeless are essential to their recovery (Darlington & Bland,

1999; Turner & Frak, 2001).

In addition to communicating hope to consumers, professionals foster hope through working collaboratively with people, encouraging supportive relationships and providing interventions that support wellbeing and self-efficacy (Schrank et al., 2012). Moreover, there is evidence that collaborative, supportive relationships with professionals and peers are valued more than consumers' treatments (Gilburt et al., 2008; Happell, 2008). In the current study almost all consumers identified that relationships with professionals as necessary to their recovery more so than any other interventions (see Appendix C, Table C-10). These findings are consistent with research into what works in therapy, with the quality of the relationship being a more reliable predictor of outcomes than the specific therapy technique (King & Bambling, 2001).

Figure 6-2

Holding hope for consumers

6.6   **Chapter Summary**

In summary, the current study's findings support the assertion that collaboration is integral to recovery-oriented practice (Australian Health Ministers, 2009). Furthermore, the outcomes are consistent with previous research (Gilburt et al., 2008; Happell, 2008), demonstrating that the relationship between professionals and consumers is crucial to recovery for consumers more so than any other specific intervention.

Three significant findings emerged from the consultation under the theme of relational recovery:

1. Consumers valued professionals that were caring and understanding and took the time to talk with them. Professionals acknowledged the importance of collaboration with consumers. However, the service could move from consultation to working more in partnership with consumers.

2. Informal peer support was encouraged by professionals and appreciated by consumers. However, staff co-researchers were aware than some services discouraged this practice.

3. The inclusion of carers was essential to both consumers and professionals, but was more aspirational than reality at the time of the research. However, staff co-researchers were instrumental in changing practise to identify carers at admission and to increase carer participation in the 'supporter's group'.

6.7   Summary of Co-Researchers' Reflections and Actions

We specifically reflected on and addressed two themes in the research group: peer support and inclusion of carers. We reflected on the importance of peer support during a hospital admission. Kim said, "*There is so much value that comes from that shared experience*." We decided that one action they could take would be to encourage consumers to contribute to a visitor's book to share their lived experience with other people admitted to the hospital. When I went back to visit the hospital the year after we competed for the project, staff co-researchers showed me the visitor's book where consumers had contributed stories and drawings to pass on messages of hope and perseverance to other consumers. Typically consumers contributed to a page in the book before their discharge reflecting on their hospitalisation experience. While staff co-researchers would consciously "*carry that hope for*

[*consumers*]" (Chris, Research Meeting 11) we agreed that the words from another consumer were more powerful than anything a professional could say.

We also reflected on how to improve the identification of carers so that they could be better supported. At Research Meeting 11, we discussed rebranding the carers group to be more inclusive of people who support a consumer, but may not identify as a carer. By the end of the project, staff co-researchers had reestablished the carers group as the supporter's group, with supporters being identified at admission and attending the monthly group.

6.8   My Reflection: Connectedness is What Matters

As a professional, the lesson I learnt from the findings in this chapter was that genuine human connection between people is integral to recovery. It does not matter whether you are a professional or a cleaner on the ward for your contribution to make a difference. What matters is that you are communicating on the same level and listening as well as talking. This makes sense to me as a psychologist trained in using a Rogerian, person-centred approach that espouses positive regard and actively listening. However, on a busy hospital ward, where consumers are acutely unwell, having time to listen competes with the demands of doing safety checks, managing risk, medical treatment, other therapeutic interventions, and record keeping. More important to consumers than all of these interventions was having everyday conversations with someone, be they a professional, general staff member or peer, who would communicate as equals and really listen. To foster these everyday conversations requires a whole-of-system approach where the naturally occurring interactions between people are valued as much as the formal, biopsychosocial interventions.

Chapter 7. Theme: Recovery Interventions

This chapter presents the three themes under the heading recovery interventions: group programs, medical intervention and discharge support. Recovery interventions build on the findings of what staff do that supports consumers' recovery. In Chapter 6, we learnt that consumers' relationships with staff, carers, and peers were central to their recovery. One of the principal ways that these relationships developed was through having time to talk. It was also critical to identify carers early in the admission and change the carers' group to the supporters group to be more inclusive of family and friends who supported the consumer.

In the current study, most consumers and professionals talked about recovery interventions (see Table 7-1) with over 150 comments about this theme. Section 7.1 covers the group programs facilitated by the allied health professionals in both the inpatient and day-patient programs at Sunshine Clinic. Section 7.2 presents the findings of medical interventions that support recovery. Section 7.3 covers discharge support before and after discharge from the hospital. Section 7.4 provides analysis and synthesis of the findings from recovery interventions (see Appendix C, Table C-9 to C-10 for number and percentage of participants endorsing each category). The chapter concludes with a summary of the findings, co-researchers' reflections and actions, and my reflection.

Table 7-1

Recovery intervention themes and sub-themes

Meta-Theme	Themes	Sub-Themes
Recovery-Oriented Practice (Interventions)	Group Programs	Common Factors
		Check-in/Peer Support
		Mindfulness
	Medical Treatment	Diagnosis
		Medication
	Recovery Planning	Recovery Care Plans
		Follow-up Phone Calls

7.1   Group Programs

Most consumers and some professionals spoke about the group programs, including the group facilitators, check-in and mindfulness. The co-researchers on the Allied Health Team were the primary facilitators for the group programs, and consumers had participated in these programs. Consequently, this study may present a positively skewed view of the group program.

Overall, consumers talked about the general helpfulness of the group programs.

The group sessions have … helped me immensely. (Tom, Focus Group 1)

The group therapy … helped a lot, enormously. (Kevin, Focus Group 2)

I'm finding group sessions are really helpful. (Steve, Focus Group 3)

I enjoyed having the groups to come to. (Emma, Focus Group 4)

No consumers talked about a particular therapy that they found useful. However, they did speak about two components of therapy: check-in, which is a standard part of Cognitive Behavioural Therapy (Beck, 2020), and mindfulness which is part of Acceptance and Commitment Therapy (Luoma, Hayes, & Walser, 2007) (see Sections 7.1.2 and 7.1.3, respectively). In addition, they spoke about the professionals who facilitated the groups (see Section 7.1.1).

Staff also indicated that the group programs were part of the recovery-oriented practice, but provided little detail about the groups.

I think the day hospital is really invaluable and the groups that they offer there.
(Rylee, Sunshine Clinic)

> *Looking at the timetable and schedule [for the group programs], there are definitely sessions aimed specifically at recovery-based programs.* (Rob, UH)

7.1.1   Group facilitators

The relationship between consumers and professionals has been discussed in Chapter 6, Section 6.1. Some consumers also mentioned how staff facilitating the groups helped them to feel comfortable.

> *To me it was the first day I came [I thought] 'I'm with people who understand'. I relaxed straight away. I could almost feel that knots running out of me.* (Jack, Focus Group 1)

> *The atmosphere, the counsellors [group facilitators] talking to you.* (Ron, Focus Group 2)

> *They [staff] create a calming feeling for me.* (Steve, Focus Group 3).

Peer support was also an important part of the group program. This was particularly evident through the check-in process.

7.1.2   Check-In

Half the consumer participants discussed group check-in with most of the discussion in the day-patient groups (Focus Groups 2 and 4). Check-in was a process at the beginning of each group where participants shared their experiences during group sessions. It is common practice in evidence-based therapies, such a Cognitive Behavioural Therapy, to check-in at the beginning of a session about any significant events that had taken place since the previous session (Beck, 2020). This process generally takes about 5–10 minutes at the beginning of each session. The inpatient groups at Sunshine Clinic, which usually ran for an hour, conformed to this norm. However, check-in for the day-programs would take at least an hour.

Each participant had the opportunity to take a turn to talk about what was working well and the challenges they experienced between sessions. Then, with that person's permission, other participants would share similar lived experiences and strategies. Participants appreciated this aspect of the groups, as exemplified by the discussion in Focus Group 2:

> *It was really great. The way* [*the psychologist*] *did it … We would go around the room talking about how we had been going. … There was a lot of interest in how the other people were getting on.* (Kevin)

> *Check-in was like your own little personal therapy, and everyone could help you and give their experience as well, so I think check-in was really useful.* (Josie)

> *I believe in open and frank discussion. It was great to hear what everyone else said. … Openness and didn't put a person down for the way they are. … Non-judgemental.* (Ron)

Staff contributed to the discussion during the check-in process, but the primary focus was on consumers sharing their lived experience. In this respect, check-in was more like the conversations in peer support groups (Copeland & Mead, 2004; GROW Mental Welbeing Programs, 2021).

Consumers identified the following benefits of the discussion with peers in the group program:

> *One of the things I found the most comforting was that you are not alone.* (Jack, Focus Group 1)

> *Lots of times you got the feeling that you are not the only one in the world … when you get here and talk to other people.* (Lance, Focus Group 2)

Being in the group, knowing that other people understand how you feel. … You learn

a lot of them. … It's easier to talk to someone if we are all on the same path, similar

path you know. (Doug, Focus Group 3)

The social connection with peers extended past the formal group session. Kevin (Focus Group 2) said, "*It was not only the conversations in the group therapy sessions but socialising with others during the breaks, that was helpful.*" Apart from the social connection, the process of sharing with peers contributed to developing hope. Olivia (Focus Group 4) said, "*You get little tips and that sort of gives you that little glimmer of hope.*"

7.1.3   Mindfulness

Mindfulness is described as present moment awareness, characterised by non-judgemental awareness (Kabat-Zinn, 2015). At Sunshine Clinic, mindfulness was a regular part of the group programs. Mindfulness is a core ingredient in evidence-based therapies, including Acceptance and Commitment Therapy (Luoma, Hayes, & Walser, 2007). Almost half of the consumer participants spoke about the usefulness of learning mindfulness in the group programs. Consumers discussed how they did not initially understand mindfulness, but it became an essential tool in their recovery.

I always thought it [*mindfulness*] *was a load of crap, and now I'll sit down outside*

and just look at the leaves in the tree. When you are in a bad place, it'll put you in a

better place. I've learnt that through coming here [*to day-groups*]. (Kevin, Focus*

Group 2)

When you walk along you can hear birds, you can see something there, going away

from all this other [*thoughts*]. *You've got to work on that of course. It doesn't come*

natural. (Lance, Focus Group 2)

Mindfulness ... thoughts ... move through in waves, keep going, instead of getting

jammed there, because I'm focused on something else. (Tom, Focus Group 1)

7.1.4 Summary

Overall, consumers reported that the group programs were helpful. The primary

factors that made groups effective were the supportive staff and peers. From the consumers'

perspectives, the check-in process where they shared their lived experience was crucial to

recovery. Mindfulness was also a useful tool that helped with recovery, although it was a skill

that they only come to appreciate with practice.

7.2 Medical Intervention

The medical treatment theme includes the sub-themes of diagnosis and medication.

Over a third of consumers indicated that medical treatment was an essential part of their

recovery. Most consumers identified more than one aspect of medical intervention that had

been helpful, such as diagnosis and medication. Other interventions mentioned included

electroconvulsive therapy (ECT) and repetitive transcranial magnetic stimulation (rTMS).

However, participants did not discuss ECT or rTMS in relation to recovery as they did with

diagnosis and medication.

7.2.1 Diagnosis

The feedback from consumers in our study indicated that diagnosis was essential to

understanding their experience.

My diagnosis helped me. ... When I first got my first diagnosis ... that explained a lot

of things. ... Understanding is helpful. (Brooke, Focus Group 3)

It was really helpful for me. ... When I got diagnosed, I had something to work with.

(Ben, Focus Group 3)

I'd had it for about 40 odd years before I had a diagnosis. Now I had an understanding of why I was like I was. (Jack, Focus Group 1)

[*A diagnosis*] *makes a big difference. I was so happy that I got diagnosed at 17. ... Because we knew early, we sort of nipped it in the bud. It was a huge learning curve for the whole family but a big turning point for us knowing what was going wrong.* (Lea, Research Meeting 11)

In Research Meeting 11, staff co-researchers reflected shared their perception about having a diagnosis.

I think a diagnosis can be really important to people. ... It gives them something to hold on to. This is part of identity but also part of the explanation. (Chris)

And acceptance. Ah, you've got that; okay now we can talk about [*it*]. (Charlie)

I guess that comes back to what is the functional loss? So, even without the name [*diagnosis*]*, what's the thing that you find difficult or challenging?* (Kim)

7.2.2 Medication

When consumers spoke about the impact of medication on recovery, they did not distinguish between clinical and personal recovery. Participants were less interested in the nuances about the definitions and more interested in whether the intervention was helpful or not.

I'm afraid for me it's been medication. (Jack, Focus Group 1)

Medication makes a big difference. (Lea, Focus Group 1)

I think medication is also important in recovery, and that's what I'm grateful for.
(Josie, Focus Group 2)

That one little tablet has made all the difference. (Ron, Focus Group 2)

Medication is a big one. … Got to get it right. (Jenny, Focus Group 3)

Participants in Focus Group 2 also discussed how medication was only part of their recovery.

It [recovery] is not as easy as taking a pill is it? … People … think that's all it is. Just take a tablet, and it all goes away! If only if it was that easy. (Kevin)

It [medication] helps, … and I need lots of sleep, and I need to eat well and exercise, and you do all of those things, and it's a whole lifetime job just maintaining health. (Lea).

Earlier on with my diagnosis, I used to think, I'm going to get well. I'm going to be symptom free and whatever medication I'm on is going to sustain me … but you realise very quickly that that isn't the case. … For me it's accepting that. You live with the disorder that you have and learn strategies and ways of dealing with it. (Josie)

Our perspective as co-researchers noted that there was a consistency with consumers' feedback that the groups and medication were helpful. Chris commented that "*For the most part, you need medication and therapy.*" Similarly, other professionals acknowledged the need to use alternatives to medication, where appropriate.

I think there should be more consideration when d/c [*discharge*] *is upcoming to …*

use coping skills/distraction techniques (that the client can use … when PRN

[*as needed medication*] *isn't available).* (Cody, Sunshine Clinic)

Need to … look at important things such as risk factors, aspects of illness, which can

be helped by intervention. … For anxiety, for example, Cognitive Behavioural

Therapy, desensitization, relaxation. (Ricki, Sunshine Clinic)

7.2.3   Summary

Consumers recognised that diagnosis helped them to understand their experience, and medication made a difference in their recovery. When professionals spoke about medication, they were likely to consider whether medicine or other interventions were more effective.

7.3   Discharge Support

Participants identified two main aspects of discharge support: Recovery care plans completed before discharge and the follow-up phone calls made to consumers one-week post-discharge.

7.3.1   Recovery care plan

Various kinds of care plans exist in inpatient contexts, including treatment plans, risk management plans, discharge plans and advanced directives (Yuen, 2012). The Recovery Care Plan is synonymous with the discharge plan. The recovery care plan defines planned interventions, desired outcomes and how these will be measured (Wrycraft, 2015). At Sunshine Clinic, staff used a document called the 'Treatment Recovery Care Plan' to record the recovery plan (Ramsay Health Care, 2017). The plan focused on problems rather than strengths. The plan was designed to be completed by a staff member in consultation with a consumer. In setting the goals, the template clearly states: "as agreed by the patient" (Ramsay Health Care, 2017, p. 2).

Approximately a third of the professionals identified recovery care plans as integral to recovery-oriented practice in Sunshine Clinic. By contrast, no consumers referred to the recovery care plan. Professionals reported having conversations with consumers about their recovery goals. Reagan (Sunshine Clinic) said, "*It's about focusing on what the patient wants and what their goals are and where they need to get to*." Staff acknowledged that for recovery care plans to be more useful, they needed to "*be done earlier*" (Reagan Sunshine Clinic) rather than when the person was close to discharge. In reflection on progress in the research meeting we noted that, since the research project's commencement, recovery care plans were being completed earlier in admissions.

> *I think that has already happened throughout this study.* [*Now*] *we say discharge planning from admission day* (Kim, Research Meeting 11).

> *Care plans, everyone has to do them now from day one, not just the last few days before they go home.* (Alex, Research Meeting 11)

The following section explores another aspect of recovery-oriented care identified as needing improvement by participants in the current study, follow-up phone calls.

7.3.2   Follow-up phone calls

Both consumers and staff identified follow-up phone calls as an essential part of recovery post-discharge. However, consumers had a mixed appraisal of the helpfulness of follow-up phone calls. Some consumers indicated that they felt that that phone calls were too brief and did not allow time to discuss how they were coping. When asked if the phone calls were helpful, Brooke (Focus Group 3) said, "*Not really. Maybe go into a bit more detail*." Overall, the consensus was that consumers appreciated getting the calls, but they could be more useful. In the research group, we ackowledged this feedback, summed up in a comment by Chris, "*The value for* [*consumers*] *may not necessarily be there*." We decided that one

action arising from the research was to recommend changes to the procedures for follow-up phone calls, including developing a template for staff to use and more time to have the conversation.

7.3.3   Summary

The current study identified areas for improvement in discharge planning. Staff acknowledged that they needed to commence working on recovery care plans with consumers earlier in their admissions, "*not just ... before they go home*." (Alex, Research Meeting 11). If staff make this change, the planning may be more meaningful to consumers than an administrative task to complete before discharge. Furthermore, co-researchers and consumers agreed that follow-up phone calls were currently too brief to be considered helpful.

7.4   Analysis and Synthesis

The findings identified three main areas of recovery-oriented practice related to interventions: connectedness, practising mindfulness and medical intervention. Each of these topics will be discussed in relation to the research on recovery-oriented practice.

7.4.1   Effective components of the group programs

Our findings suggest that two components of the group programs supported consumer recovery: connectedness with group facilitators and peers through the check-in process and mindfulness.

Our findings indicate that relationships with professionals and peers matter more than the type of therapy. This finding is consistent with Wampold's (2015) contextual model of the common factors that require a strong working alliance with the therapist for therapy to be effective. Likewise, Yalom and Leszcz (2005) identified cohesiveness, i.e., the therapeutic alliance in a group, as essential for successful group therapy. These common factors correlate

more strongly with client outcomes than the specific intervention (Lambert & Barley, 2001).

Furthermore, Davidson and Chan (2014) highlight that professionals building trusting

relationships with consumers could foster hope in recovery.

In addition to connectedness, mindfulness supported consumer recovery in our study.

Consumers in the current study identified mindfulness as a tool that was helpful to their

recovery. However, to obtain the benefits, it was a skill that they had to practise. Participants

talked about their appreciation of 'present moment awareness' and how mindfulness could

transport them from a "*bad place*" to a "*better place*" (Kevin, Focus Group 2). Several

meta-analyses support mindfulness in reducing distressing symptoms of anxiety (Hofmann,

Sawyer, Witt, & Oh, 2010; Khoury et al., 2013; Kim et al., 2009) and mood disorders (Chiesa

& Serretti, 2011; Hofmann et al., 2010; Khoury et al., 2013; Klainin-Yobas, Cho, & Creedy,

2011; Piet & Hougaard, 2011). However, there is a shortage of research on the relationship

between practising mindfulness and recovery.

7.4.2   Medical intervention

This study's findings support the view that diagnosis and medication, which are part

of the medical model, also help recovery. Therefore, the medical model and recovery

approach are more like "oil and vinegar" than "oil and water" (Davidson, Drake, Schmutte,

Dinzeo, & Andres-Hyman, 2009). The two main components highlighted in this study,

diagnosis and medication, will be addressed in the sections below.

Our finding was that consumers found diagnosis to support recovery contrasts with

the view that diagnosis is antithetical to recovery (Pavlo, Flanagan, Leitner, & Davidson,

2019) and de-values lived experience (Byrne, Happell, & Reid-Searl, 2016; Rufer, 2007;

Strickler, 2009). Whether the diagnosis is helpful or unhelpful might depend on the approach

to diagnosis. Flanagan, Davidson and Strauss's (2010) studies found that asking the

consumer about their experience improves diagnosis by incorporating a greater understanding of their lived experience. Similarly, Zisman-Ilani, Roe, Flanagan, Rudnick, and Davidson (2013, p. 152) suggested asking simple questions, such as "And what is that experience like for you?" to improve diagnosis by incorporating a person's ipsative experience.

Consumers in our study found that the diagnosis gave them "*an understanding*" (Jack, Focus Group 1) and "*something to work with*". (Ben, Focus Group 3). Likewise, professionals focused more on diagnosis, adding to the "*explanation*" (Chris, Research Meeting 11) and a starting point for further discussion. Our findings suggest that Pavlo et al.'s (2019) recommendations that diagnosis can be part of recovery-oriented practice if the process is collaborative, future-focused and incorporates strengths and addressing *challenges*.

Our results were consistent with Piat, Sabetti, and Bloom's (2009) findings that consumers associated medications with their recovery, either alone or in combination with other factors. However, other studies found that medication, mainly the side effects, impeded recovery (Andresen, Oades, & Caputi, 2003; Lunt, 2002; Mead & Copeland, 2000). Whether or not medication is helpful might depend on the individual consumer. Therefore, consumers should make an informed choice about using medications or other treatments (Stratford, Brophy, Beaton, & Castle, 2013). Medicine is one of many possible interventions that consumers can use to recover (Baker et al., 2013).

7.4.3   Time to talk about recovery

Consumers reported having good collaboration with staff who took the time to talk about recovery (see discussion in Chapter 6, Section 6.4.2) but did not mention recovery care plans in the consultation. Based on the staff's feedback that discharge plans were completed just before discharge, it is likely that there was insufficient time to collaborate with

consumers on their plan. Similarly, the effectiveness of follow-up phone calls was limited due to the brief duration. Recovery care plans and follow-up phone calls will be discussed in relation to the need to have time to talk and engage consumers in both processes.

Our study's findings support the view that working on recovery plans sooner would allow consumers to be meaningfully involved in developing their recovery plans. This sentiment is supported by Rickwood (2006), who asserted that discharge planning should commence at admission and be designed with consumers, their families/carers, and support services input. Two other studies demonstrated positive outcomes associated with recovery planning. Kisely et al. (2017) found that developing recovery plans with consumers can identify more triggers, thus, reducing relapse. Likewise, Taylor et al. (2016) found that a recovery-oriented discussion before discharge was associated with reduced re-admission rates. Other obstacles in the effectiveness of recovery care plans at Sunshine Clinic was that the plan focused on problems rather than strengths and was completed by staff with consumers' agreement. While seeking agreement on goals is a step towards consumer consultation, it falls short of full collaboration.

Practice guidance documents recommend using a recovery approach for care planning (Care Services Improvement Partnership, Royal College of Psychiatrists, & Social Care Institute for Excellence, 2007; National Institute for Mental Health, 2005). Recovery plans are developed collaboratively with the consumers and their family/carers (Adams, 2005; Marston & Weinstein, 2013; Rickwood, 2006). Palmer et al. (2014) found that the benefits of developing a plan included having a clear direction, being able to inform family/carers about how to provide support, tracking progress and empowering consumers. Similarly, Cook et al. (2012) found that consumers who developed a WRAP experienced both better clinical recovery, and personal recovery.

The primary improvement in the planning identified in our research group was to commence the recovery planning process earlier in the admission and to involve consumers in developing their plans across their hospital stay. To achieve this outcome would involve staff talking with consumers and writing the plan together.

Like recovery care plans, follow-up phone calls were impacted by a lack of time for staff to talk with consumers. Our findings indicated that the phone calls were too brief to be effective in checking on consumers' welfare. Without adequate support, people are more likely to relapse post-discharge, which increases their risk of suicide or re-admission to the hospital (Australian Government & Department of Health, 2013). While national policy provides discharge guidelines for services, these are related to clinical care, not recovery (Australian Goverment, 2016).

Previous research found that consumers find it difficult to ask for help post-discharge (Redding, Maguire, Johnson, & Maguire, 2017). Therefore, active follow-up is crucial in the first days and weeks post-discharge when consumers are more vulnerable (Gerson & Rose, 2012) and are adjusting to being back in the community and to the expectations of being 'normal' (Redding et al., 2017). A systematic review of predictors of re-admission for psychiatric patients found that the outcomes ranged from post-discharge follow-up being associated with a reduction in readmissions to no difference to an increase in readmissions (Sfetcu et al., 2017). The divergent results suggest that it may be difficult for health professionals to determine the right amount of support to provide to consumers via follow-up phone calls.

In addition to post-discharge follow-up, three factors provide continuity of care between inpatient admission and community support: sharing the discharge plan with community support services, linking with community support services before discharge, and

involving the family in planning during the hospital admission (Boyer, McAlpine, Pottick, & Olfson, 2000). Each of these strategies extended two critical concepts identified in our study: connectedness with professionals and informal supporter, and having adequate time to talk with the relevant parties to ensure that the process is meaningful rather than administrative.

7.5   Summary

Four significant findings emerged under the heading of recovery interventions.

1. Consumers identified group programs as the most helpful recovery intervention. The aspects of the group programs most valued by consumers were the relationships with staff and peers, the check-in process and mindfulness.

2. Medical interventions, such as diagnosis and medication, can be critical to recovery for some consumers.

3. Staff indicated that recovery plans were critical, whereas no consumers identified recovery plans as part of their recovery. This difference highlighted the need to begin working on consumers' plans earlier in their admission and be more collaborative.

4. Finally, while consumers appreciated receiving the post-discharge phone calls, they were too brief to support recovery effectively.

The message emerging from this chapter is that it is not the specific interventions that are critical but the process of connecting with consumers and the opportunities for them to talk with each other. What mattered to consumers was that they had a chance to share their experience, and having time to talk to staff and peers about their experiences.

7.6   Summary of Co-Researchers' Reflections and Actions

In our research group, we agreed that medical interventions, such as medication and diagnosis, were essential to some consumers' recovery. Since the commencement of the project, staff co-researchers had been proactive in commencing recovery care plans earlier in admission so that consumers could be more actively involved in developing the plan, rather than it being an administration task to complete before discharge. The other area co-researchers identified for improvement was the follow-up phone calls made to consumers post-discharge. We recommended that the staff needed more time to make these calls and guidance on what to cover in the conversation.

7.7   My Reflection: What Helps Recovery?

In reflecting on the findings in this chapter, it was humbling for me to realise that something as simple as taking the time for participants to share their experience was more potent in supporting recovery than all our evidence-based therapies. On reflection, this finding is not so surprising, given the similarities to what we know works in therapy, i.e., that the therapeutic relationship contributes significantly to therapeutic outcomes, regardless of the type of therapy (Norcross and Lambert, 2011).

The findings also confirmed that medication has a role in supporting recovery. When I was working on the ward, I observed that medicine often helped reduce the acuity of symptoms which enabled consumers to actively participate in the groups, connect with others and focus on their recovery. Perhaps the biopsychosocial model, with a combination of medication, group therapy and social interaction, can support personal recovery, in addition to clinical recovery.

Chapter 8. Bringing It All Together

This chapter brings together the findings from the meta-themes: the conceptualisation of recovery, relational recovery and recovery-oriented interventions. Section 8.1 examines how this thesis addresses the gap in the literature about the conceptualisation of recovery. Section 8.2 explores how this thesis contributes to the knowledge about what constitutes recovery-oriented practice in hospital-based mental health services. Section 8.3 looks at how this thesis explores a new approach to implementing changes to practice. The chapter concludes with a summary and my reflection.

8.1   The Reconceptualisation of Recovery

When we commenced our study, we assumed that while there was a debate in the literature about the conceptualisation of recovery (Jacob, 2015), the research evidence strongly ed the CHIME conceptualisation of recovery (Bird et al., 2014; Leamy et al., 2011; Slade et al., 2012; Stuart, 2017; Van Weeghel et al., 2019). However, when I systematically reviewed the literature, I noticed a dearth of studies that included the perspective of consumers during an acute admission to hospital. As a result, our research group sought to establish whether the CHIME conceptualisation (Leamy et al., 2011) developed in other contexts was relevant to consumers accessing a hospital-based mental health service. Our findings indicated that the CHIME conceptualisation of recovery only partially reflected the experience of consumers in our study, who were experiencing the challenges of disconnectedness, loss of hope and disempowerment. Similar to Bird et al.'s findings that consumers experienced a loss of their lifestyle, consumers in our study wanted to get back to everyday living after their lives had been disrupted by acute mental illness. The CHIME conceptualisation did not specifically identify this recovery process that was integral to consumers during a hospitalisation. Section 8.1.1. explores how acknowledging challenges within theconceptualisation of recovery provides a more holistic conceptualisation that

incorporates the experience of people experiencing an acute exacerbation of mental illness.

Section 8.1.2 provides a rationale for adding the component, everyday living, to CHIME,

updating it to CHIME-E to better reflect the experience of consumers acessing mental health

services

8.1.1   Recovery as spectrum

Our study's findings suggest that each of the positively named CHIME processes of

connectedness, hope, identity, meaning and empowerment (Leamy et al., 2011) are part of a

continuum that moves back and forth between challenges and living well. Taken together the

continuums for each of the five CHIME processes form a spectrum that represents the unique

experience of each person at any point in time. Reconceptualising recovery as a spectrum

reflected our finding that recovery did not progress in stages across all processes as suggested

by previous models (Andresen et al., 2003; Leamy et al., 2011). Instead, a consumer might be

at a different place on the continuum for each recovery process. For example, consumers

talked about increasing connectedness and hope during their admissions, but they had little

opportunity to construct a new identity and meaning during this time. The closest consumers

came to change in relation to identity and meaning was in talking about being on the recovery

track. Consumers also spoke about taking more responsibility for their own recovery as their

admission progressed, which represented a transition from disempowerment to

empowerment. Also, each person's journey was fluid with bidirectional movement between

challenges and living well. Such as, Lance (Focus Group 2) who spoke about "*going really*

good until … [*he*] *crashed down*." Leamy et al.'s (2011) staged model of recovery also

describes recovery as non-linear and dynamic, inferring bidirectional movement between

stages. However, conceptualising recovery as a spectrum recognises that someone may be in

a different place on the recovery continuum for each CHIME process.

This variability of experience across processes changed the conceptualisation of recovery, from moving in stages from moratorium to growth (Andresen et al., 2003), to seeing recovery processes as moving back and forth on a continuum between challenges and living well. . The spectrum conceptualisation recognises that each recovery process can move independently back and forth between challenges and living well, rather than all processes simultaneously progressing in stages. Therefore, someone may be at a different placeon the continuum for each recovery process and experience recovery as "*a growing thing and a changing thing*" (Emma, Focus Group 4). A person's position on each process may vary from day to day. For example, Jack (Focus Group 1) spoke about days where he would withdraw into himself as if "*almost in a cupboard*" and other days where he could "*go and do the things I want to do*." Similarly, Lea spoke about how "*it's not easy*" (Focus Group 2), but that sometimes she experienced "*blue sky days … where everything is easy*" (Focus Group 1). Thus, conceptualising recovery as a spectrum, where recovery processes are fluid, and do not progress through stages provides a more holistic conceptualisation of CHIME, which recognises the unique nature of each person's recovery journey (Ellison et al., 2018; Jacob et al., 2017)), exemplified by our finding that 'one size does not fit all' (Section 5.1.1).

8.1.2   Everyday living in recovery

Our findings identified another recovery process that was not identified in the initial studies that validated the CHIME conceptualisation (Leamy et al., 2011; Slade et al., 2012; Stuart, 2017; Van Weeghel et al., 2019). Bird et al. (2014) referred to consumers losing touch with their lifestyle, and consumers in our study spoke more explicitly about getting back on track (Section 5.1.2), which reflected the desire to return to everyday living and being normal, everyday activities, such as socialising and working. Finding a new identify and meaning may be more critical post-discharge, when consumers are trying to find a new, but equally valued, pathway to live with mental health challenges.

The other end of the continuum is the disruption to everyday living that happens in the context of an acute episode of mental illness. This experience is similar to the concept of "biographical disruption" in chronic illness where everyday life is severely disrupted (Bury, 1982; p. 167). In this context, Olivia (Focus Group 4) described recovery as "*where you can get on with your life, and you can do most things.*" Existing CHIME processes of connectedness, hope, identity, meaning and empowerment do not reflect a return to everyday living. Still, consumers in our study spoke about this concept being essential after an acute mental illness episode had disrupted their lives. Adding 'everyday living' to the conceptualisation of recovery, i.e., CHIME-E, reflects consumers' experience during an acute episode of mental illness. Like other CHIME processes, everyday living spans both living well and challenges. Figure 8-1 provides an example, using quotes from Emma (Focus Group 4), of how someone can be at different places on different processes along the recovery spectrum. While Emma experienced isolation, hopelessness and disruption to everyday living, she had become more accepting of life with the disorder and took responsibility for maintaining her wellbeing through using strategies like mediation and relaxation. Despite this, Emma still described life as "vanilla", lacking those things that made life more interesting or meaningful.

8.2 Knowledge of Recovery-Oriented Practice

Our findings added to the knowledge of recovery-oriented practice in the context of a hospital admission. Four recovery processes: connectedness, hope, empowerment, and everyday living, were vital to recovery in this context. Almost all consumers talked about feeling disconnected or isolated, then re-connecting with others through their relationships with staff, peers, and family. Consumers spoke about their sense of hopelessness; moving towards hope and about taking control of their recovery. Kevin (Focus Group 2) said: "*If you want to get over it, you're going to have to do something yourself.*" Consumers also talked

about finding ways to cope with distressing symptoms and get back to doing everyday

activities. Knowing what processes are crucial to recovery during an inpatient admission will

assist professionals to improve recovery-oriented practice in hospital-based mental health

services.

Figure 8-1

Emma's recovery spectrum

Recovery-oriented practice provided a bridge to support consumers to move along the

spectrum from challenges to living well in all recovery processes identified previously and

with our new addition, everyday living (see Figure 8-2). Relational recovery was core to

consumers finding connectedness with staff, peers and family. Not only did consumers talk

about needing "*something to look forward to*" (Emma, Focus Group 4), but staff identified

that they had a role to play in holding hope when consumers were experiencing hopelessness. While finding new identity and meaning seemed unattainable for some consumers during a hospital admission, where they did talk in general about being on the recovery track. The processes of identity and meaning may be more critical post-discharge, when consumers are trying to live a valued life, following a new path. Co-researchers supported this concept, talking about the idea of taking "*a different path*" (Charlie, Research Meeting 11), suggesting a new direction, a new purpose and moving forward with an acceptance of living with mental health challenges. Almost half of the consumer participants spoke about developing self-efficacy as part of their recovery. Staff can empower consumers by moving away from making decisions for them to working collaboratively with consumers in relation to all aspects of their care. As co-researchers acknowledged, consumers may need to take "*small steps*" (Chris, Research Meeting 11) towards self-efficacy when they are recovering from an acute episode of illness. The other area of recovery-oriented practice that this study highlighted was the need to support consumers to return to the activities of everyday living by providing a range of opportunities to engage in social and recreation activities during their admission.

8.2.1   Supporting relational recovery

Our findings show that recovery does not happen in isolation but in context of supportive relationships with professionals, peers and family. Furthermore, in a hospital, where consumers are acutely unwell, staff have a pivotal role in enhancing relational recovery through creating opportunities for consumers to talk with others. Our findings indicate that staff taking time to have informal, one-to-one conversations with consumers, being inclusive of family and supporting peer conversations contributed to consumers sense of being heard and understood. Jack (Focus Group 1) said, "*They* [*staff*] *take the time to talk to you. They understand … what you're going through.*" Our findings indicated that taking

the time to talk was more powerful than any specific intervention in enhancing recovery.

Also the interventions that were most supportive of recovery (such as the group programs)

fostered connectedness between staff and consumers.

Figure 8-2

The role of recovery-oriented practice: Bridging challenges to living well

Consumers identified talking with the staff, conversations with other consumers, and

their families' support as most helpful in their recovery. The types of conversations that

consumers referred to with professionals were informal conversations rather than formal

discussions in individual therapy. Trevor (Focus Group 3) said, "*Even goes down to*

environmental service or cleaning staff. They'll have a chat [with you] when they are working

away."

While professionals at Sunshine Clinic valued having time to talk with consumers, responses by staff who did not regularly work in Sunshine Clinic indicated that they had limited knowledge about recovery and lacked the confidence to speak with consumers, especially when they were distressed. Chris (Research Meeting 11) described what a generalist nurse might say: "*I'll do the medication … and sign off the care plan. You can deal with the feelings.*"

8.2.2   Recovery-oriented interventions

Contrary to the belief that the medical model and recovery approaches are incompatible (Byrne et al., 2016) there were three medical model interventions that consumers identified as supporting their recovery: the group therapy programs, diagnosis, and medication. Conversely, the two interventions designed to help recovery recovery care plan and follow-up phone calls, needed revision to be genuinely recovery-oriented, The common thread through the findings was that the interventions that were most helpful reinforced connectedness or reduction of distressing symptoms.

The group therapy programs were based on therapies targeting clinical recovery, not recovery-oriented programs as in previous studies (see Chapter 3, Sections 3.4.2. and 3.5.2). Despite this, consumers found the groups helpful in their personal recovery. However, consumers did not speak about the evidence-based therapy aspects or clinical recovery. What consumers valued was the check-in process, which allowed them to share their lived experience and support each other in their personal recovery. Josie (Focus Group 2) said: "*everyone could help you and give their experience as well, so I think check-in was really useful.*" This finding reinforced the importance of providing opportunities for connectedness through peer support. The other component of the group programs that was helpful was practising mindfulness. Consumers spoke about how practising mindfulness "*doesn't come*

natural" (Lance, Focus Group 2), but they came to appreciate mindfulness over time.

For example, Kevin (Focus Group 2) said: "*When you are in a bad place, it'll put you in a better place.*"

Similar to Bird et al.'s (2014) findings, the other two interventions that consumers in the current study identified as critical to their recovery were diagnosis and medication. Brooke (Focus Group 3) said, "*When I first got my first diagnosis ... that explained a lot of things. ... Understanding is helpful. Medication, like mindfulness, provided symptom relief.* Consumers were thankful for *that one little tablet has made all the difference*" (Ron, Focus Group 2). However, they were aware that medication was only one aspect to support recovery. Lea (Focus Group 2) said: "*It* [*medication*] *helps ... and I need lots of sleep, and I need to eat well and exercise.*"

The two interventions that were designed to be recovery-oriented: the recovery care plan and follow-up phone calls, fell short of expectations. Both interventions had become more like administrative tasks to be completed by staff rather than collaborative activities conducted with consumers. The value for consumer recovery was not there without staff working in partnership with consumers to complete their recovery plan and taking more time to check in with consumers post-discharge. This finding suggests that recovery-oriented practice needs careful planning so that the purpose of practice, i.e., to support consumer recovery, is not lost in translation.

The common thread across interventions was not whether it was developed under the medical model or recovery approach, but the level of connectedness consumers experienced through collaboration with staff or peers, or the intervention's capacity to reduce acuity of symptoms and allow consumers to focus on their recovery (see Figure 8-3).

8.3   Participatory Health Research

Our approach to doing this research was different from previous studies included in the systematic reviews of research and quality improvement studies in hospital-based services (see Chapter 3). Previous studies took one of three approaches to implement recovery-oriented practice: staff training, recovery-oriented consumer programs or a comprehensive approach encompassing staff training, consumer programs and changes to processes, i.e., discharge planning. While the comprehensive approaches were more successful in changing practice, staff whose behaviour the studies sought to change were not actively

Figure 8-3

Features of recovery-oriented interventions

involved as researchers, and there was little evidence of consumer involvement in the design or implementation of the studies. These gaps led to improvements made during the studies not being integrated into practice-as-usual (Coffey et al., 2019; Waldemar et al., 2019) and limited the validity of outcomes, without consumer input. Consistent with the mantra "nothing about us without us" (National Mental Health Commission, 2012, p. 9), consumers should be involved in all aspects of research and practice, working alongside professionals.

The process of how we did the project was essential to facilitating changes to practise in Sunshine Clinic. We started with an approach to doing research, i.e., Participatory Health Research, and a research question developed by the research group comprised of staff, a consumer advocate and myself as the academic researcher. The methodology, analysis and decisions about actions were all made collaboratively in the group. Our research group also consulted extensively with other key stakeholders, including consumers, other staff and managers to ensure that they had a voice in the project, and we had support to implement changes arising from the project.

Three crucial elements of Participatory Health Research made a difference to the outcomes: participation; reflection and action. Staff and consumers were motivated to contribute to the project because the aim was to enhance recovery-oriented practice in Sunshine Clinic that would benefit consumers of the service. Co-researchers could see that their participation could make a difference, not just to the broader research knowledge, but directly to consumers accessing the service. Co-researchers were excited to consult with consumers and other staff, as it provided them with evidence about improvements to support recovery. Practice in Sunshine Clinic became more recovery-oriented as the project progressed (see Figure 8-4). Most of these changes happened almost organically, as the staff co-researchers reflected on issues identified through our consultation with stakeholders and actioned changes to address these. The process of making changes was facilitated by the Nurse Unit Manager being directly involved in the project and being able to advocate for changes within the service. For example, The Nurse Unit Manager encouraged nurses to become involved in the group programs and ensured that recovery care planning commenced earlier in admission. Co-researchers from the Allied Health Team were also instrumental in making changes to processes that were under their control. For instance, the Allied Health Team re-designed the carers group to be a supporters' which would lead to the group being

more inclusive of people who supported the consumer, but did not identify as a carer.

The Allied Health Team also worked with consumers to start a visitor's book for consumers

who were discharging to leave messages of hope and encouragement for new consumers.

Contributing to the project's success was that the people whose behaviour we wanted

to change were the co-researchers. Co-researchers had the power to design a study to answer

a research question they were interested in and to make changes to their practice-based on the

findings. The Nurse Unit Manager and Allied Health Team Leader were also in positions to

directly support the implementation of recovery-oriented practice in their teams. The project

also had organisational support from managers at the hospital, so that changes recommended

by the research group were more likely to be implemented. These finding support using a

whole system approach to implementation, involving the key stakeholders who have the

power to change their practice and the organisational expectations for practice-as-usual.

8.4   Chapter Summary

By including the perspectives of consumers during a hospital admission, the current

study expanded the conceptualisation of recovery developed in community-based settings

(Leamy et al., 2011). The reconceptualization of recovery in this thesis suggests that the

recovery processes do not progress in stages as proposed by previous authors (Leamy et al.,

2011, Andresen et al., 2003). Instead, recovery may move up and down on a spectrum of

recovery, with different recovery processes being at different points on the spectrum at any

time. The reconceptualisation of recovery provides a more holistic understanding of

recovery, inclusive of the fluidity of experiences between the recovery processes for each

person. Recovery can be conceptualised as a spectrum where each of the five CHIME

processes may be at different points on the continuum between challenges and living well,

rather then simultaneously moving through stages of recovery. In addition, consumers in the

current study talked about another component of recovery, viz., everyday living which is not articulated in the current CHIME processes (Leamy et al., 2011). Everyday living spans the spectrum from the disruption to everyday living experienced in the context of an acute episode of ill health to a return to everyday living. For consumers during an inpatient adminssion, adding the component 'everyday living', extending CHIME to CHIME-E, may better represent their experience of recovery.

The current study also expanded our understanding of the experience of recovery during a hospital admission, where the challenges of isolation and disconnectedness, hopelessness, disempowerment, and disruption to everyday living were more salient during this time than the living well end of the spectrum, described by the terms connectedness, hope, empowerment and a return to everyday living. Apart from acknowledging that life could still be good albeit different on the recovery track, there was little discussion of the recovery processes of finding new identity and meaning during an acute episode of mental illness resulting in a hospital admission. These findings indicate that professionals supporting recovery during this time need to help people through the challenges to move along the continnum to living well. While the process is not linear, with each recovery process moving up and down the spectrum, working through the challenges is integral to recovery during an inpatient admission.

8.5   Summary of Co-Researchers' Reflections and Actions

Our research group reflected on the conceptualisation of recovery from consumers' perspectives in our study. We acknowledged that the challenges consumers experience during admission were part of their recovery experience. We realised that consumers were keen to return to everyday living after having their lives disrupted by an acute episode of illness.

Figure 8-4

Progression of recovery-oriented actions across the project

Staff co-researchers were instrumental in getting diversional activities introduced to the inpatient ward on weekends to support a return to everyday living..

In reflecting on recovery-oriented practice we came to appreciate that in addition to our relationships with consumers, peer support was central to progressing from challenges to living well in recovery. Staff co-researchers worked with consumers to introduce a visitor's book so that consumers who were discharging could share messages of hope with others. Our research group also provided feedback to managers and the Consumer Reference Committee about the need to upskill all staff about recovery and communication with

consumers. We also reflected on how to improve the identification of carers so that they could be better supported. Staff co-researchers focused on identifying support people at admission and rebranded the' carers group' to 'supporters' group'. Staff co-researchers reported that these strategies led to increased monthly attendance at the supporters' group.

When we reflected on interventions that support recovery we agreed that medical interventions, such as medication and diagnosis, were essential to some consumers' recovery. We also realised that some interventions intended to be recovery-oriented, such as recovery care plans and follow-up phone calls, could be improved. During the project, staff co-researchers took action to ensure recovery care planning started earlier in admission and was completed in collaboration with consumers. Our research group also recommended that staff needed more time for follow-up phone calls and guidance on what to cover, so consumers were better supported. These findings suggest that identifying an intervention as recovery-oriented is not sufficient to ensure that it is implemented in a way that supports recovery. In other words, talking the talk about recovery is not the same as walking the walk. Mental health services need to ensure that the intention of the intervention, i.e., to support consumer recovery, is applied in practice rather than remaining rhetoric, with the intervention becoming an administrative task to be checked off as complete.

8.6   My Reflection: What I've Learnt

At the inception of this thesis, I aimed to do something that would have a real-world application and help my colleagues support recovery. I thought the focus might be how to implement recovery-oriented policy into practice. My initial research proposal laid out a plan to systematically collect data to address this problem. However, I wanted to do research with people rather than on people, which led to a radical change in my approach. One of my supervisors (WM) introduced me to Participatory Health Research. The first thing I learnt

was that I could not pre-plan the project, as all aspects of the project needed to be made in collaboration with my co-researchers. Together we decided on the research question, design of the study, data analysis and actions.

The research then took an unexpected turn, based on the feedback from consumers. We expected that consumers would share a similar conceptualisation of recovery to previous studies and that our primary focus would be on enhancing recovery-oriented practise. However, what we found fundamentally changed our understanding of recovery, which in turn changed our understanding of recovery-oriented practice. We found that we could not have a conversation about recovery without listening to consumers' experiences of challenges. Initially, we had trouble working out how our findings fitted with the CHIME conceptualisation of recovery. Where CHIME talked about living well, consumers in our study spoke about challenges. It was not until I was writing the thesis and trying to make sense of our findings that I identified the concept of recovery as a spectrum. At that point, I started to see how our research could contribute to the broader knowledge about recovery. Previous research into the conceptualisation of recovery had not included consumers' perspective during an acute admission to the hospital, which was integral to seeing the whole picture.

I also learnt how powerful Participatory Health Research could be in giving people a voice and having the capacity to make changes in real-time. Changes to professional practice were taking place as the project progressed, without a formal implementation plan. Nurses were becoming more involved in facilitating group programs, increasing their connectedness with consumers. Carers were being identified and attending the renamed 'supporters' group'. Recovery care plans were commencing earlier so they could be completed collaboratively

with consumers. Consumers were writing in a visitors' book to pass on messages of hope to their peers.

Through the process of doing this project, I learnt to do research differently. I became more aware of how researchers' views and perspectives influence all aspects of the research, from the research question to the design, analysis, and conclusions. And therefore, the study's participants must be directly involved as researchers. To do this type of research, you need to see the 'knots' as challenges that can make the study fabric stronger and trust the iterative process will help you make sense of the phenomena of interest.

Finally, I learnt the importance of talking with and listening to people who have a lived experience of being in recovery, similarly to how Participatory Health Research takes its lead from the people whose lives are at the research centre. I expected that this research would contribute to changes in practice. I did not realise how much my perception of recovery, recovery-oriented practice and research would change through the process. I now have a deeper understanding of recovery from a consumer perspective, an appreciation for the role of connectedness in recovery, and an awareness of the power of doing participatory research with people who can make a positive difference in their own community. As a result, I will be a better psychologist who takes the time to listen to, and collaborate with, people with lived experience of mental health challenges.

Chapter 9. Conclusions

The purpose of this Participatory Health Research was to enhance the recovery-oriented practice of professionals working in a private, hospital-based mental health service, Sunshine Clinic. Consistent with Participatory Health Research principles (International Collaboration for Participatory Health Research, 2013), the research partnership was with the professionals who wanted to change their practise. The findings of this thesis not only changed the way we conceptualise recovery, but how we understand recovery-oriented practice and its implementation in a hospital-based mental health service. Sections 9.1 summarise this thesis's contribution. Section 9.2 review the study's strengths and limitations. Sections 9.3 and 9.4 provide recommendations for practice and further research, respectively. Section 9.5 concludes the thesis.

9.1   Contribution of the Thesis

This thesis has confirmed Leamy et al.'s (2011) conceptualisation of recovery as being dynamic and having distinct processes (i.e., CHIME) in a hospital-based mental health service. Our finding builds on previous studies that have validated CHIME for consumers living in the community and accessing mental health services (Bird et al., 2014; Slade et al., 2012b; Stuart et al., 2017; Van Weeghel et al., 2019). Furthermore, this thesis has reconceptualised recovery as a spectrum, where each of the recovery processes move on a continuum between challenges and living well. The spectrum conceptualisation recognises that a person may be at a different place on the continuum for each of the CHIME recovery processes. Therefore, recovery may not necessarily progress in stages, as posited by previous studies (Leamy et al., 2011, Andersen et al. 2003), but be more fluid and flexible across recovery processes. Also, in contrast to Leamy et al.'s (2011) conceptualisation of recovery which focuses on positive aspects of living well, the current study demonstrated that for consumers at Sunshine Clinic, challenges and difficulties define the recovery journey as

much as the positive attributes of CHIME. The results suggest a more balanced concept, which is inclusive of peoples' experiences in the context of hospital admission. The findings also indicate that adding the process 'everyday living' to CHIME, updating the acronym to CHIME-E, better represents the experience of recovery for consumers after the disruption of an acute episode of illness.

The thesis also contributed to the knowledge about what professionals can do to support consumer recovery. Understanding what recovery processes are essential during an inpatient admission helps co-researchers identify aspects of practise that could be enhanced to be more recovery-oriented. The findings indicated that connectedness is the component of recovery that is central in the context of inpatient admission. In practise, increasing opportunities for connectedness meant taking the time to talk and listen to consumers and carers and providing consumers with the opportunity to connect with others. These findings support the need for a whole-system approach where time to talk is valued and prioritised. Embedding time to talk within a mental health service requires that professionals in a position of power see that the benefits to consumer recovery outweigh the costs of staff time. Also, our findings indicated that the benefits of talking are not limited to the professional-consumer relationship. Talking with peers and carers was integral to the recovery process of connectedness. To support consumer connectedness, mental health services may need to increase peer and carer support opportunities during inpatient admission.

It was also crucial for staff to hold hope when consumers were experiencing hopelessness and to empower them to take responsibility for their recovery. The thesis also highlighted that traditional, medical model interventions like diagnosis and medication can support consumer recovery. Consistent with the view of Mountain and Shah (2008) we found that it is not a choice between the medical model or the recovery approach, but incorporating

both. Our study demonstrated that interventions that supported recovery were those that either increased connectedness and decreased distressing symptoms so that the person could focus on living well in the here and now.

Finally, the thesis provided an exemplar of how the implementation of recovery-oriented practice can occur through Participatory Health Research. By working in partnership with professionals as co-researchers, the people who wanted to become more recovery-oriented were empowered to learn what they needed to do in order to change their practice. Implementation using Participatory Health Research did not require formal training courses, new programs or procedures, as identified in Lorien et al. (2020), but rather for co-researchers to embed connectedness and collaboration in their current practices.

9.2   Strengths and Limitations

Our research project had some strengths and limitations related to the participatory approach and methodology that impacted the findings, analysis and conclusions.

A key driver of participatory research is that the people who the research affects are involved in designing the research and using the knowledge they acquire to action social change (Lindhult, 2019). The primary strength of the current research was that it directly involved the professionals whose practice was the study's focus, and actions could flow directly from the project into practice within the service. Co-researchers collaboratively developed the research question and methodology, analysed the data and implemented the changes. A criticism of a participatory approach is that the researchers and the researched are "too close" to be objective (Karim, 2001, p. 34), which could skew or biase the findings. However this "closeness" may also increase the validity of the data (Karim, 2001, p. 34), as the participants have first hand knowledge about their own experience.

A limitation of the current study was that the findings were interpreted primarily by professionals rather than consumers who were study participants. Therefore, the reconceptualisation of recovery was interpreted by professionals, based on consumer feedback in the focus groups, rather than being developed directly by consumers. Also, while carers are significant stakeholders in recovery (Commonwealth of Australia, 2010), there was no carer participation in this research. The service addressed engagement with carers during the research, however, no carers participated in the consultation that informed the project's findings.

Another strength of the research being conducted by co-researchers who were insiders (i.e., current and previous staff members) was that we had existing relationships with   the hospital managers and the Consumer Reference Committee who supported the study. This close working relationship resulted in the hospital allowing staff co-researchers to participate in work time over two years and to make changes in Sunshine Clinic's practise. However, a limitation of being insiders, was that we did not consider asking for an organisational commitment to providing additional resources to implement changes arising from our findings. We simply assumed that, any changes would be limited to what we could do with existing resources. Perhaps outsider researchers, who were not subordinates to hospital managers, may not have accepted the status-quo and asked for additional resources.

Another advantage of the research being conducted by insiders was that hospital managers trusted us to talk with consumers and staff about recovery and recovery-oriented practice in Sunshine Clinic. This trust was significant as we requested to consult with a vulnerable population, i.e., consumers hospitalised with acute mental health symptoms. A limitation was that the pre-existing relationships meant that we may have been less critical of our own workplace, leading to a more positive perception of recovery-oriented practice in

this setting than the findings warranted. To counter this limitation, I kept a reflexive journal throughout the project to be aware of my own biases, assumptions and interpretations as an outsider who had also been an insider. I discussed my reflections with one of my supervisors (WM) and shared exerts of this journal in this thesis. In writing up the thesis, I consciously used direct quotes from participants to demonstrate the evidence on which our conclusions were based and sought feedback from my university supervisors, as outsiders, about whether the conclusions logically flowed from the evidence.

We tailored the study to meet the needs of consumers and professionals in one private mental health service. Therefore, a weakness of the study was its limited transferability to other consumers and other hospital-based mental health services. As discussed in the context (see Chapter 2) private and public hospital-based mental health services differences include the range of interventions offered and the proportion of consumers presenting with different diagnoses. Much of the previous research on recovery has been conducted with consumers living with serious mental illness, such as psychotic disorders, either living in the community or accessing public mental health services (Bird et al., 2014; Slade et al., 2012b; Stuart et al., 2017; Van Weeghel et al., 2019). While schizophrenia is the most common diagnosis of consumers seen in public health services hospitals (Australian Institute of Health and Welfare, 2019a), only a small percentage of consumers accessing private hospital services in Australia have a similar diagnosis (Australian Institute of Health and Welfare, 2019a). Consequently, the findings of the current study may be more representative of the experience of consumers with mental health issues commonly seen in private hosptial mental health services. Other factors impacting on recovery of consumers accessing private hospitals, may also be different from consumers accessing public health services. An assumption is that consumers who can afford private health insurance, to access private hospitals, may be more likely to have financial security, employment and stable accommodation. Therefore,

consumers in our study may differ significantly from consumers who have contributed to previous studies. While Sunshine Clinic has more similarities with other private mental health services than public mental health services, private hospitals are not homogenous, with variations in size, location, type of diagnoses, and interventions offered. To counter this limitation, we tried to provide a comprehensive description of the context, participants, and process of our research so that other investigators can decide if the process or outcomes are relevant their circumstances and setting.

Another limitation of the study was that consumers' voices in the research group was limited to one co-researcher. While we were privileged to have access to Lea's perception during a group discussion and were deliberate in seeking out other consumers' perspectives, we acknowledge this limitation and the burden of responsibility placed on this one person. Our study's focus was to change staff behaviours, so it was integral for staff to be involved as co-researchers. We discussed the option of having current consumers and staff working together as co-researchers. However, this raised an ethical dilemma about how to manage dual relationships and the need to maintain a consistent working group over a longer duration. In hindsight, we could have sought out more consumer co-researchers who had previously had an admission, so were familiar with the context, but were not current consumers.

A limitation was that the focus groups' consumer participants had actively engaged with the group programs offered at Sunshine Clinic. While we did offer one-to-one interviews as an alternative to the focus groups, we did not actively seek out participants who did not participate in the groups and may have had alternative views. My experience in working in the service previously was that some people enjoyed the group programs and the fellowship they offered. However, other people tended to stay in their rooms and only attend

when required. Therefore, our outcomes may present an overly optimistic picture of consumers' perception of the group programs and the need for connectedness with others. Consumers who were more ambivalent about connecting with others may have chosen not to participate in the research. Also, the dual relationship that most co-researchers had with consumers, as consumer/clinican and participant/researcher, may have impacted on the findings. Consumer who had existing positive relationships with co-researchers may have been more likely to volunteer to participate in the research, and to report positive findings in relation to recovery-oriented practice, than consumers whose dual relationship with the researchers was not as positive.

Another limitation was the practicalities of the time co-researchers had to commit to the project. While management supported staff participation in work time, the realities of working in a busy hospital meant that collaboration was limited to an initial half-day workshop, email communication, and a one-hour meeting approximately every six weeks. We addressed this challenge by sharing de-identified data between sessions and using our time together to analyse data, reflect on findings and collectively make decisions. Despite having limited time, staff co-researchers did reflect on the findings and implement actions. Our desire for inclusion and participation by all researchers, but with limited time, also impacted our analysis choice. Consequently, we choose a more simplistic system for data analysis, i.e., thematic analysis, that everyone could be involved in at group meetings, rather than a more complex approach, i.e., grounded theory.

Overall, our project's strengths helped us answer our research question in the Sunshine Clinic context, within the limitation of our study. Future researchers will need to assess whether the strengths and limitations of our participatory approach will be helpful in designing projects in other settings.

9.3   Recommendations for Practice

Based on the conceptualisation of recovery identified in this study, there are five

recommendations to improve recovery-oriented practice:

1. Challenges are particularly salient for consumers in the context of admission to a

    hospital-based mental health service. Therefore, professionals must acknowledge

    the challenges and take the time to listen atttentively to consumers when they talk

    about their lived experience.

2.   Connectedness is key to recovery. Thus, professionals need to create

    opportunities for consumers to connect with staff, family, and peers. All

    interventions need to be designed and implemented in partnerships with

    consumers and with sufficient time for genuine collaboration.

3. Consumers are often experiencing hopelessness during a hospital admission.

    Consequently, professionals have a vital role in holding hope for the person until

    they regain hope in their recovery. To foster hope, staff need to express their hope

    for consumers and provide opportunities for consumers to hear from others who

    have been through a similar experience, i.e., a hospital admission, and are now

    more hopeful about their future.

4. Consumers have experienced significant disruption to daily living in the event of a

    hospital admission and want to return to doing everyday activities. Thus,

    providing opportunities for consumers to start doing some of these activities,

    i.e., taking responsibility for self-care and socialising, can support their recovery.

5. Finally, some staff may benefit from training about recovery and how to have a

    supportive conversation with consumers. This training should be delivered to

    consumers who have lived the experience of hospitalisation and then recovery in

the community, so that staff gain a more wholistic picture of recovery across the spectrum.

9.4   Recommendations for Research

This thesis' literature review indicated that research about the experience of recovery and recovery-oriented practise in hospital-based mental health services is limited. Our study's findings indicated that the recovery experience during a hospital admission is substantively different from recovery in the community. Further research is required to:

1. Validate the conceptualisation of recovery as a spectrum, incorporating challenges and living well, reflecting the recovery experience for consumers accessing hospital-based mental health services.

2. Confirm whether the additional component of recovery, everyday living, can be generalised to other consumers who are accessing mental health services due to an acute exacerbation of symptoms.

3. Confirm whether the recovery processes of connectedness, hope and empowerment are the most salient for consumers accessing hospital-based mental health services.

4.   Ascertain what strategies are most effective in operationalising support for relational recovery during a hospital-based admission.

5. Explore how Participatory Health Research can bring key stakeholders together to enhance recovery-oriented practice within hospital-based mental health services. Future research will need to involve consumers, carers, and professionals as co researchers to ensure all key stakeholders have a voice.

9.5   Conclusion

At the commencement of the research, my co-researchers and I held three assumptions. First, we expected that consumers' descriptions of recovery would mirror Leamy et al.'s (2011) CHIME conceptualisation. Second, we expected to find that Sunshine Clinic staff were already doing some recovery-oriented things. Third, we thought that we would identify some areas of practise that could be enhanced to be more recovery-oriented.

We discovered that we needed to rethink the conceptualisation of recovery-based on consumers' experience during a hospital admission. Challenges were more prominent than the concept of living well, and consumers wanted to return to everyday living. The quote, "*Life is vanilla*" (Emma, Focus Group 4) examplifed how it can be challenging to live a full and meaningful life in the context of mental illness. In reconceptulisng recovery, we also needed to to reflect the uniqueness and non-linear nature of recovery across the different processes of CHIME-E. Depicting recovery as a spectrum provided a more holistic representation of recovery incorporating each of the recovery process on a continuum from challenges to living well, while recognising that each person may be at a different place in relation to each process at any point in time.

Our assumption that staff were already practising recovery-orientation was correct. However, it was not the tasks staff identified as recovery-oriented, e.g., recovery care plans and follow-up phone calls, that consumers found helpful. What was most beneficial was the opportunity for relational recovery. It did not matter if the interaction was an informal conversation or a traditional medical intervention, e.g., medication and group therapy. What mattered was that the increased the opportunity for connectedness with others, i.e., staff, peers, family, or decreasing the impact of acute symptoms so consumers could focus on their recovery. These findings highlighted that it we did not need to choose between

the medical model or recovery approach, but to incorporate the best from both worlds to support recovery.

Our final assumption that practice could be enhanced was also correct. However, we did not need to change the tasks, but make them more collaborative to work with consumers as equal partners. In Kevin's words (Focus Group 2) our key finding about how to enhance recovery-oriented practice, was for professionals to "*listen … and … talk back on the same level*" as the person with the lived experience. Connectedness and collaboration were the key to recovery-oriented practice in a hospital-based mental health service.

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Appendix A: Forming the Research Partnership

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

RESEARCH INFORMATION SHEET

Project Overview

This Participatory Action Research (PAR) project aims to form a research partnership between CQUniversity and [Sunshine] Clinic. Six co-researchers, including the PhD Candidate (Leonie Lorien), will collaboratively design a research project to explore how to implement recovery-oriented practice at [Sunshine] Clinic. In Phase One, co-researchers will meet regularly to review the current literature on recovery-oriented practice in Australia and internationally and to develop Phase Two of the research project. Phase Two may involve exploring staff/stakeholders understanding of recovery-oriented practice in this setting. Phase Two will inform Phase Three, which will be an action phase where staff, with management approval, implement specific recovery-oriented practices and review the outcomes.

Participation in Research Procedure

Participation in the research project as a co-researcher will involve attending an initial half-day workshop on recovery-oriented practice and attendance at research group meetings, approximately once a month for one hour, to:

A. Develop a research project, based on current research and policy guidelines, exploring how to implement recovery policy into recovery-oriented practice at [Sunshine] Clinic;

B. Implement a research project at [Sunshine] Clinic. This may involve talking to other staff or stakeholders about the project to get their input and implementing changes to increase recovery-oriented practice at [Sunshine] Clinic;

C. Evaluating the outcomes from the research project.

Benefits and Risks

The risks of participating may include minor discomfort or inconvenience. Some co-researchers may experience discomfort discussing conflicts between issues such as evidence-based practice, client safety and consumers' personal recovery choices. Attending meetings may sometimes be inconvenient for co-researchers who have competing demands on their time. However meetings will be scheduled at times that are most convenient for co-researchers. Some co-researchers may directly or indirectly report to other co-researchers so ground rules will be negotiated for group discussion and how decisions are made in the group, to allow all co-researchers equal opportunity to express their views and contribute to decision making.

Benefits of participating include having an active voice in how [Sunshine] Clinic develops recovery-oriented practice and access to professional development on recovery-oriented practice. The research project will allow [Sunshine] Clinic to apply recovery policy to practice, meeting service requirements and contributing to better recovery outcomes for consumers of the service.

Confidentiality

Pseudonyms will be used for meeting records, so co-researchers' individual contributions will not be identified by name or profession and all co-researchers will be asked to maintain confidentiality about who says what in meetings. Any data will be stored securely for five (5) years in accordance with CQUniversity policy, with any identifying demographic information being stored on a separate site to other research data.

Outcome/Publication of Results

Details of the outcome of the project will be available from the PhD Candidate, see contact details below. Research articles may be submitted for publication to relevant journals or conference papers at a later date yet to be determined. No individual identifying information will be included within the publications nor the name of the Agency.

Consent

A written consent form will be given to co-researchers to read and any questions answered prior to commencement.

Right to Withdraw

Co-researchers have the right to withdraw at any time without having to provide a reason nor subject to penalty.

Questions/Further Information

If you have any further questions in relation to this research project, please contact Leonie Lorien at the following email address: l.lorien@cqu.edu.au or Dr. Wendy Madsen, CQUniversity at w.madsen@cqu.edu.au.

Concerns/Complaints

Please contact CQUniversity's Office of Research (Tel: 07 4923 2607; Email:

research-enquiries@cqu.edu.au; Mailing address: Building 32, CQUniversity, Rockhampton

QLD 4702) should you have any concerns about the nature and/or conduct of those involved

in this research project.

If you feel you need further personal support with any issues that participation in this project

may raise, please contact Ramsay Employee Assistance Program.

All ethical aspects of this study have been approved by the CQUniversity HREC Ref:

EC00158; [Ramsay Health] HREC Protocol 17/01.

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

AGENCY CONSENT FORM

I consent to participation of .... (**The Agency**) **in this research project and agree that:**

1. A Research Information Sheet has been provided to me that I have read and understood.

2. I have had any questions about the project answered to my satisfaction by the Research Information Sheet and any further verbal explanation provided.

3. I understand that staff employed by the Agency have the right to withdraw from the project at any time, and I confirm that participation or non-participation in the research project will not affect employment for staff employed by the Agency.

4. I understand that the Agency has the right to withdraw from the project at any time without penalty.

5. I understand the research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet.

6. I understand that to preserve anonymity and maintain confidentiality of participants that publications will not include any individual identifying information nor the name of the Agency.

7. I am aware that a Plain English statement of results will be available from the email address provided in the Information Sheet.

8. I agree that I am providing informed consent for staff of the Agency to participate

   in this project.

I wish to have a Plain English statement of results emailed to me at the address I provide below.	YES	NO

Signature: _____   Date: _____

Name (please print): _____

Position (please print): _____

Email Address: _____

Research Project: Policy to Practice: Implementation of Recovery-Oriented Practice

INVITATION TO PARTICIPATE AS A CO-RESEARCHER

Leonie Lorien, a psychologist, and PhD student from CQUniversity (supervised by Dr. Wendy Madsen, Professor Kevin Ronan and Dr. Peter Rofe) is currently conducting research into the implementation of recovery-oriented practice in an inpatient mental health service. This research aims to use PAR to work collaboratively with staff co-researchers at [Sunshine] Clinic to explore how to implement recovery policy into practice within their service.

To participate in this project as a Co-Researcher you must meet the following criteria:

1. A staff member at [Sunshine] Clinic (Nursing, Allied Health or Administration)

2. Committed to attending regular research group meetings (during work time) for up to two years duration, to develop, implement and evaluate the research project.

Participation in the study as a co-researcher involves:

1. Attending Research Group meetings (approximately once a month for one hour) to:

   A. Develop a research project (based on current research and policy guidelines) exploring how to implement recovery policy into recovery-oriented practice at [Sunshine] Clinic.

   B. Implement a research project at [Sunshine] Clinic. This may involve talking to other staff or stakeholders about the project to get their input and implementing changes to increase recovery-oriented practice at [Sunshine] Clinic.

   C. Evaluating the outcomes from the research project.

2. You will also need to complete a brief questionnaire regarding your demographic details, qualifications and experience.

All participating co-researchers will receive:

1. A copy of the study outcomes

2. The opportunity to participate in a half-day workshop on recovery-oriented practice. This workshop is open to co-researchers who agree to participate in the study, even if you decide to withdraw from the study at any stage.

For more information: Contact the Principal Researcher, Leonie Lorien, at the following email address: l.lorien@cqu.edu.au or Dr. Wendy Madsen at CQUniversity at w.madsen@cqu.edu.au

All ethical aspects of this study have been approved by the CQUniversity HREC Ref: EC00158; [Ramsay Health] HREC Protocol 17/01.]

Research Project: From Policy to Practice: Implementation of Recovery-Oriented

Practice

CO-RESEARCHER CONSENT FORM

I consent to participation in this research project and agree that:

1. A Research Information Sheet has been provided to me that I have read and understood.

2. I have had any questions about the project answered to my satisfaction by the Research Information Sheet and any further verbal explanation provided;

3. I confirm that I am a staff member at Hillcrest Rockhampton Private Hospital (the Agency) and work in Archerview Clinic (the Inpatient Mental Health Service);

4. I understand that my participation or non-participation in the research study will not affect my employment.

5. I understand that I have the right to withdraw from the project at any time without penalty.

6. I understand the research findings will be included in the researcher's publication(s) on the study and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet;

7. I understand that to preserve anonymity and maintain confidentiality of participants that any publications will not include any individual identifying information nor the name of the Agency.

8. I am aware that a Plain English statement of results will be available from the email address provided in the Information Sheet.

BE WHAT YOU WANT TO BE
cqu.edu.au

CRICOS Provider Code: 00219C

9. I agree that I am providing informed consent to participate in this project.

I wish to have a Plain English statement of results emailed to me at the address I provide below.	**YES**	**NO**

Signature: _____ Date: _____

Name (please print): _____

Position (please print): _____

Email Address: _____

08/06/2017

PARTNERSHIP AGREEMENT

Agreement between Co-Researchers in Research Partnership between [Sunshine] Clinic, [Unity] Hospital, and CQUniversity (referred to as the Partnership).

The purpose of this agreement is to outline how the partnership will operate between Co-Researchers and Research Supervisors from CQUniversity and [Sunshine] Clinic.

Co-Researchers (in alphabetical order)

- [Alex] [Role]/[Sunshine] Clinic)

- [Charlie] [Role]/[Sunshine] Clinic)

- [Chris] [Role]/[Sunshine] Clinic)

- [Eden] (Admin Assistant/[Sunshine] Clinic)

- [Frankie] [Role]/[Sunshine] Clinic)

- [Jordan] [Role]/[Sunshine] Clinic)

- [Kim] [Role]/[Sunshine] Clinic)

- [Lea] [Role]/[Sunshine] Clinic)

- Leonie Lorien (PhD Researcher/CQUniversity).

Research Supervisors

- Dr Wendy Madsen (Principal Supervisor/CQUniversity)

- Professor Kevin Ronan (Associate Supervisor/CQUniversity)

- Dr [Name] (Associate Supervisor/Consultant Psychiatrist - [Sunshine] Clinic)

The objective of this agreement is to:

1) To articulate the goals for the partnership.

2) To facilitate collaboration and equitable decision making between Co-researchers in the partnership.

3) To clarifying processes for reporting outcomes from the partnership.

Goals for the Partnership:

1) To answer the research Question: How do we collaboratively enhance and deliver recovery-oriented practice at [Sunshine] Clinic?

2) To consult with key stakeholders (identified by the partnership) including consumers, carers, [Unity] Hospital staff and senior management to answer the research question.

3) To action changes in practice to enhance the delivery of recovery-oriented practice at [Sunshine] Clinic.

4) To review the implementation of changes, listening to feedback from key stakeholders in addition of Co-researchers in the partnership, to confirm that the partnership has enhanced recovery-oriented practice at [Sunshine] Clinic.

All co-researchers will be responsible for:

1) Upholding the values of Community-Based Participation Action Research, including:

   - Acknowledging [Sunshine] Clinic as a community of identity.

   - Building on strengths and resources within the [Sunshine] Clinic and the broader community across Hillcrest Rockhampton Private Hospital.

- Facilitating a collaborative, equitable partnership with Co-Researchers in all phases of the research.

- Fostering co-learning and capacity building for all participants in the project, including Co-Researcher's and other staff working at [Sunshine] Clinic.

- Integrating and achieving a balance between knowledge generation and intervention of mutual benefit to all Co-Researchers.

- Focusing on local relevance to the [Sunshine] community and the immediate context.

- Enhancing development of recovery-oriented practice using a cyclic and iterative process of planning, action and reflection.

- Involvement in the wider dissemination of results from this project.

- Commitment to sustainability of the outcomes of project.

2) Attending and actively engaging in discussion in partnership meetings. Co-researchers will speak up and say what they think while being respectful of differing perspectives.

3) Co-researchers who may be unable to attend a meeting, will read and provide feedback on minutes from the previous meeting and provide input into agenda items to be discussed at the meeting.

4) Co-researchers may be involved in data analysis and writing papers for publication and/or conference presentations related to the project.

PhD researcher (Leonie) will be responsible for:

1) Facilitating the partnership meetings.

2) Typing up and disseminating the minutes and agenda for meetings to co-researchers.

3) Providing a summary of the discussion to Nurse Unit Manager to disseminate to senior management and Consumer Reference Group.

4) Liaison with Research Supervisors regarding design and progress of the project.

5) Primary responsibility preparing applications for ethics approval, for each phase of the process, in collaboration with co-researchers.

6) Dissemination of results of the project to all Co-Researchers and Key Stakeholders (identified by the partnership).

Nurse Unit Manager [Name] will be responsible for:

1) Liaison with senior management and Consumer Reference Group regarding progress of the project, including planned actions and outcomes.

2) Liaison with PhD researcher and CEO at Hillcrest to organise Partnership meetings within work time.

Research supervisors will be responsible for:

- Primary Supervisor will meet with PhD Researcher fortnightly to discuss design and progress of the project.

- Associate Supervisors will meet with the PhD Researcher at key decision points in the project (e.g. ethics applications, at the commencement and end of each phase of the research, and for specific advice relating to their areas of expertise.)

- The Primary and Associate Supervisors may be involved in data analysis and writing papers for publication and/or conference presentations related to the project.

Term and Termination:

This agreement will commence on 08/07/2017 for a period of two years. If the agreement is not working, co-researchers can re-negotiate or terminate the agreement with 15 days written notice to all co-researchers.

Signatories to the Agreement
Co-Researchers:

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Signature: _____Date: _____

Name: _____   [Role]/[Sunshine] Clinic

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Name: _____   [Role]/[Sunshine] Clinic

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Research Supervisors:

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Signature: _____   Date: _____

Name: _____   [Role]/[Sunshine] Clinic

Table A-1 RESEARCH MEETING SCHEDULE

No.	Date	Meeting—Agenda	Participants No. Pseudonyms
1	23//03/2017 (1/2 Day)	Forming the Partnership Assessing Strengths & Resources Identification of Research Question	N = 10. Alex, Bailey, Charlie, Chris, Eden, Frankie, Jordon, Kim, Lea, Leonie
2	17/06/2017	Partnership Agreement Planning Consultation	N = 7. Alex, Charlie, Frankie, Jordon, Kim, Lea, Leonie
3	20/07/2017	Ethics Application Discuss Consultation Plan	N = 5. Alex, Charlie, Frankie, Lea, Leonie
4	31/08/2017	Ethics Amendments	N = 5. Alex, Frankie, Kim, Lea, Leonie
5	05/10/2017	Review of Consultation	N = 6. Alex, Charlie, Eden, Kim, Lea, Leonie
6	23/11/2017	Implementation Updates	N = 3. Alex, Charlie, Leonie
7	08/02/2018	Sorting Themes	N = 7. Alex, Charlie, Chris, Eden, Kim, Lea, Leonie
8	01/03/2018	Sorting Themes	N = 7. Alex, Charlie, Chris, Eden, Kim, Lea, Leonie
9	10/05/2018	Agreeing on Themes	N = 5. Alex, Charlie, Eden, Kim, Leonie
10	26/07/2018	Review Themes Benchmarking Current Practice against Practice Guidance	N = 5. Alex, Charlie, Kim, Lea, Leonie
11	08/09/2018	Reflection & Action Planning	N = 5. Charlie, Chris, Kim, Lea, Leonie
12	25/10/2018	Review Draft Action Plan Reflection on Project	N = 4. Alex, Kim, Lea, Leonie

Appendix B: Consultation with Research Participants

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

Phase Two—Consultation with Key Stakeholders

INFORMATION SHEET: CONSUMERS

FOCUS GROUPS OR INDIVIDUAL CONSULTATION

Project Overview

You are invited to participate as a Key Stakeholder in this Participatory Action Research (PAR) project. The project is a collaboration between CQUniversity PhD Candidate (Leonie Lorien), [Sunshine's] Consumer Advocate [Lea] and seven [Sunshine] staff members [Frankie, Chris, Jordon, Eden, Charlie, Kim and Alex]. Ms Lorien is supported in her candidature by a supervisory team, led by Dr Wendy Madsen.

Current government policy in Australia requires that Mental Health Services are recovery-oriented, respecting the choices and personal decision making of consumers on their personal journey of recovery. However, there is limited research on recovery-oriented practice within inpatient settings and no practice-based examples of how to implement recovery-oriented practice using a collaborative, participatory action framework.

The project aims to answer the research question: How do we collaboratively enhance and deliver recovery-oriented practice at Archerview Clinic?

- Phase One entailed forming the research partnership. (Note: This phase has been completed.)

- Phase Two involves consultation with key stakeholders (consumers, carers, staff, senior managers and psychiatrists) to explore stakeholders' understanding of recovery-oriented practice at [Sunshine] Clinic.

- Phase Three (informed by Phase Two) will be an action phase where staff, with management approval, implement specific recovery-oriented practices at [Sunshine] Clinic and review the outcomes.

The purpose of this consultation is to get feedback from Key Stakeholders on three questions:

1) What is your understanding of recovery and recovery-oriented practice in mental health?

2) What are staff currently doing to support consumers with their recovery in mental health?

3) What more could staff and management do to enhance consumers' recovery in mental health?

The following consultations will be conducted:

- Consumer Focus Groups/Individual Consultations for Inpatients/Day-Patients at [Sunshine] Clinic.

- Carers Focus Groups/Individual Consultations for family members and friends who care for a current or previous consumer at [Sunshine] Clinic.

- Staff—Online Survey for all staff at [Unity] Hospital.

- Senior Managers/Psychiatrists -Individual Consultations.

Participation Procedure

Consumers who participate must have the capacity to provide informed consent. Consumers who are currently inpatients at [Sunshine] Clinic and therefore likely to be experiencing more acute mental health issues need to be assessed by an Archerview Nurse (independent of the research team) as having the capacity to consent. Capacity to provide informed consent will be assessed based on four generally accepted components of decision-making competence listed below:

1) Understanding the information provided in this Information Sheet.

2) Appreciation of the risks and benefits of participating.

3) Use of reason to make an informed choice to participate or not, and

4) Ability to communicate that reasoned choice.

Consumers who participate in the focus group or individual consultations will be current inpatients, day-patients or previous patients who have indicated, prior to discharge, that they would like to participate in the research.

Exclusion criteria: acute psychosis, significant cognitive impairment, limited understanding of English language, not currently being able to provide informed consent.

Focus Group. Focus groups will take place in an [Sunshine] Clinic group room, at a time that is convenient for staff and consumers and will last for one hour. There will be four consumer focus groups. Three focus groups for current and previous consumers at [Sunshine] Inpatient Clinic. One focus group for current and previous consumers at [Sunshine] Clinic Day Program. Consumers will only participate in one focus group. The consumer focus

groups will be facilitated by Leonie Lorien (PhD Candidate) and [Lea] (Consumer Advocate).

If you agree to participate in a focus group, you will be asked to participate in discussion with other consumers about the three questions raised above. You may choose how much or how little you want to speak during the focus group. You may also choose to leave the focus group at any time.

Individual Consultation. If you agree to participate in an individual consultation, you will be asked for your feedback on the three questions raised above. You can choose to skip any question/s and to discontinue the consultation at any time.

Focus group and individual consultations will be audio-recorded in order to accurately capture what is said. You may request that the recording be paused at any time.

Benefits and Risks

We believe that there are minimal risks of being in this research, no more than participating in other group programs offered at [Sunshine] Clinic.

Risks may include:

1) Informational risk involving breach of confidentiality or loss of privacy from accidental disclosure of research information by other participants in the focus group.

2) Emotional risk if discussion of research questions triggers an unwanted emotional response (e.g., distress at past negative experiences of care in mental health services). Should you experience any distress from participating in this research, please advise Frankie (Nurse Unit Manager) at [Sunshine] Clinic who can provide support.

Participating in this research may not benefit you directly, but it will help us to learn about ways to enhance recovery-oriented practice in [Sunshine] Clinic, which may benefit consumers who access the clinic in the future.

Confidentiality/Anonymity

Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants and not repeat what is said in the focus group to others.

Limits of confidentiality: If a participant discloses potential risk of harm to themselves or others, the researchers have a duty of care to inform [Sunshine] Clinic staff. Researchers will also advise staff if a participant becomes distressed during the consultation.

The group facilitators will not share 'who says what in the focus group' with other co-researchers or participants. The group facilitators will de-identify the focus group transcripts (transcribed from the audio recordings). To further protect the anonymity of participants, the PhD Candidate will collate the themes raised across all consumer and carer focus groups. The collated data may include direct quotes from the discussion but neither the participant nor the specific focus group will be identified.

The PhD Candidate will keep all records in a locked filing cabinet at CQUniversity. Research records will be labelled with a code. A master key that links names and codes will be maintained in a separate locked filing cabinet. All electronic files containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. The research data will be

destroyed seven (7) years after the publication date of the last publication based upon the data in accordance with the CQUniversity policy.

Outcome/Publication of Results

At the conclusion of this project the co-researchers may publish their findings. Information will be presented in summary format and may include direct quotes from the consultations. To preserve anonymity and maintain confidentiality fictitious names may be used in any publications. No individual identifying information nor name of the hospital nor location will be included in publications, although Ramsay Health may be acknowledged for providing support for this research. The PhD Candidate will also include de-identified information from the consultations in her thesis.

Consent

A written consent form will be given to you to read and sign prior to commencement.

Right to Withdraw

You do not have to participate in the research if you do not want to. If you agree to participate but later change your mind, you may withdraw at any time without penalty. Please be advised that if you withdraw after the data from focus groups/individual consultations has been collated into themes we may not be able to identify and remove all of your contributions.

Feedback

All participants will be emailed a plain English statement of results from the consultations.

Questions/Further Information

If you have further questions about this research, you may contact Leonie Lorien (PhD Candidate) at the following email address: l.lorien@cqu.edu.au or Dr Wendy Madsen (CQUniversity PhD Supervisor) at w.madsen@cqu.edu.au

Concerns/Complaints

If you feel you need further personal support with any concerns that participation in this research has raised, please advise [Frankie] (Nurse Unit Manager) at [Sunshine] Clinic.

Please contact CQUniversity's Office of Research (Tel: 07 4923 2603; Email: ethics@cqu.edu.au; Mailing address: Building 32, CQUniversity, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

This project has been approved by the CQUniversity Human Research Ethics Committee, reference number (0000020680) and [Ramsay Health] Ethic Committee, protocol number (17/44).

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

Phase Two—Consultation with Key Stakeholders

INFORMATION SHEET: CARERS

FOCUS GROUPS OR INDIVIDUAL CONSULTATION

Project Overview

You are invited to participate as a Key Stakeholder in this Participatory Action Research (PAR) project. The project is a collaboration between CQUniversity PhD Candidate (Leonie Lorien), [Sunshine Clinic's] Consumer Advocate [Lea] and [Sunshine] staff members [Chris, Jordon, Eden, Charlie, Kim and Alex]. Ms Lorien is supported in her candidature by a supervisory team, led by Dr Wendy Madsen.

Current government policy in Australia requires that Mental Health Services are recovery-oriented, respecting the choices and personal decision making of consumers on their personal journey of recovery. However there is limited research on recovery-oriented practice within inpatient settings and no practice-based examples of how to implement recovery-oriented practice using a collaborative, participatory action framework.

The project aims to answer the research question: How do we collaboratively enhance and deliver recovery-oriented practice at Archerview Clinic?

- Phase One entailed forming the research partnership. (Note this phase has been completed.)

- Phase Two involves consultation with key stakeholders (consumers, carers, staff, senior managers and psychiatrists) to explore stakeholders' understanding of recovery-oriented practice at [Sunshine] Clinic.

- Phase Three (informed by Phase Two) will be an action phase where staff, with management approval, implement specific recovery-oriented practices at [Sunshine] Clinic and review the outcomes.

The purpose of this consultation is to get feedback from Key Stakeholders on three questions:

1) What is your understanding of recovery and recovery-oriented practice in mental health?

2) What are staff currently doing to support consumers with their recovery in mental health?

3) What more could staff and management do to enhance consumers' recovery in mental health?

The following consultations will be conducted:

- Consumer Focus Groups/Individual Consultations for Inpatients/Day-Patients at [Sunshine] Clinic.

- Carers Focus Groups/Individual Consultations for family members and friends who care for a current or previous consumer at [Sunshine] Clinic.

- Staff – Online Survey for all staff at [Unity] Hospital.

- Senior Managers/Psychiatrists -Individual Consultations.

Participation Procedure

Carers who participate in the focus group or individual consultations will be friends or family members, who care for a current or previous consumer at [Sunshine] Clinic.

Exclusion criteria: Limited understanding of English language.

The focus group will take place in [Sunshine] Clinic group room, at a time that is convenient for staff and carers, and will last for one hour. The focus group will be offered on two occasions. Carers will only participate in one focus group. For carers who are not available for a focus group and/or prefer talking individually with a researcher, individual consultations will take place in [Sunshine] Clinic, at a time that is convenient for the researcher and carer. The individual consultation will take approximately 20 -30 minutes. The Carers Focus Group and individual consultations will be facilitated by Leonie Lorien (PhD Candidate).

If you agree to participate, you will be asked for your feedback on the three questions raised above. You can choose to skip any question/s and to discontinue the consultation at any time. The consultation will be audio- recorded in order to accurately capture what is said. You may request that the recording be paused at any time.

Benefits and Risks

We believe that there are minimal risks of being in this research, no more than participating in other carers groups offered in [Sunshine] Clinic or informal discussions with staff about consumer care.

Risks may include:

1) Informational risk involving breach of confidentiality or loss of privacy from accidental disclosure of research information by other participants in the focus group.

2) Emotional risk if discussion of research questions triggers an unwanted emotional response (e.g. distress at past negative experiences of a family member/friend's care in mental health services).

Should you experience any distress from participating in this research, please advise [Chris] (Nurse Unit Manager) at [Sunshine] Clinic who can provide support. Alternatively you can contact the CQUniversity Psychology Wellness Centre to access free counselling sessions for any issues raised by participation in this research.

Participating in this research may not benefit you directly, but it will help us to learn about ways to enhance recovery- oriented practice in [Sunshine] Clinic, which may benefit consumers who access the clinic in the future.

Confidentiality/Anonymity

Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants and not repeat what is said in the focus group to others.

The group facilitators will not share 'who says what' in the focus group with other co-researchers or research participants. The group facilitators will de-identify the focus group transcripts (transcribed from the audio recordings). To further protect the anonymity of participants, the PhD Candidate will collate the themes raised across all carer and consumer focus groups. The collated data may include direct quotes from the discussion but neither the participant nor the specific focus group will be identified.

The PhD Candidate will keep all records, including any codes to your data, in a locked filing cabinet at CQUniversity. Research records will be labelled with a code. A master key that links names and codes will be maintained in a separate locked filling cabinet. All electronic files containing identifiable information will be password protected. Any computer

hosting such files will have password protection to prevent access by unauthorized users. The research data will be destroyed seven (7) years after the publication date of the last publication based upon the data in accordance with the CQUniversity policy.

Outcome/Publication of Results

At the conclusion of this project the co-researchers may publish their findings. Information will be presented in summary format and may include direct quotes from the consultations. To preserve anonymity and maintain confidentiality of participants' fictitious names may be used in any publications. No individual identifying information nor name of the hospital nor location will be included in publications, although Ramsay Health may be acknowledged for providing support for this research. The PhD Candidate will also include de-identified information from the consultations in her thesis.

Consent

A written consent form will be given to you to read and sign prior to commencement.

Right to Withdraw

You do not have to participate in the research if you do not want to. If you agree to participate but later change your mind, you may withdraw at any time without penalty. Please be advised that if you withdraw after the data from focus groups/individual consultations has been collated into themes we may not be able to identify and remove all of your contributions.

Feedback

All participants will be emailed a plain English statement of results from the consultations.

Questions/Further Information

If you have further questions about this research, you may contact Leonie Lorien (PhD Candidate) at the following email address: l.lorien@cqu.edu.au or Dr Wendy Madsen (CQUniversity PhD Supervisor) at w.madsen@cqu.edu.au

Concerns/Complaints

If you feel you need further personal support with any concerns that participation in this research has raised, please advise Nurse Unit Manager at [Sunshine] Clinic.

Please contact CQUniversity's Office of Research (Tel: 07 4923 2603; Email: ethics@cqu.edu.au; Mailing address: Building 32, CQUniversity, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

This project has been approved by the CQUniversity Human Research Ethics Committee (reference number 0000020680) and [Ramsay Health] Hospital Ethic Committee (protocol number 17/44).

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

Phase Two—Consultation with Key Stakeholders

INFORMATION SHEET: SENIOR MANAGERS/PSYCHIATRISTS

Project Overview

You are invited to participate as a Key Stakeholder in this Participatory Action Research (PAR) project. The project is a collaboration between CQUniversity PhD Candidate (Leonie Lorien), Archerview's Consumer Advocate [Lea]and [Sunshine] staff members (Chris, Jordan, Eden, Charlie, Kim and Alex]. Ms Lorien is supported in her candidature by a supervisory team, led by Dr Wendy Madsen.

Current government policy in Australia requires that Mental Health Services are recovery-oriented, respecting the choices and personal decision making of consumers on their personal journey of recovery. However, there is limited research on recovery-oriented practice within inpatient settings and no practice-based examples of how to implement recovery-oriented practice using a collaborative, participatory action framework.

The project aims to answer the research question: How do we collaboratively enhance and deliver recovery-oriented practice at [Sunshine]Clinic?

- Phase One entailed forming the research partnership. (Note this phase has been completed.)

- Phase Two involves consultation with key stakeholders (consumers, carers, staff, senior managers, and psychiatrists) to explore stakeholders' understanding of recovery-oriented practice at [Sunshine] Clinic.

- Phase Three (informed by Phase Two) will be an action phase where staff, with management approval, implement specific recovery-oriented practices at [Sunshine] Clinic and review the outcomes.

The purpose of this consultation is to get feedback from Key Stakeholders on three questions:

1) What is your understanding of recovery and recovery-oriented practice in mental health?

2) What are staff currently doing to support consumers with their recovery in mental health?

3) What more could staff and management do to enhance consumers' recovery in mental health?

The following consultations will be conducted:

- Consumer Focus Groups/Individual Consultations for Inpatients/Day-Patients at Archerview Clinic;

- Carers Focus Groups/Individual Consultations for family members and friends who care for a current or previous consumer at [Sunshine] Clinic;

- Staff—Online Survey for all staff at [Unity] Hospital;

- Senior Managers/Psychiatrists—Individual Consultations.

Participation Procedure

Senior Managers and Consultant Psychiatrists at [Unity] Hospital are invited to participate in individual consultations facilitated by Leonie Lorien (PhD Candidate).

The individual consultations will take place at either [Unity] Hospital or the Private Practice of participating Psychiatrists, at a time that is convenient for each participant. The individual consultation will take approximately 15-20 minutes. If you agree to participate, you will be asked for your feedback on the three questions raised above. You can choose to skip any question/s and to discontinue the consultation at any time. The consultation will be audio-recorded in order to accurately capture what is said. You may request that the recording be paused at any time.

Benefits and Risks

There are minimal risks of being in this study. You may experience discomfort in talking about issues relating to implementation of recovery and inconvenience for the time required to complete the consultation. Should you experience any distress from participating in this research you can contact the CQUniversity Psychology Wellness Centre to access free counselling sessions for any issues raised by participation in this research.

Participating in this study may not benefit you directly, but it will help us to learn about ways to enhance recovery-oriented practice in [Sunshine] Clinic, which may benefit consumers who access the clinic in the future.

Confidentiality/Anonymity

The PhD Candidate will not share 'who says what' in the individual consultations with staff co-researchers or other research participants. The PhD Candidate will de-identify the consultation transcripts (transcribed from the audio recordings) and collate the themes raised across individual consultations with senior managers and psychiatrists.

The PhD Candidate will keep all records, including any codes to your data, in a locked filing cabinet at CQUniversity. Research records will be labelled with a code. A master key that links names and codes will be maintained in a separate locked filling cabinet. All electronic files containing identifiable information will be password protected. Any computer hosting such files will have password protection to prevent access by unauthorized users. The research data will be destroyed seven (7) years after the publication date of the last publication based upon the data in accordance with the CQUniversity policy.

Outcome/Publication of Results

At the conclusion of this project, the co-researchers may publish their findings. Information will be presented in summary format and may include direct quotes from the consultations. To preserve anonymity and maintain confidentiality of participants fictitious names may be used in any publications. No individual identifying information nor name of the hospital nor location will be included in publications, although Ramsay Health may be acknowledged for providing support for this research. The PhD Candidate will also include de-identified information from the consultations in her thesis.

Consent

A written consent form will be given to you to read and sign prior to commencement.

Right to Withdraw

You do not have to participate in the research if you do not want to. If you agree to participate but later change your mind, you may withdraw at any time without penalty. Please be advised that if you withdraw after the data from individual consultations has been collated into themes we may not be able to identify and remove all of your contributions.

Feedback

All participants will be emailed a plain English statement of results from the consultations.

Questions/Further Information

If you have further questions about this research, you may contact Leonie Lorien (PhD Candidate/Co-researcher) at the following email address: l.lorien@cqu.edu.au or Dr Wendy Madsen (CQUniversity PhD Supervisor) at w.madsen@cqu.edu.au

Concerns/Complaints

Please contact CQUniversity's Office of Research (Tel: 07 4923 2603; Email: ethics@cqu.edu.au; Mailing address: Building 32, CQUniversity, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

This project has been approved by the CQUniversity Human Research Ethics Committee (reference number 0000020680) and [Ramsay Health] Hospital Ethic Committee (protocol number 17/44).

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

Phase Two—Consultation with Key Stakeholders

CONSUMER CONSENT FORM

I consent to participation in this research project and agree that:

1) An 'Information Sheet: Consumer' has been provided to me that I have read and understood.

2) I have had any questions about the project answered to my satisfaction by the Information Sheet and any further verbal explanation provided.

3) I confirm that I am, or was, a consumer at [Sunshine] Clinic, [Unity] Hospital.

4) I understand that my participation or non-participation in the research study will not affect my admission at [Sunshine] Clinic.

5) I understand that I have the right to withdraw from the project at any time without penalty.

6) I understand the research findings will be included in the researchers' publications and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet.

7) I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used in any publications. Publications will not include any individual identifying information nor the name of the specific hospital nor location, although Ramsay Health may be acknowledged for providing support for this research.

8) I agree to maintain the confidentiality of the information discussed by all participants during the focus group session (Focus Group only. N/A to Individual consultation);

9) I agree that I am providing informed consent to participate in this project.

Signature: _____   Date: _____

Name (please print): _____

Name (please print): _____

Please check the box below:

I wish to have a Plain English statement of results emailed to me at the email address I provide below.	**YES**	**NO**

Email Address: _____

CQUHREC reference number: 0000020680; [Ramsay Health] HREC protocol number: 17/44

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice Phase Two—Consultation with Key Stakeholders

CARER CONSENT FORM

I consent to participation in this research project and agree that:

1) An 'Information Sheet: Carers' has been provided to me that I have read and understood.

2) I have had any questions about the project answered to my satisfaction by the Information Sheet and any further verbal explanation provided.

3) I confirm that I am a carer of a family member/friend who is/has been a consumer at [Sunshine] Clinic, [Unity] Hospital.

4) I understand that my participation or non-participation in the research study will not affect my family member/friend's admission at [Sunshine] Clinic.

5) I understand that I have the right to withdraw from the project at any time without penalty.

6) I understand the research findings will be included in the researchers' publications and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheet.

7) I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used in any publications. Publications will not include any individual identifying information nor the name of the specific hospital nor location, although Ramsay Health may be acknowledged for providing support for this research.

8) I agree to maintain the confidentiality of the information discussed by all participants during the focus group session (Focus Group only. N/A to Individual consultation).

9) I agree that I am providing informed consent to participate in this project.

Signature: _____   Date: _____

Name (please print): _____

Name (please print): _____

Please check the box below:

	YES	NO
I wish to have a Plain English statement of results emailed to me at the email address I provide below.		

Email Address: _____

CQUHREC reference number: 0000020680; [Ramsay Health] HREC protocol number: 17/44

BE WHAT YOU WANT TO BE

SENIOR MANAGER/PSYCHIATRIST CONSENT FORM

I consent to participation in this research project and agree that:

1) An Information Sheet: Senior Managers/Psychiatrists has been provided to me that I have read and understood.

2) I have had any questions about the project answered to my satisfaction by the Information Sheet and any further verbal explanation provided.

3) I confirm that I am a Senior Manager or Consultant Psychiatrist at [Sunshine] Clinic, [Unity] Hospital.

4) I understand that my participation or non-participation in the research study will not affect my employment or practice at [Unity] Hospital.

5) I understand that I have the right to withdraw from the project at any time without penalty.

6) I understand the research findings will be included in the researchers' publications and this may include conferences and articles written for journals and other methods of dissemination stated in the Research Information Sheet.

7) I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used in any publications. Publications will not include any individual identifying information nor the name of the specific hospital nor location, although Ramsay Health may be acknowledged for providing support for this research.

8) I agree that I am providing informed consent to participate in this project.

Signature: _____   Date: _____

Name (please print): _____

Please check the box below:

I wish to have a Plain English statement of results emailed to me at the email address I provide below.	**YES**	**NO**

Email Address: _____

CQUHREC reference number: 0000020680; [Ramsay Health HREC protocol number: 17/44]

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

Phase Two—Consultation with Key Stakeholders

AGENCY CONSENT FORM

I consent to participation of …………………………………………………… (**Agency Name) in this research project and agree that:**

1) Information Sheets have been provided to me that I have read and understood;

2) I have had any questions about the project answered to my satisfaction by the Information Sheets and any further verbal explanation provided.

3) I confirm that participation or non-participation in the research study will not affect employment for staff, practice rights for consultant psychiatrists or access to services for consumers.

4) I approve staff and senior managers participating in this consultation in work time;

5) I approve focus groups and individual consultations taking place in [Sunshine] Clinic at times that are convenient for staff and participants.

6) I understand that that the Agency has the right to withdraw from the project at any time without penalty.

7) I understand the research findings will be included in the researchers' publications on the research project and this may include conferences and articles written for journals and other methods of dissemination stated in the Information Sheets.

8) I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used in any publications. Publications will not include any individual identifying information nor the name of the specific hospital nor

location, although Ramsay Health may be acknowledged for providing support for this research.

9) I am aware that a risk and benefit of participating is that the research may identify areas for improvement in recovery-oriented practice at the Agency.

I agree that I am providing informed consent for staff of the Agency to participate in this project.

Signature: _____   Date: _____

Name (please print): _____

Please check the box below:

I wish to have a Plain English statement of results emailed to me at the email address I provide below.	**YES**	**NO**

Email Address: _____

CQUHREC reference number: 0000020680; [Ramsay Health] HREC protocol number: 17/44

Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

Phase Two—Consultation with Key Stakeholders

CONSUMER CAPACITY TO CONSENT FORM

To be completed by Nursing Staff Member at [Sunshine] Clinic (who is not a Co-Researcher)

for Inpatients who would like to participate in the research project.

I certify that _____ has the capacity to provide

(Consumer name, date of birth)

informed consent to participate in the research described in the 'Information Sheet:

Consumer Focus Groups or Individual Consultation'.

_____ demonstrated that he/she has the

(Consumer name, date of birth)

decisional capacity to be able to:

- Understand the information in the Information Sheet about the purpose of the

  research and procedures.

- Appreciate the risks and benefits of participating.

- Use reason to make an informed choice to participate or not to participate, and

- Communicate that reasoned choice.

Signature: _____ Date: _____

Name (please print): _____

Position: _____

Agency: [Sunshine] Clinic, [Unity] Hospital

STAFF SURVEY: RECOVERY-ORIENTED PRACTICE AT [UNITY] HOSPITAL
How do we collaboratively enhance and deliver recovery-oriented practice in Mental Health?

Project Overview & Participation

You are invited to participate as a Key Stakeholders in this Participatory Action Research (PAR) project. The project is a collaboration between CQUniversity PhD Candidate (Leonie Lorien), Archerview's Consumer Advocate (*Name removed**) and seven [Sunshine Clinic] staff members (**Names removed to de-identify co-researchers*). Ms Lorien is supported in her candidature by a supervisory team, led by Dr Wendy Madsen.

Current government policy in Australia requires that Mental Health Services are recovery-oriented, respecting the choices and personal decision making of consumers on their personal journey of recovery. However, there is a paucity of research on recovery-oriented practice within inpatient settings and no practice-based examples of how to implement recovery-oriented practice using a collaborative, participatory action framework.

The three survey questions are about recovery-oriented practice. Your responses will help co- researchers to identify what we know, what we are already doing and ways to enhance recovery-oriented practice at [Unity] Hospital.

The survey will take approximately 5-10 minutes to complete. Your participation in this project is entirely voluntary and you can withdraw at any time. You are free to skip any question, including questions on location and work role.

Benefits and Risks

We believe there are minimal risks associated with this research project, including:

1) Inconvenience of time it takes to complete the survey;

2) Mild discomfort if some of the questions prompt recall of past workplace incidents or practices that may have been detrimental to patient care; and

3) the risk online data being breached is always possible. We will minimize any risks to your privacy be not tracking any information that you do not voluntarily provide (e.g., IP addresses). All data collected from the survey will be securely stored for seven (7) years after the publication date of the last publication based on the data in accordance with the CQUniversity policy.

Participating in the project may not benefit you directly but it will help us to learn about ways to enhance recovery-oriented practice, which may benefit consumers in the future.

Outcomes/Publication of Results

The research findings will be included in the researchers' publications on the project and this may include conferences or articles. Information will be presented in summary format and may include direct quotes from survey responses. To preserve anonymity and maintain confidentiality, fictitious names may be used in any publications. No individual identifying information nor name of the hospital nor location will be included in publications, although Ramsay Health may be acknowledged for providing support for this research.

Questions/Further Information

If you have further questions about this research, you may contact Leonie Lorien (PhD Candidate/Co-researcher) at the following email address: l.lorien@cqu.edu.au or Dr Wendy Madsen (CQUniversity PhD Supervisor) at w.madsen@cqu.edu.au

If you feel you need any further personal support with any concerns that participation in this project has raised, please contact the Ramsay Employee Assistance Program for staff.

Please contact CQUniversity's Office of Research (Tel: 07 4923 2603; Email: ethics@cqu.edu.au ; Mailing address: Building 32, CQUniversity, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

1) **Please indicate which location you usually work in**

   ○ [Sunshine] Clinic
   ○ Other location at [Unity Hospital]

2) **What is your work role?**

   ○ Clinical (Nurse/Allied Health)
   ○ Non-Clinical (Administration/Auxiliary/Other)

3) **What is your understanding of recovery and recovery-oriented practice in mental health?**

4) **What are staff currently doing to support consumers with their recovery in mental health?**

5) **What more could staff and management do to enhance consumers' recovery in mental health?**

Thank you for taking the time to answer our survey. Co-researchers will summarise the main themes identified by staff and share these with staff and management at [Unity] Hospital

Table B-1

Consultation schedule

Date	Data	Facilitator/s	Participants No. Pseudonyms
Focus Groups			*N = 15*
01/10/2017	Focus Group 1—Inpatients	Leonie & Lea	N = 4. Myles, Marie, Jack, Tom
01/10/2017	Focus Group 2—Day-patients	Leonie & Lea	N = 4. Kevin, Jose, Ron, Lance
01/11/2017	Focus Group 3—Inpatients	Leonie & Lea	N = 6. Brooke, Trevor, Doug, Ben, Jenny, Myles
01/11/2017	Focus Group 4—Day-patients	Leonie & Lea	N = 2. Emma, Olivia
Online Survey			*N = 15*
01/11/17–31/01/2018	Online Survey—Staff	N/A	#1 Incomplete #2 Consumer—not included #3 Ashley UC #4 Billie SC #5 Cody SC #6 Drew SC #7 Erin UC #8 Flynn AC #9 Glenn UC #10 Harley UC #11 Jules UC #12 Logan UC #13 Marley UC #14 Nico UC #15 Payton UC #16 Quinn UC #17 Sam UC

Date	Data	Facilitator/s	Participants No. Pseudonyms
Managers			*N = 7*
31/10/2017	Individual Interview—Manager	Leonie	N = 1. Reagan
23/11/2017	Individual Interview—Manager	Leonie	N = 1. Ricki
06/12/2017	Individual Interview—Manager	Leonie	N = 1. Rylee
24/01/2018	Individual Interviews—Manager x 3	Leonie	N = 3. Rob, Renee, Rett
31/01/2018	Individual Interview—Manager	Leonie	N = 1. Rhys

HC = Unity Other/Clinical; AC = Sunshine Clinic/Clinical

Appendix C: Thematic Analysis

Thematic Analysis Development: Consumer Consultation (Tables C-1 to C-4)

Table C-1

What is recovery?

Themes coded by Leonie 07/03/18	Themes coded by Lea and Leonie 06/04/18[1]	Leonie's suggested combination from Leonie and Lea/Leonie's coding with representative quotes	Proposed Themes Summary—for discussion with Co-Researchers
Individual journey	**Different Journeys** Hard Work/Good Days and Bad	**Different Recovery Journeys:** "Everyone's journey is different": [394]; "There is no one cap fits all. Everything is so individual" [336] **Hard Work**: "It requires a lot of hard work. If you put in the hard work, you usually get results but it's not easy" [393] **Good Days & Bad**: "There's good days and bad" [392]	**Recovery Journey** ~ Different Journeys • Challenges • Hard Work • Good & Bad Days • Everyday Living • Relationships ~ Living Well • Hope/Positivity • Acceptance • Getting back to where we were
Everyday Living Living with MH Challenges Having Hope	**Living-Well/Everyday Living** **Happiness/Positivity/Hope** **Learning Acceptance** **It's Not Cure**	**Living-Well/Everyday Living**: "To be able to do your everyday things" [276]; "Recovery to me is where you can get on with your life and you can do most things" [275] ~ **Living with MH Challenges/Not Cure:** "It's different to cure … With mental illness you are going to always have it, it's just the way that you live with it that's important" [329]; "My belief is that you can't ever by cured. The rest of our lives we're on a recovery track." [391] ~ **Happiness/Positivity/Hope**: "To be able to wake up of a morning, get out of bed, have a positive outlook on the day" [331]; "Hope, having something to look forward to" [224]; "I have what's called 'blue sky days'. The sky is blue, the sun is shining and everything is easy" [333]	

Themes coded by Leonie 07/03/18	Themes coded by Lea and Leonie 06/04/18[1]	Leonie's suggested combination from Leonie and Lea/Leonie's coding with representative quotes	Proposed Themes Summary—for discussion with Co-Researchers
		~ **Acceptance**: "For me I have to accept that I've got this disease. I have to somehow learn to love myself with it" [229]; "You have to be able to live with what you're got and make the best of it." [391]	
Back to Previous Functioning	**Getting Back to where we were Relationships**	**Getting back to where we were**: "Trying to get back to where we were. As close as we could where we were happy or close to being to that liveable state" [330] ~ **Relationships**: "Forming relationships, like being able to participate in them" [225]	

Note:[1] *I had originally thought Lea and I would code the themes independently, but Lea's preference was to do the coding together. I did not look back at that coding I had completed independently (the month prior) until after Lea and I had doing the coding together).*

Table C-2

Recovery challenges

Nodes coded by Leonie 07/03/18	Nodes coded by Kim 08/03/18	Leonie's suggested combination from Leonie and Kim's coding with representative quotes	Proposed Themes Summary—for discussion with Co-Researchers
Loss of Role/Identity	**Grief, change, Identity?**	**Grief and Loss of Identity**: "Mine is grieving for who I once was … I can't do my old work now. I lost my identity" [236].	**Grief and Loss of Identity**
Challenging Life Events Ups and Downs	**How Acute Symptoms Are**	**Living with Mental Health Challenges** **External Stressors**: "Everything came to a hear about 8 years ago when I lost my (partner)" [351].	**Living with Mental Health** Challenges External Stressors Ups and downs Distressing Symptoms

Nodes coded by Leonie 07/03/18	Nodes coded by Kim 08/03/18	Leonie's suggested combination from Leonie and Kim's coding with representative quotes	**Proposed Themes Summary— for discussion with Co-Researchers**
Impact of Symptoms/ Unhelpful Thinking/ Low self-worth Challenges with Treatment/Access to Services Isolation/Lack of Understanding		**Ups and downs** (Fluctuating Symptoms): "I've had a few ups and down" [389]; "I've been going really good until I've had these last couple of episodes" [400]. **Distressing Symptoms**: "When my thoughts are running wild, my whole body is tense, stomach is knotted and you just feel like rubbish" [338]; "I said 'I can't do this anymore, I'm going to go and get a rope.' I ended up in hospital that day" [244]. **Unhelpful Treatment**: "Some other places I've gone to you feel like cattle going through a crush" [413]. **Isolation**: " I really dug myself a deep hole and totally isolated myself" [364]; "I don't connect with people … I stay with my door locked and I stay at home" [291].	Unhelpful Treatment Isolation
Impact of Symptoms Loss of Role/Identity	**Low Motivation**	**Impact on motivation**: "When I was bad, I couldn't even get off the couch. I wanted to" [342]; "Mentally I'm so down that every single think seems pointless" [243]; "I see everyone getting to work and living their lives and … I struggle just to get through the day" [242].	**Impact on motivation**
Unhelpful Thoughts	**Hopelessness**	**Hopelessness/Negative thinking**: "It just takes away the hope sometimes and the meaning. It's like you can't forward because there is a wall there" [243]; "It's not hard not to go straight to the negative" [234].	**Hopelessness/Negative thinking**
It's Not Easy		**It's Not Easy**: "I've worked really hard … It's not easy" [202]; "You drag yourself up" [401]; "You've just got to deal with what you've go. Just keep plodding on" [420].	**It's Not Easy** **Lack of Support/Understanding and Isolation**
Impact of Symptoms	**Lack of Understanding** Lack of Support	**Lack of Support/Understanding and Isolation** "When you are not critical and you are not good, that's the stage where you can wear a mask for a short period of time. Then you go home and fall	Difficulty Communicating Lack of Financial Resources

Nodes coded by Leonie 07/03/18	Nodes coded by Kim 08/03/18	Leonie's suggested combination from Leonie and Kim's coding with representative quotes	**Proposed Themes Summary— for discussion with Co-Researchers**
Challenges with Treatment/Access to Services Isolation/Lack of Understanding	Stigma Difficulty Communicating **Lack of Financial Resources**	in a heap. But they wouldn't admit you to hospital for that, so you are in no-man's land" [294]; "When you are out in the real world …It's hard to get people to understand" [348]; "I usually just isolate. I could be home a week and wouldn't see anybody" [285]; "You feel so alone" [339]. **Difficulty Communicating**: "I still don't tell a lot of people" [411]; "I find it very, very, very hard to talk to my kids about it" [408]. **Lack of Financial Resources**: "It costs a lot of money to go to the doctor outside of hospital" [287]; "I changed doctors because I couldn't afford who I was seeing"	

Table C–3

What currently supports recovery?

Coded by Leonie07/03/18	Coded by Kim 08/03/18/Group Program quotes coded by Leonie and Lea 06/04/18[2]	Leonie's suggested combination from Leonie, Kim and Lea/Leonie's coding with representative quotes	**Proposed Themes Summary— for discussion with Co-Researchers**
		Treatment	**Treatment**
Groups	**Groups Programs/ Helpful/Supportive *** Sub-Node: Day-Programs— Check-In/Peer Support * Day Program—Doing it Twice Something to look forward to	**Group Programs** **Helpful/Supportive:** The group therapy … helped a lot, enormously [421]. They are life changing … If I didn't have those programs to keep the momentum going, once I started to get treatment, I would not be here today [485]. Being in the group, knowing that other people understand how you	~ **Group Programs** Check-in/Peer Support Resources/Information Mindfulness ~ **Medical Treatment**

Coded by Leonie 07/03/18	Coded by Kim 08/03/18/Group Program quotes coded by Leonie and Lea 06/04/18[2]	Leonie's suggested combination from Leonie, Kim and Lea/Leonie's coding with representative quotes	Proposed Themes Summary—for discussion with Co-Researchers
	Helpful Resources/Information	feel. … You learn a lot from them. They've been unreal, (the) groups [231]. I enjoyed having the (day) groups to come to. You had something to look forward to … You knew you were going to get something out of it. It was with familiar faces and that was really helpful [318].	~ Medication
Treatment	**Group Programs & rTMS/ECT Treatment** **Medication**	**Check-in/Peer Support:** Check-in was like your own little personal therapy and everyone could help you and give you their experiences as well, so I think the check-in was really useful [427]. The check-ins where something that myself and all the other participants … looked forward to. … It's so important … We could start the day feeling horrible and at the end feeling positive, taking things we have learnt for next week [483].	**Activities** ~ Mindfulness ~ Exercise ~ Daily Living **Support** ~ Sunshine Clinic ~ Health Professionals ~ Doctors/Staff ~ Peer Support ~ Family Support ~ Self-Care
		Resources/Information: What made a difference is the information. … It helped me to understand what the problem was, some triggers, how to deal with different techniques on coping. That was just amazing [476]. The workbooks were wonderful because they had so many activities, I'd never have been able to do by myself [315].	
		Medical Treatment: My diagnosis helped me … That explained a lot of things [253]; The rTMS has helped me [487]; The psychologists talk more about the cognitive side of things. … That's as important, if not more important, to your recovery than the actual drugs [310].	

Coded by Leonie07/03/18	Coded by Kim 08/03/18/Group Program quotes coded by Leonie and Lea 06/04/18[2]	Leonie's suggested combination from Leonie, Kim and Lea/Leonie's coding with representative quotes	Proposed Themes Summary— for discussion with Co-Researchers
		Medication: Josie: I think medication is also important in recovery and that's what I'm grateful for. Ron: Yes so am I. That one little tablet has made all the difference. [430].	
Activities/Exercise		**Activities**	
	Mindfulness/Meditation/ Relaxation Exercise Program Exercise	**Mindfulness:** I always thought meditation was a load of crap and now. … I'll sit down outside and just look at the leaves in the tree. … When you are in a bad place, it'll put you in a better place. I've learnt that through coming here [458]. The mindfulness, I thought was stupid. I could not get my head around that for ages. Didn't do my homework. Couldn't understand it. But now, honest to God, it totally works [488]. **Exercise:** Exercise is a big thing for me. I've noted that if I consistently go to the gym, go for walks then my mood lifts [241]. Exercise is pretty important for me. [298]. **Daily Activities**: It would be lovely to be able to control my moods or keep it in the comfortable zone of where you can go out and have coffee with friends, and do a day's work [240]. Even if you just get up, have a shower, have some breakfast. [238].	

Coded by Leonie07/03/18	Coded by Kim 08/03/18/Group Program quotes coded by Leonie and Lea 06/04/18[2]	Leonie's suggested combination from Leonie, Kim and Lea/Leonie's coding with representative quotes	Proposed Themes Summary—for discussion with Co-Researchers
Support from others		**Supports**	
Support from Doctor/Health Professional Support from Family & Friends Peers Other Agencies/General Self-Motivation/ Self-Care Sunshine Clinic—General Staff Empathy/Support	**Doctors** **External Support/Peer Support/Family Support** **Sunshine Clinic**	**Sunshine Clinic:** I have been so fortunate to access the service. Best thing I ever did in my life [473]. I did have to go to the (Public Hospital) first to be stabilised before I could come here but I was so grateful that this place existed. … To be able to come here was much nicer … and the supportive staff [436]. To be honest. … I'm really positive about life. It has really helped me coming through here. It's opened a different life to me [453]. **Health Professionals** **Doctors**: (My psychiatrist) is great. He's been my saviour a lot of times [370]. **Staff:** They create a calming feeling for me. … Having people that listen to you and actually talk back to you, on the same level, same understanding they do it well [244]; All the staff I've worked with I find very understanding and I think they do a marvellous job [438]; The first day I came (I thought) I'm with people who understand. I relaxed straight away. I could almost feel that knots running out of me [362]; Taking time out, without rushing and talking me through things [481]. **Peer Support:** A lot of good stuff comes out of talking, just sharing stories. Makes you feel that bit normal at the time, because people out in the world don't understand properly. But when you are with other patients who are going through the same thing as you don't feel judged or different [249].	

Coded by Leonie07/03/18	Coded by Kim 08/03/18/Group Program quotes coded by Leonie and Lea 06/04/18[2]	Leonie's suggested combination from Leonie, Kim and Lea/Leonie's coding with representative quotes	Proposed Themes Summary—for discussion with Co-Researchers
		Family Support: Family to me is a big thing. … You sort of draw on their strength [255]; My daughter was the one who got me to come along and seek help [443]. **Self- Care:** The psychologists can guide you but it's up to you to make the effort. It's up to the individual, if you want to get over it … you're going to have to do something yourself **[445].** Sometimes, you've got to give yourself permission just to chill out. … To give yourself permission to have mental health days until you feel a little bit better and not be too hard on yourself [446].	

Note:[2] Kim did not have time to complete coding for this question at the research meetings, so Lea and I reviewed the quotes related to the group program later.

Table C-4

What could enhance recovery?

Themes coded by Leonie 07/03/18	Themes coded by Kim 08/03/18	Leonie's suggested combination from Leonie& Kim's coding with representative quote	Proposed Themes Summary—for discussion with Co-Researchers
Carer Support	**Carer Education**	**Carer Education:** I think if there was some more education towards the whole family, like our partners … before the discharge [389].	Carer Education
Staffing (more staff)	**Staffing**	**Staffing**: (Sunshine Clinic) needs more nurses. … Sometimes they are just too busy to sit down (to talk) because of their workload [494]. I think another	Staffing

Themes coded by Leonie 07/03/18	Themes coded by Kim 08/03/18	Leonie's suggested combination from Leonie& Kim's coding with representative quote	Proposed Themes Summary—for discussion with Co-Researchers
		psychologist would be great because they are so busy running group (and) one-on-one sessions [494]. When we have had our little chats in the tea room … an extra psychologist and nurses is what everyone thinks we should (have) [495].	
Facilities	**Environmental** Diet	**Environment/Facilities:** Does anyone else have a problem with the air conditioning in their room? That's something that really needs to be sorted [267]. 497. I think we need to recognise that meditation … is important. … A designated room, a quite space. [497]. We need to have other diet options [499].	Environment/Facilities
Activities	**Activities** Relaxation Groups Outdoors Technology	**Activities:** They don't have enough activities in here. It gets boring [261]. If they had a garden of some sort, would be nice [260]. Games room [387]. **Relaxation**: Kevin: Massage. Ben: Or a really good massage chair for when you are stressed [264]. (A meditation room) would be nice [321]. **Groups:** A variety would be good [327]. The afternoons are pretty long for me … maybe another two sessions would be really helpful in the afternoon [382]. **Outdoors:** Tom: Some general exercise. Lea: A couple of outings. Tom: That would be really helpful for me, just to get out for an hour in the sunshine [384]. **Technology:** On the weekend it would be nice if we had … Netflix [386].	Activities ~ More Variety Relaxation ~ Outdoors ~ Technology
	Follow-up	**Follow-up (post-discharge):** Are they (follow-up phone calls) helpful? Sue: Not really. … Maybe go into a bit more detail. Kevin: I had (psychologist) ring me once or twice, which as good, after the day activities. Myles: If they could face time. It's more personal than a phone call [270]. I think I would have been more comfortable if I knew that, within 5 days, I could go back to Sunshine Clinic, instead of doing this thing over the phone, … a follow-up appointment [498].	Follow-up (Post-Discharge)

Thematic Analysis Development: Professional Consultation (Tables C-5 to C-8)

Table C-5

What is recovery?

Nodes coded by Leonie 07/02/18	Nodes coded by Kim 08/02/18	Leonie's suggested combination from Leonie and Kim's coding with representative quotes	Proposed Themes Summary – for discussion with Co-Researchers
Do Not Know	**I Don't Know**	**I Don't Know** "I have not heard this term before" [169].	~ I don't know
Not Cure	**Not Clinical Recovery**	**Not Cure/Not Clinical Recovery** "Recovery I wouldn't consider to be clinical recovery" [54]. "Not about cure" [58].	**Theme: Treatment** ~ Learning Strategies
Acceptance	**Diagnosis Acceptance**	**Acceptance** "This is just part of who I am. I have this and I can manage it." [5].	**Theme: Recovery as a Journey** ~ Not Cure/Not Clinical Recovery
Improved Functioning	**Learning Strategies**	**Learning Strategies** "Recovery may be that they are able to cope at a certain level, with certain strategies in place" [137].	~ A Journey ~ Acceptance and Hope/Goals
Journey	**A Journey**	**A Journey** "With mental illness there has to be an understanding that this is a journey" [55] … "It's an up and down journey" [56].	

Nodes coded by Leonie 07/02/18	Nodes coded by Kim 08/02/18	Leonie's suggested combination from Leonie and Kim's coding with representative quotes	Proposed Themes Summary – for discussion with Co-Researchers
Various: Future Focus Improved Functioning Collaborative Process Goal Oriented; Quality of Life	**Having Hope**	**Hope/Goals** "A process that enables the individual to … formulate a goal of what they hope to achieve" [28].	

Table C-6

What is recovery-oriented practice in mental health?

Themes coded by Leonie 07/02/18	Nodes coded by Alex and Kim 08/02/18	Leonie's suggested combination from Leonie, Alex and Kim's coding with representative quotes	Proposed Themes Summary–for discussion with Co-Researchers
Do Not Know	(no heading)	**I Don't Know** "I do not know that field of nursing" [175].	~ I Don't Know
Sub-nodes: Collaborative Planning Patient Goals, Wants De-stigmatising	**Client-Centred**	**Client-Centred/Collaboration** "It's about focusing on what the patient wants and what their goals are and where they need to get to"[7].	**Theme: Collaboration & Supportive Culture** ~ Client-Centred/Collaboration ~ Staffing/Environment ~ Team approach
Sub-nodes: Educating Patient Family Empowerment Increased Functioning	**Treatment**	**Treatment** "By engaging …with the individual in education and empowering them with ability to learn about their illness and triggers and how you can manager it" [59].	**Theme: Treatment** ~ Transition to Community

Themes coded by Leonie 07/02/18	Nodes coded by Alex and Kim 08/02/18	Leonie's suggested combination from Leonie, Alex and Kim's coding with representative quotes	**Proposed Themes Summary–for discussion with Co-Researchers**
Evidence-based Treatments			
Sub-nodes: Empowerment Identifying social supports Educating Patient Family	**Transition to Community**	**Transition to Community** "Empowering (patients), working with them to say how can we get you back to your best functioning … not just in hospital but beyond" [8].	
Sub-nodes: Calm Atmosphere 1:1 Support & Groups	**Staffing/Environment**	**Staffing/Environment** "It's more about one-to-one or groups and spending that time. It's a different type of nursing and a different pace" [88].	
Sub-nodes: Collaborative Planning	**Multi-D Approach (Team)**	**Team Approach** "Helping within a team to be an advocate for patient's needs and wants" [32].	

Table C–7

What are staff currently doing to support consumers with their recovery in mental health?

Themes coded by Leonie 07/02/18	Nodes coded by Lea and Charlie 08/02/18	Leonie's suggested combination from Leonie, Lea and Charlie's coding with representative quote	**Proposed Themes Summary— for discussion with Co-Researchers**
Do not know	**Uncertainty**	**I don't know** "I would not know as I am predominantly a medical staff" [150].	~ I don't know
Carer Support	**Carers**	**Carers – Involvement and Support**	

Themes coded by Leonie 07/02/18	Nodes coded by Lea and Charlie 08/02/18	Leonie's suggested combination from Leonie, Lea and Charlie's coding with representative quote	Proposed Themes Summary—for discussion with Co-Researchers
		"We try to see the relatives, spouse or carers within that admission" [41].	**Theme: Collaboration & Supportive Culture**
Time and Training	**Organisational Process**	**Organisational Support** "Spending little time with clients and too much time completing paperwork" [185].	~ Consumer—Collaboration & Support • Talking 1:1 • Care Plans • Collaboration
Staff Team Sub-Node: Allied Health	**Team Treatment Approach**	**Team Approach** "It is a fairly harmonious team that communicates and collaborates well together for that goal of recovery-based management of patients" [143].	~ Carers—Collaboration & Support ~ Supportive Culture/Team Approach
	Peer Support	**Peer Support** "(Patients) will have their own spontaneous group (that) … that will appropriately get together and talk about stuff … like good, therapeutic, peer support" [23].	~ Organisational Support **Theme: Treatment**
Sub-Nodes: MH Nurses Care Plans Ward Meeting	**Consumer Involvement and Feedback**	**Consumers – Collaboration & Support** ~ **Talking one-to-one:** "Listening to one-on-one conversations, recognising the uniqueness of each patient" [182]. ~ **Care Plans:** "Those care plans are pivotal and really important because there is consultation with the patient" [94]. ~ **Collaboration:** "The weekly meeting that the NUM has with patients. That doesn't happen in the surgical ward or a medical ward when a NUM sits down and has that weekly meeting with patients" [140].	~ Medical Treatment ~ Groups ~ One-to-one Sessions
Recovery Plans	**Recovery-Focused**	**Recovery-Focused** "We do their inpatient recovery plan. That's identifying with the patient what goals (they) want to achieve" [15].	

Themes coded by Leonie 07/02/18	Nodes coded by Lea and Charlie 08/02/18	Leonie's suggested combination from Leonie, Lea and Charlie's coding with representative quote	Proposed Themes Summary—for discussion with Co-Researchers
Positive Culture	**Ward Culture**	**Supportive Culture (Holding Hope)** "We maintain that positive, hopeful, you will recovery attitude" [18].	
Treatment Sub-Nodes: Medical T$_x$ Group Program	**Formal/Clinical Treatment Options**	**Treatment Options** "ECT" [123]; "Medications" [192]; "rTMS" [194]; "CBT" [214]; "The groups are really invaluable" [69]; "Day-Programs" [213]. "We have got some amazing mental health nurses who are very comfortable having those therapeutic talks" [101].	

Table C-8

What more could staff and management do to enhance consumers' recovery in mental health?

Themes coded by Leonie 07/02/18	Themes coded by Chris and Kim 08/02/18	Leonie's suggested combination from Leonie, Chris and Kim's coding with representative quote	Proposed Themes Summary—for discussion with Co-Researchers
Don't Know	**I Don't Know**	**I Don't Know:** "I don't know" [115].	~ I don't know
Time and Resources	**Administration**	**Administration (Admin vs. Time to Talk):** "Staff time to sit and listen/talk with clients instead of endless reams of paperwork" [186].	**Theme: Collaboration & Supportive Culture**

Staff Training Awareness	**Relationships**	**Therapeutic Relationships**
		
		Lack of confidence to talk (Generalists): "Lack of one-on-ones because the generalists (nurses) … don't feel confident having those conversations with patients" [26].
		
		Time to Listen/Talk with patients (As above—see Administration).
			~ Collaboration
			  • Consumer Collaboration
			  • Carer Collaboration

Themes coded by Leonie 07/02/18	Themes coded by Chris and Kim 08/02/18	Leonie's suggested combination from Leonie, Chris and Kim's coding with representative quote	Proposed Themes Summary—for discussion with Co-Researchers

Sub-Nodes: Staff Training	**Management**	**Management (Staff Training Needs)**
		
		Culture and Support: "You have to lead that kind of collaborative culture on the ward from the top" [83].
		
		Staff Training: "Some up-skilling and training in therapeutic discussion with the patient" [106]; "Training and looking at what we offer to keep up to date with concepts around recovery and service provision" [84].
			• Professional Collaboration
			• Peer Support
			
			Theme: Treatment
			~ Care Planning Processes
			  • Discharge Planning
			  • Diverse Activities
			~ Therapeutic Relationships
			  • Time to Talk
			  • Confidence to Talk

Sub-Nodes: Carer Involvement Peer Support Collaborative Planning	**Collaboration**	**Collaboration** Carer Collaboration: "We try to see the relatives, spouse or carers within that admission. But that doesn't always happen" [47]. "I wish that (the carers group) was more utilised by … carers" [102]. Peer Support: "Consumer run support groups" [179]. Collaboration with Consumer: "it is very much about collaborative care and listening and making sure that they (patient and family) feels very much involved in the delivery of care" [78]. Collaboration other professionals: "Need to get better at gaining further collateral from support people, other sources—GPs, Psychologists etc." [159].	
Recovery Processes Sub-Nodes: Diverse Activities Transition Planning Treatment Compliance	**Care Planning**	**Care Planning** Care Planning Processes (incl. discharge planning): " (Care Planning) needs to be done earlier"[24]; "Realistic goals and expectations discussed in a meeting involving nurses, psychiatrist and patient, and family if possible" [158]. Diverse Activities: "There could be a bit more diversity in the activities that we offer" [144].	

Themes coded by Leonie 07/02/18	Themes coded by Chris and Kim 08/02/18	Leonie's suggested combination from Leonie, Chris and Kim's coding with representative quote	**Proposed Themes Summary— for discussion with Co-Researchers**
		Discharge Planning: "The care is focused on the inpatient admission. How beneficial would it be to join with the patient out in the community setting." [174].	

THEMES AGREED TO BY CO-RESEARCHERS

Three meta-themes were identified: lived experience of recovery, recovery-oriented practice and organisational support for recovery. Three themes were identified under the lived experience of recovery: different pathways, living well and challenges. Five themes were identified under recovery-oriented practice: medical treatment, care planning, multi-disciplinary team, group program and culture. Two themes were identified under organisational support: environment and 'time, resources and training'.

Lived Experience of Recovery

Theme 1: Different Pathways

Within this theme, participants spoke about a myriad of pathways to recovery which was seen as a personal journey for each patient.

"There is not one cap fits all. Everything is so individual". "Everyone's journey is different"

The recovery journey itself was conceptualised as either regaining lost functioning or developing a new way of living, the "recovery track".

"Trying to get back to where we were. As close as we could to where we were happy or close to that liveable state".

"My belief is that you can't ever be cured. The rest of our lives we're on a recovery track".

Theme 2: Challenges

It was notable that all patient participants talked extensively about the challenges of recovery, even though there was not a specific research question about challenges. To talk about their experience of recovery necessitated talking about the challenges. In the focus groups, there

was no instance where challenges were not part of patients' lived experience of mental illness.

There were four sub-themes identified under challenges: It's not easy, ups and down, hopelessness and distress, and lack of support/understanding and isolation.

'It's not easy' reflected how hard patients had to work on their recovery and how it could be a struggle to get through the day.

> "I've worked really hard. It's not easy".

> "I see everyone getting to work and living their lives and I struggle just to get through the day".

'Ups and downs' described how life could oscillate between going well and not so well for patients.

> "I've had a few ups and downs".

> "There are good days and bad".

'Hopelessness and distress' included patient reflections on how mental illness can take away hope and the distress of living with challenging symptoms.

> "It takes away the hope sometimes and the meaning. It's like you can't go forward because there is a wall there".

> "When my thoughts are running wild, my whole body is tense, (my) stomach is knotted and you just feel like rubbish".

Patients talked about how out in the community they often experience lack of understanding and have a tendency to isolate themselves from the world.

> "When you are out in the real world, it's hard to get people to understand".

"I really dug myself a deep hole and totally isolated myself".

While there were no comments critical of the support from health professionals at Sunshine Clinic, patients described experiences at other services that were not supportive.

"Some other places I've gone you feel like cattle going through a crush".

Theme 3: Living-Well

There were three sub-themes identified under living well: everyday living, hope and acceptance and self-efficacy.

In the focus groups, patients discussed how recovery was about being able to do everyday things like socialising and working.

"To be able to do your everyday things".

"It would be lovely to be able to control my moods or keep it in the comfortable zone of where you can go out and have coffee with friends, and do a days work".

'Hope and acceptance' included patients having something to look forward to and also acceptance of themselves living with a mental illness.

"Hope. Having something to look forward to".

"I have to accept that I've got this disease. I have to somehow learn to love myself with it".

'Self-efficacy' reflected patients acknowledgement that if they were going to recover then they would have to take responsibility themselves.

"The psychologists can guide you but it's up to you to make the effort. It's up to the individual, if you want to get over it you're going to have to do something yourself".

Recovery-Oriented Practice

Theme 1: Culture *(Note: This theme was changed to Relational Recovery for the thesis, based on feedback from supervisors. Relational recovery better reflected the quotes that supported this theme, and the focus on what staff do that is recovery-oriented rather than the broader organisational culture)*

There were three sub-themes identified under culture: collaborative and supportive health professionals, inclusions of family/carers, and peer support.

An important aspect of the supportive culture on the ward was health professional holding hope for patients who, when they were acutely unwell, may be unable to do so themselves.

"We maintain that positive, hopeful, you will recover attitude".

Patients talked about the ward feeling like a safe, supportive place where their felt understood and listened to by staff.

"They (staff) create a calming feeling for me. Having people that listen to you and actually talk back to you, on the same level, same understanding. They do it well".

Health professionals described working in collaboration with patients and their families to support them to be involved in decision making about their own recovery.

"It is very much about collaborative care and listening and making sure they (the patient and family) feel very much involved in the delivery of care".

While health professionals recognised the importance of including family and carers in care planning, they lamented that this did not always happen.

"We try to see relatives, spouse or carers within that admission but that doesn't always happen".

In addition to trying to include carers in consultations about care planning, health professionals offered regular carers groups however the attendance was low and intermittent.

"I wish that (the carers group) was more utilised by carers."

Both patients and health professionals recognised the value of peer support on the ward.

"A lot of good stuff comes out of talking, just sharing stories. When you are with other patients who are going through the same thing as you, you don't feel judged or different."

"(Patients) will have their own spontaneous group … that will appropriately get together and talk … good, therapeutic peer support".

Theme 2: Group Program

There were three sub-themes identified under group program: group therapy, group check-in/peer support, and mindfulness.

Group therapy encompassed feedback from both the inpatient and day-patient groups. Unanimously the feedback was that the groups were helpful and enjoyable and in some cases, life-changing and life-saving. The groups provided something to look forward to, especially for day-patients experiencing loneliness and isolation in the community.

"The group therapy helped a lot, enormously".

"They are life changing. If I didn't have those programs to keep the momentum going, I would not be here today".

"I enjoyed having the (day) groups to come to. You had something to look forward to".

Health professionals also saw group therapy as being an important part of treatment provided.

"The groups are really invaluable".

There were two activities in the groups that patients spoke about consistently: check-in and the benefits of learning mindfulness. In relation to check-in, it was the peer support that was

seen as the most important part of this process. Check-in was a process at the beginning of each group where patients shared their experience between group sessions, including the 'ups and downs' of their week.

> "Check-in was like your own like your own little personal therapy and everyone could help you and give their experience as well, so I think check-in was really useful".

> "The check-ins were something myself and all the other participants looked forward to. It's so important".

Patients talked about initially not understanding the usefulness of mindfulness but then it becoming an important tool that they learnt to appreciate with practice.

> "I always thought (mindfulness) was a load of crap and now I'll sit down outside and just look at the leaves in the tree. When you are in a bad place, it'll put you in a better place. I've learnt that through coming here (to day-groups)".

Theme 3: Multi-disciplinary Team

There were two sub-themes identified under a multi-disciplinary team: mental health nursing and allied health. Health professionals and patients talked about how imperative it was for mental health nurses to take the time to talk to patients one-to-one.

> "(Nurses) taking time out, without rushing and talking me through things".

There was recognition from health professionals from across the hospital that mental health nursing is different from working in medical or surgical wards.

> "It's more about one-to-one or groups and spending that time. It's a different type of nursing and a different pace".

In addition to nursing staff, health professionals and patients recognised the contribution of the allied health staff who facilitated the group programs and provided one-to-one interventions for inpatients.

> "The allied health staff have a really good input in terms of psychologists and the individual psychotherapy and the groups; the OT, particularly looking at structure activities".

> "The psychologists are really good. The sessions that we have with them. The psychologists talk more about the cognitive side of things. That's as important, if not more important, to your recovery than the actual drugs".

Organisational Support for Recovery *(Note: While the thesis does touch on the importance of organisational support for recovery, the focus is on the conceptualisation of recovery and what staff do that is recovery-oriented. Therefore, this theme was incorporated into the recovery-oriented practice theme for the thesis).*

Theme 1: Time, Resources and Training

Two sub-themes comprised the theme of time, resources and training: staffing and staff training.

'Staffing' could be alternatively called 'paperwork versus time to talk' as it reflected the challenge of staff being too busy to spend time talking to patients.

> "Sometimes they (nurses) are too busy to sit down (to talk) because of their workload".

> "Spending little time with (patients) and too much time completing paperwork".

Staff training reflected the lack of skills and knowledge of generalist nursing staff in knowing how to have a conversation with patients.

"Some up-skilling and training in therapeutic discussion with the patient".

Health professionals, including experienced mental health staff, acknowledged the need to stay up to date with recovery policy and practice for service provision.

"Training and looking at what we offer to keep up to date with concepts around recovery and service provision."

Theme 2: Environment *(Note: While environment factors were identified in the consultation process, the focus of the thesis is on the conceptualisation of recovery and what staff do that is recovery-oriented. The theme everyday living picks on on the importance of a return to activities of everyday living.)*

There were two sub-themes identified under environment: facilities and diversional activities.

Facilities covered the management of the physical assets and comfort of the environment provided on the ward. Issues raised by patients included problems with the temperature of the air conditioning (being either too hot or too cold in some rooms) and wanting more space for activities.

"Does anyone else have a problem with the air conditioning in their room? That's something that really needs to be sorted".

"Meditation is important. A designated room, a quiet space".

Patients talked about wanting more diversional activities on the ward, in addition to the therapy groups, and some outings away from the ward.

"They don't have enough activities here. It gets boring. Groups help but they're not fun".

Health professional also commented on wanting to see more outings, and patients having input into what these included at the weekly ward meetings.

"I'd like to see more outing. (The outings) can be structured from patient input into (the) weekly meetings". Research Project: From Policy to Practice: Implementation of Recovery-Oriented Practice

SUMMARY OF THEMES

Thank you for participating in this research project which has been a collaboration between CQUniversity PhD Candidate (Leonie Lorien), Archerview's Consumer Advocate ([Lea]) and seven Archerview staff members ([Frankie, Chris, Jordan, Eden, Charlie, Kim and Alex]).

The project aimed to answer the research question: How do we collaboratively enhance and deliver recovery-oriented practice at Archerview Clinic?

Consultation Outcomes

The consultation with key stakeholders identified three themes: lived experience of recovery, recovery-oriented practice and organisational support for recovery. Within each theme there were a number of sub-themes described below.

Lived Experience of Recovery

1. **Different Pathways**. Participants spoke about a myriad of pathways to recovery which was seen as a personal journey for each consumer.

2. **Challenges**. Consumer participants talked extensively about the challenges of recovery. Challenges were grouped under the headings: It's not easy, ups and down, hopelessness and distress, and lack of support/understanding and isolation in the community.

3. **Living-Well.** Living-well comprised everyday living, hope and acceptance and self-efficacy. Consumers described recovery as being able to do everyday things like

socialising and working. Hope and acceptance included having something to look

forward to and also acceptance of living with a mental illness. Self-efficacy reflected

consumers' acknowledgement that they needed to take some responsibility for their

own recovery.

Recovery-Oriented Practice

1. **Care Planning**. This theme comprised medical treatment, recovery planning and

    post-discharge support. Consumers commented on how being diagnosed helped their

    understanding, and the importance of medical treatments to their recovery. Recovery

    planning was discussed by health professionals in relation to completing recovery

    plans with consumers and their families. Consumers identified follow-up phone calls

    after as important but with a mixed appraisal of the helpfulness.

2. **Culture**. An important aspect of the supportive culture on the ward was health

    professional holding hope for consumers when they were acutely unwell. Consumers

    talked about the ward feeling like a safe, supportive place where their felt understood

    and listened to by staff. Health professionals recognised the importance of including

    family and carers however they noted the low attendance rates at carers groups. Both

    consumers and health professionals recognised the value of peer support on the ward.

3. **Group Program**. Unanimously the feedback from consumers was that the therapy

    groups were helpful and enjoyable and in some cases, life-changing and life-saving.

    Health professionals also saw group therapy as being an important part of the

    treatment provided. There were two activities in the groups that consumers found the

    most useful: check-in and learning mindfulness.

4. **Multi-disciplinary Team**. Consumers and health professionals talked about how

    important it was for mental health nurses to take the time to talk to consumers one-to-

one. There was recognition from health professionals from across the hospital that

mental health nursing is different from working in medical or surgical wards. In

addition, consumers recognised the contribution of the allied health staff who

facilitated the group programs and provided one-to-one interventions.

Organisational Support for Recovery

1. **Time, Resources and Training**. This theme reflected the tension between staff

   needing to complete administrative tasks and having time to talk. It also identified the

   needs for additional training for generalist nursing staff in knowing how to have a

   conversation with consumers.

2. **Environment**. The environment included facilities and diversional activities on the

   ward. Issues raised by consumers included wanting more space for activities and more

   diversional activities, including outings.

Actions

Co-researchers agreed on the following actions, based on the consultation outcomes, under

each theme:

1. **Lived Experience of Recovery**. To have a Guest Book the consumers who are

   discharging can write in to provide hope for the next consumers coming through.

2. **Recovery-Oriented Practice**. Co-researchers identified the need to re-brand the

   carers group so it was inclusive of all the people who might support a consumer

   (partners, parents, children, close friends) and to make the focus on providing

   information about what's happening on the ward**.**

3. **Organisational Support for Recovery**. Co-researchers decided to seek management

   approval for additional staff training, especially related to having conversations with

   consumers about risk and safety. In addition, Co-researchers decided to make changes

to the procedures for follow-up phone calls, including developing a template for staff

to use and more time to have the conversation**.**

Questions/Further Information

If you have further questions about this research, you may contact Leonie Lorien (PhD

Candidate) at the following email address: l.lorien@cqu.edu.au or Dr. Wendy Madsen

(CQUniversity PhD Supervisor) at w.madsen@cqu.edu.au This project has been approved by

the CQUniversity Human Research Ethics Committee, reference number (0000020680) and

Greenslopes Private Hospital Ethic Committee, protocol number (17/44).

Table C-9

Endorsement of conceptualisation of recovery themes

Number (and Percentage) of Professionals and Consumers endorsing each Theme and Sub-theme

Theme/ Sub-themes	Professionals	Professional Responses	Consumers	Consumer Responses	All Participants	Total Responses
Theme: Different Pathways	**14(63%)**	**24**	**7 (41%)**	**13**	**21(54%)**	**37**
No one cap fits all	5 (23%)	6	3 (18%)	5	8 (21%)*	11
Recovery track	7 (32%)	11	4 (24%)	6	11 (28%)*	17
Getting back to where we were	0	0	2 (12%)	2	3 (8%)*	3
Limited Knowledge of Recovery	6 (27%)	9	0	0	6 (15%)	9
Theme: Challenges	**2 (9%)**	**2**	**15 (88%)**	**96**	**17 (44%)***	**98**
It's not easy	0	0	8 (47%)	17	10 (26%)*	17
Ups & downs	2 (9%)	2	10 (59%)	14	12 (31%)*	16
Hopelessness & distress	0	0	10 (59%)	26	10 (26%)*	26
Lack of support/ Understanding & Isolation	0	0	12 (71%)	39	12 (31%)*	39
Theme: Living-Well	**3 (14%)**	**9**	**10 (59%)**	**27**	**13 (33%)***	**36**
Everyday living	2 (9%)	2	7 (41%)	10	9 (23%)*	12
Hope & acceptance	0	0	4 (24%)	4	4 (10%)*	4
Self-Efficacy	3 (14%)	7	9 (53%)	13	12 (31%)*	20

Note: Professionals = 22; Consumers = 17; All Participants = 39

Number (and Percentage) of Health Professionals and Consumers endorsing each theme/sub-theme identified under Recovery-Oriented Practice

Table C-10

Endorsement of recovery-oriented practice themes

Number (and Percentage) of Professionals and Consumers endorsing each Theme and Sub-theme

Theme/ Sub-themes	Professionals (P)	Professionals Responses	Consumers (C)	Consumer Responses	All Participants	Total Responses
Relational Recovery	**10 (63%)**	**52**	**16 (95%)**	**53**	**26 (67%)**	**105**
Relationship between Professionals & Consumers	8 (36%)	34	16 (95%)	38	24(62%)	72
Inclusion of Carers	7 (32%)	14	9 (53%)	12	16 (42%)	26
Peer Support	3 (14%)	4	3 (18%)	3	6 (15%)	7
Group Program	**8 (36%)**	**14**	**13 (76%)**	**65**	**21 (54%)**	**79**
Group Facilitators	8 (36%)	12	13 (76%)	41	21	53
Check-in	0	0	9 (53%)	11	9 (23%)	11
Mindfulness	1 (5%)	2	8 (47%)	13	9 (23%)	15
Medical Treatment	**6 (27%)**	**20**	**7(41%)**	**14**	**13 (33%)**	**34**
Diagnosis						
Medication						
Theme: Care Planning	**10 (63%)**	**51**	**12 (71%)**	**27**	**22 (56%)**	**78**
Recovery Care Planning	6 (27%)	25	0	0	6 (15%)	25
Follow-up Phone Calls	4 (18%)	6	8 (47%)	13	12 (31%)	19

Note: Total Research Participants: = 22; Consumers = 17; All Participants = 39