Recovery-Oriented Care in Acute Inpatient Mental Health Settings: An Exploratory Study

Article *in* Issues in Mental Health Nursing · July 2014

DOI: 10.3109/01612840.2014.890684 · Source: PubMed

7 authors, including:

Trentham Furness
Australian Catholic University
43 PUBLICATIONS **104** CITATIONS
SEE PROFILE

Deepa Dhital
Wyndham City Council
11 PUBLICATIONS **7** CITATIONS
SEE PROFILE

James Houghton
University of Melbourne
3 PUBLICATIONS **3** CITATIONS
SEE PROFILE

Issues in Mental Health Nursing, 35:526–532, 2014

ISSN: 0161-2840 print / 1096-4673 online
DOI: 10.3109/01612840.2014.890684

informa
healthcare

Recovery-Oriented Care in Acute Inpatient Mental Health Settings: An Exploratory Study

Brian McKenna, RN, BA, MHSc (Hons), PhD
Australian Catholic University, School of Nursing, Midwifery and Paramedicine, Fitzroy and NorthWestern Mental Health, Melbourne Health, Parkville, Australia

Trentham Furness, PhD
School of Nursing, Midwifery and Paramedicine, Australian Catholic University, Fitzroy, Australia

Deepa Dhital, PhD
Australian Catholic University, School of Nursing, Midwifery & Paramedicine, Fitzroy, Australia

Garry Ennis, RN, BHSc, PGCert
NorthWestern Mental Health, Melbourne Health, Parkville, Australia

James Houghton, RN, BHSc, PGDip
NorthWestern Mental Health, Melbourne Health, Parkville, Australia

Christine Lupson, RN, PGCert
NorthWestern Mental Health, Melbourne Health, Parkville, Australia

Nigel Toomey, RN, PGDip
NorthWestern Mental Health, Melbourne Health, Parkville, Australia

Australian mental health nurses will need to care with consumers of mental health services, within the domains of recovery. However, in acute inpatient mental health settings, nurses are without a clear description of how to be recovery-oriented. The intent of this qualitative study was to ask nurses to reflect on and describe current practice within acute inpatient services that are not overtly recovery-oriented. Results show that nurses can identify recovery and articulate with pragmatic clarity how to care within a recovery-oriented paradigm. Pragmatic modes of care described by nurses support using "champions" to assist with eventual system transformation in the delivery of mental health services.

Recovery-oriented care is the policy directed, preferred mode of clinical practice among acute inpatient (McLoughlin, Du Wick, Collazzi, & Puntil, 2013), forensic (Drennan, Law, & Alred, 2012), and community mental health services (Whitley, Gingerich, Lutz, & Mueser, 2009). Recovery is a broad empirical and philosophical paradigm (Leamy, Bird, LeBoutillier, Williams, & Slade, 2011) that emphasizes an individual's journey to a full and productive life, with or in the absence of episodes of mental illness (Drake & Latimer, 2012; Onken, Craig, Ridway, Ralph, & Cook, 2007). Consumers of mental health services have expressed their recovery journey as a desire to attain a good life (Oads & Anderson, 2012; Turton et al., 2011). Among Australian mental health services, recovery-oriented service delivery is expected to adapt to the needs and aspirations of each consumer and assist with each person's unique journey (Department of Health and Aging, 2013). The onus is on health professionals to care within the domains of recovery-oriented practice—to promote a culture of hope, autonomy, and self-determination through holistic and personalised care; to establish collaborative partnerships and meaningful engagement; to focus on consumers' strengths; to include families and carers; and to encourage community participation and citizenship (Department of Health, 2011).

However, in acute inpatient mental health settings characterised by high acuity, rapid turnover, a perception of risk, and involuntary treatment (Bowers & Flood, 2008; Horsfall, Cleary, & Hunt, 2010), mental health nurses are grappling with how recovery-oriented practice applies in their workplace

Address correspondence to Brian McKenna, Australian Catholic University, School of Nursing, Midwifery & Paramedicine, 115 Victoria Parade, Fitzroy, 3065 Australia. E-mail: brian.mckenna@mh.org.au

(Aston & Coffey, 2012; Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013). Education that focuses on the need for care to be recovery-oriented is endorsed (McLoughlin, Du Wick, Collazzi, & Puntil, 2013), and mental health nurses acknowledge the importance of collaboration and a strengths-focus in supporting consumers' recovery journeys (Cleary et al., 2013; Woodbridge & Fulford, 2004). Concurrently, the inability of mental health nurses to include empowerment, social inclusion, or peer support in their definition of recovery (Cleary et al., 2013), despite evidence for the importance of such (Department of Health, 2011; Leamy et al., 2011), requires further understanding. As such, knowledge about current models of care that may fit within the domains of recovery, and pragmatic descriptions of how to practice recovery-oriented care in acute inpatient settings, remains scant.

The intent of this qualitative study is to allow mental health nurses the opportunity to reflect on and describe current practice within services that are not yet required to use the recovery-oriented care model. The aims are to determine the extent to which elements of existing nursing practice resemble the domains of recovery-oriented care and to provide a baseline understanding of practice in preparation for transformation to recovery-oriented services reflected in policy directives (Department of Health, 2011; Department of Health and Aging, 2013).

METHODS

Research Design

An exploratory research design, which is used when a problem is not clearly defined (Stebbins, 2001), was used to meet the research aims. This approach involves qualitative in-depth focus group interviews (Kitzinger, 1995). This research meets the ethical requirements of the Melbourne Health Office for Research.

Participants

A purposive sample of mental health nurses was recruited in five acute inpatient services within a large mental health service provider from July to September, 2013 using a hospital-based informational flyer that invited nurses to participate in a one-off focus group. A 60–90-minute focus group was conducted at each acute inpatient service. A total of 46 mental health nurses voluntarily provided informed consent to participate in this research.

Procedures

The focus group interview schedule enquired about current practice based on the domains of recovery-oriented care in the Australian context (Department of Health, 2011): (1) to promote a culture of hope, autonomy, and self-determination through holistic and personalised care, (2) to establish collaborative partnerships and meaningful engagement, (3) to focus on strengths, (4) to include families and carers, and (5) to encourage community participation and citizenship. For example, mental health nurses were asked if their "care focuses on the strength of consumers?" with prompts to describe how their clinical practice may focus on strengths and to provide specific pragmatic examples. The focus group interview schedule was identical across all five focus groups. The same researcher conducted all focus groups. Responses were recorded to an audio-digital recorder (Sony ICD-PX333M).

Data Analysis

A general inductive approach was used to analyse the qualitative data (Thomas, 2006) with the use of NVivo (QSR International Pty Ltd. Version 10). The coding was aligned with the pre-existing domains of recovery previously described (Department of Health, 2011). As necessary during analysis, content and codes were either collapsed or split into pre-existing or different categories until central relationships began to emerge (Patton, 2002). Each pattern was examined for supporting quotes from the data. Rigor was enhanced by collective agreement among the research team on the categorical analytic framework, emergent patterns, and supporting evidence (Guba & Lincoln, 2005; Mays & Pope, 1995).

RESULTS

Description of Focus Group Participants

A total of 46 mental health nurses (mean years of mental health nursing experience = 9) participated in the five focus groups. The range of years' experience in an acute inpatient mental health setting was 1–21 years ($M = 4$ years). The majority of nurses were female ($n = 25$). The nurses were trained in Australia ($n = 27$), the United Kingdom ($n = 10$), New Zealand ($n = 4$), India ($n = 3$), Singapore ($n = 1$), and Ireland ($n = 1$).

Content Domains

The mental health nurses in this study readily discussed aspects of their current practice that they thought integrated into the recovery domains upon which the interview schedule was based. These aspects of their practice are discussed below in detail under the recovery domains and summarised in Table 1.

Hope—Crucial to Starting the Recovery Journey

Initiating the consumer's recovery journey toward a better life was seen as being challenged by the context of the acute inpatient environment:

> I think it's hard in inpatient settings, often initiating recovery is not what the consumer wants. So they will come in, they will be admitted to high dependency, they will be an involuntary patient and they don't want to be here, they don't want to talk to you.

Yet, supporting a culture of hope was viewed as a fundamental clinical need to a pathway forward. Central to supporting hope

TABLE 1
Pragmatic Examples of Recovery-Oriented Care across Acute Inpatient Units

Recovery Domain	Pragmatic Processes
Creating/supporting hope	Collaborative care planning Narrative discussions with the consumer Focussing on short-term achievable steps Respect for the unique consumer circumstance Gently prepare the way forward
Promoting autonomy and self-determination	Immediate awareness of need to rebuild autonomy Encourage engagement in compulsory treatment Discussion of illness and situations that temper crisis Exploring flexibility around limited choice Gradual introduction of psychoeducation • Recognise early warning signs • Medication compliance • Maintain wellness
Collaborative partnerships and meaningful engagement	Advocate the consumers' needs in multidisciplinary decision-making forums Micro-communication • Build trust • Build rapport • Validate • Affirm • Corridor conversations Peer support co-facilitation
A focus on strengths	Identification • Read case files (past successful outcomes) • Micro-communication skills (unstructured) • Hobbies • Ambitions • Enjoyable pursuits Difficulties re-framed as unrefined strengths • Short- and long-term goal achievement strategies • Incorporate multidisciplinary team members
Holistic and personalised care	Sensory modulation Gender sensitive areas in the ward Providing prayer mats for religious obligations Meeting religious meal preferences Involve family and carers • Family meetings and family peer support meetings • Flexible visiting hours
Community participation and citizenship	Learn/relearn life and social skills • Create and maintain a clean living space • Tidy up • Do laundry • Prepare food Case manager visits to the unit (continuity of care)

was developing the collaborative planning of care. This clinical process commenced through narrative discussions with the consumer:

> . . . basically, it's about going out and starting the conversation and working it out from there. What their physical needs are, their mental needs, and working from there.

Mental health nurses expressed the need to avoid overwhelming the consumer during these tentative negotiations. Rather, a collaborative focus was directed at the small steps of the recovery journey achievable within the short time frame of the consumer's stay in the acute inpatient setting:

> I try to find just one collaborative thing the [consumer] and I can work on together . . . and that way we have at least got this collaborative approach to something.

It was viewed as imperative that the collaborative planning of care was not imposed on the consumer; that there was respect for the consumer's acute circumstances. The metaphor of recovery as a non-linear journey implied obstacles that slow progress down and that need to be traversed. Admission to inpatient services was seen as one such obstacle and mental health nurses expressed the need to gently prepare the pathway forward:

> . . . some people say that they are happy the way they are . . . So what I do is that I just plant the seed of hope—of what they could do when they are ready . . . I don't think you can make someone take that journey.

Promoting Autonomy and Self-Determination

Promoting autonomy and self-determination presented as a conundrum for the mental health nurses as many consumers enter the acute inpatient setting under circumstances of legal coercion, through little choice of their own. The nurses were aware of this paradox and for the need to rebuild a sense of autonomy with consumers from the onset of admission. Initially, consumers were encouraged by mental health nurses to engage with compulsory treatment. Conversations occurred about the experiences of being unwell and what helped to temper those experiences. Although the degree of choice was minimal, flexibility was explored, as limited as that might be. As such the conundrum did present as an ethical challenge: negotiating limited choice, when in reality, there was none:

> "You can choose an injection or a tablet." Like, I think sometimes we try to create choice when there is no choice. It may be an illusion of choice—"Where do you want your depot? In your arm or in your buttock?"

The exploration of flexibility around compulsory treatment required the nurses to take an advocacy role. One pragmatic solution was for the mental health nurse to become the spokesperson for consumer concerns and wishes in multidisciplinary decision-making forums:

> Advocating really helps with the rapport because often [consumers] might say, "I have been on this medication for so long but no one told me," or "my dose has been increased but I didn't know." Then we go and have a chat with the doctor and possibly get the doctor to sit down and talk to the [consumer] about it.

Autonomy and self-determination were gradually supported through psychoeducation, as the acuity of illness associated with admission was resolving. The intent of psychoeducation was to increase autonomy, in increments, with the goal of maximising the consumer's decision-making at the time of discharge.

> You are slowly trickling information, paralleling their decision making ability.

To this end, the mental health nurses discussed being involved in education about early warning signs, medication compliance, and the maintenance of wellness. Some nurses expressed enthusiasm for the use of advanced directives whereby the starting point for choice at the time of admission is negotiated when the consumer is well, prior to a potential hospital admission:

> What I am really looking forward to in the new Mental Health Act is advanced directives and the emphasis on it . . . where people are making informed decisions when they are well and these are decisions that the service will respect.

Collaborative Partnerships and Meaningful Engagement

Micro-communication skills of mental health nurses were central for genuine engagement and establishing meaningful partnerships. Getting to know and connecting with the consumer by building rapport and founding trust were crucial. The skills of positive affirmation and listening to a consumer's concerns (validation) were central to the recovery journey. However, the mental health nurses lamented the lack of time to sometimes prioritise this vital need:

> There is so much going on. You are allocating in your mind when you are to go and spend time with that [consumer], but something else will happen.

Instead of the luxury of a designated time to engage to facilitate collaborative partnership and meaningful engagement, the nurses discussed the importance of making the most of opportune moments. They described passing conversations with consumers in corridors as key moments to engage. Small-talk focused on discussions of the meals and living environment in the unit. Discussions on hobbies, pets, loved ones, and sports were seen as a necessary prelude to more meaningful engagement.

> They have a cat at home and somebody they love, and they enjoy football and things like that. Talking to them about all the other things in their life.

Continuity of care and the time to engage were seen as necessary to strengthen collaborative partnerships and meaningful engagement. Building on the largely superficial overtures of passing conversations, some nurses discussed the benefits of primary nursing:

> Yeah, we have a primary nursing care model in place and, you know, we are getting time to talk with the [consumers]. . . . So, there is that

> contact person who knows that much more about the individual than perhaps the rest of the collective nursing group.

Other mental health nurses discussed pragmatic means of creating the opportunity to engage with consumers in meaningful ways unique to their work environment. For example, one acute inpatient unit was exploring the notion of protected therapeutic time. Management would consider release from administrative roles to allow nurses protected time to engage meaningfully with consumers. Other units had developed a specialist admission and discharge role to relieve administrative responsibilities. Two acute inpatient units had developed psychoeducation group programmes, co-facilitated by a clinician and a peer support worker, as a means of allowing nurses to engage at a meaningful level.

> The group program where consumers co-facilitate ... They come along to the group and people are able to talk to them more than they can to us at times. So it's really important.

A Focus on Strengths

The mental health nurses prioritised focusing on the strengths of consumers, once strengths were identified. To identify strengths, the nurses would most commonly read consumer case files and engage in everyday conversations with consumers. Strengths were commonly understood and articulated through conversations about hobbies, ambitions, and around enjoyable pursuits.

> I try to identify one strength that I see in them and say, "Oh, that's fantastic!" In the conversation I find they have a hobby or something, and I focus on that, and say how great it is that they do such and such. It also builds rapport.

For consumers with multiple admissions to the acute inpatient unit, past successful outcomes of hospitalisation were highlighted as strengths and affirmed as evidence of the potential for positive outcomes from the current admission:

> Always be optimistic and say, you know, you come back again but it's not the end you know, it's just another phase, it's another time, and we will take it for what it is. Then, you know, we try to work strength from that and maintain that optimism.

The mental health nurses reframed previous difficult lived experiences as unrefined strengths and systematically devised strategies (short- and long-term goals) to develop these, often including input from other multidisciplinary team members.

Holistic and Personalised Care

There was a belief by the mental health nurses that they were involved in holistic care. Involvement in sensory modulation, as a de-escalation therapy to avoid more restrictive interventions such as restraint and seclusion, was cited as an example. The nurses talked about the use of music, perfumed oils, weighted blankets, and visually soothing media to assist consumers in regulating their emotional responses.

However, again the mental health nurses talked about the pressure of time impinging on the ability to be holistic and requiring referral of holistic needs to other members of the multidisciplinary team:

> I guess the line of demarcation is little bit clearer in the inpatient unit because we do have a social worker team, we do have an occupational therapy team, we do have a recreation officer, so everyone collaborates, and it does become holistic.

Evidence of holistic and personalised care across the acute inpatient units was noted in the nurses' responsiveness to diversity and the incorporation of social, cultural, and religious needs. To accommodate specific gender requests, the mental health nurses spoke of establishing male, female, and unisex areas within the unit and in outdoor areas. Empowering consumers to continue their religious practices involved the supplying of prayer mats, organising meals, and facilitating visits by local religious leaders. During Ramadan, for example, clinicians were cognisant and flexible with medication schedules to accommodate fasting. Knowledge of these needs was assisted by the cultural diversity of the nursing staff.

> A male [consumer] we had, he did not want to take any medications during the day because of fasting at Ramadan. We were respecting of him not taking medications until dusk or whenever he was allowed to eat or drink.

A holistic approach also was discussed through the proactive inclusion of family and carers within the collaborative partnership with consumers. Within the acute inpatient environment, the views and involvement of carers was sought. Family meetings and regular family peer support sessions were arranged. Visiting hours were flexible and modified to suit the circumstances of carers in an effort to support the holistic and personalised care of the consumer:

> We talk to the family whenever they are visiting the consumers and explain what is happening. We have to maintain confidentiality according to the consumer's permission. But if the person [consumer] is happy, we talk to the family.

Community Participation and Citizenship

Acute inpatient admission is only a small phase of the recovery journey. The mental health nurses were aware that this phase required integration into a better life in the community:

> We can only start the recovery process. It has to be continued in the community because it is not only about maintaining the symptoms. It is about learning to manage the symptoms and living an adequate life.

The short duration of admission was viewed by the nurses as an opportunity for consumers to learn and relearn life and social skills. Essential skills to assist consumers with community participation and citizenship focussed on creating and maintaining an organised and aesthetically clean environment. Consumers were assisted and encouraged to tidy up, do their laundry, and

on some occasions, prepare food. This strategy also was thought to build confidence and self-esteem.

> So, little things, like learning not to live in a mess . . . so [consumers] can help to tidy up. Learn to use the laundry and the washing machine because nobody is going to be around at home . . . They start developing confidence and self-esteem.

However, again, there was a challenge to maintain this focus in the context of high acuity and rapid turnover in the inpatient environment. As one nurse commented:

> So our primary role as nurses . . . we are here to get them back on track, but with the time element, it's very fast. The turnover is quick here, in-out, in-out. We do our best with the resources we've got, with the knowledge that we have, to empower [consumers] enough to get them going through the next step. . . . We used to take [consumers] down to the market and stuff like that. But, it has been about a year since I last did that.

It was seen as important that the inpatient stay did not sever the continuity of the recovery journey, which happens primarily in the outside world. Continuity of care with external support agencies was encouraged. This was most successful in relation to community mental health services whereby, in some services, case managers would visit consumers during admission at the inpatient unit:

> If there is a case manager allocated, we try to arrange for the case manager to come in and meet the person before they are discharged—just to touch base and start to build the rapport.

The mental health nurses also were cognisant of the need for the continuity of therapeutic processes, started in the inpatient units, to flow over into engagement with similar processes in community mental health services.

> We started a drug and alcohol process here, so we go through withdrawal management and do some harm minimization. So, we can pass that onto one of our community services and involve them post-discharge as well, so that they can continue our work.

DISCUSSION

Results of this study describe the extent to which mental health nurses pragmatically apply a recovery-oriented model of care in acute inpatient mental health units that are not overtly recovery-oriented. These findings support earlier work of awareness of recovery-oriented care (Cleary et al., 2013) and add descriptions of nurses' willingness to engage in a model of care that supports empowerment, social inclusion, and peer support through advanced directives, care planning, protected therapeutic time, and continuity of care. Pragmatic examples of sensitivity to cultural behaviour and spiritual processes by nurses in this study are supported within mental health nursing literature (Holland & Hogg, 2010; Thompson, 2002) and further reinforce the intent and full potential to be recovery-oriented when the time for system transformation arrives.

The use and examples of micro- and phatic communication by mental health nurses in this study to establish rapport, affirm consumers, and lead to meaningful engagement resemble previously published literature on the topic (e.g., Burnard, 2003; Crawford & Brown, 2009). Nurses strongly advocated for time to allow phatic communication to develop into more meaningful engagement and lamented the absence of such. Concerns about the absence of time, or potential rationing of nursing care, are not uncommon among nurses in general, regardless of years of experience, location, and size of health service (Aiken, Sloabe, Bruyneel, Van den Heede, & Sermeus, 2012; Schubert, Clarke, Aiken, & de Geest, 2012). Mental health nurses have described the negative effect of administrative load (Cleary, 2003). As such, consumers have expressed the negative effect of unmet expectations regarding protected therapeutic time (Stenhouse, 2010).

Accordingly, the challenges of systemic mental health service change in acute inpatient settings have been described and broadly include quality of care, staff workload, professional support, attitudes of staff, and the culture of the service (Cleary, 2004; Davidson, Tondora, Staebeli Lawless, O'Connell, & Rowe, 2008; Shepherd, Boardman, & Burns, 2010). The results of this study indicate that regardless of how the National policy of recovery-oriented care may be applied in the near future, mental health nurses are challenged more by the structure of the health service than the comprehension of recovery-oriented care as a new paradigm of mental health service delivery.

As mental health services across Australia begin the systemic transformation to a recovery-oriented model of care, results of this study show that a cohort of mental health nurses with a broad range of experience within the acute adult setting (1–21 years) can identify recovery in their units and articulate with pragmatic clarity how to care within a recovery-oriented paradigm (see Table 1). As recovery-oriented service provision is now central to mental health policy in Australia (Department of Health and Aging, 2013; Oades & Anderson, 2012), the pragmatic modes of care described by mental health nurses in this study support the notion of having champions of change, who would be essential for a cultural shift to take place within mental health services (Crowe, Oades, Deane, Ciarrochi, & Williams, 2011; Hadikin, 2004; Oades & Anderson, 2012).

Limitations of this Research

The pragmatic descriptions that fit within the domains of recovery-oriented care by mental health nurses in this study were collected with a small number of nurses in one of Australia's largest mental health services. As such, data may not represent the model of care used by mental health nurses across other areas of the service, or indeed, mental health nurses in general. Nurses who were ill-informed about recovery-oriented care, or were resistant to the concept, may not have consented to the focus groups, leading to a potential selection bias. As recovery-oriented care enables the consumer to be proactive about their journey, the results of this study are limited without the opinions of consumers within the multidisciplinary service.

Therefore, generalisations about the effect of care that resembles recovery-oriented domains may not be externally valid without consumer, carer, and multidisciplinary team input. Furthermore, focus group questions were leading, rather than facilitating an open-ended group discussion on recovery at the discretion of participants.

Future Research

Mental health nurses in this study indicated their existing nursing practice was recovery-supportive despite the acute context of service delivery, which is pressured by high acuity, rapid acuity, risk assessment and management, and involuntary treatment. Furthermore, given the absence of specific templates that articulate the fine details of recovery-oriented care, the results highlight a proactive approach to service delivery. Future research could (1) seek pragmatic examples of recovery-oriented care among other multidisciplinary stakeholders within acute inpatient mental health services, (2) seek opinions of consumers and carers about how recovery should look and feel in acute inpatient units, and (3) devise strategies to assist the recovery-oriented care transition in acute inpatient units that support mental health nursing care.

Declaration of Interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

REFERENCES

Aiken, L., Sloane, D., Bruyneel, L., Van den Heede, K., & Sermeus, W. (2012). Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe. *International Journal of Nursing Studies*, *50*(2), 143–153.

Aston, V., & Coffey, M. (2012). Recovery: What mental health nurses and service users say about the concept of recovery. *Journal of Psychiatric and Mental Health Nursing*, *19*, 257–263.

Bowers, L., & Flood, C. (2008). Nurse staffing, bed numbers and the cost of acute psychiatric inpatient care in England. *Journal of Psychiatric & Mental Health Nursing*, *15*, 630–637.

Burnard, P. (2003). Ordinary chat and therapeutic conversation: Phatic communication and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *10*, 678–682.

Cleary, M. (2003). The challenge of mental health care reform for contemporary mental health nursing practice: Delivery of nursing care. *International Journal of Mental Health Nursing*, *12*, 213–222.

Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*, *13*(1), 53–60.

Cleary, M., Horsfall, J., O'Hara-Aarons, M., & Hunt, G. (2013). Mental health nurses' views of recovery within an acute setting. *International Journal of Mental Health Nursing*, *22*, 205–212.

Crawford, P., & Brown, B. (2009). Mental health communication between service users and professionals: Disseminating practice-congruent research. *Mental Health Review Journal*, *14*(3), 31–39.

Crowe, T., Oades, L., Deane, F., Ciarrochi, J., & Williams, V. (2011). Parallel processes in clinical supervision: Implications for coaching mental health practitioners. *International Journal of Evidence Based Coaching and Mentoring*, *9*, 56–66.

Davidson, L., Tondora, J., Staebeli Lawless, M., O'Connell, M., & Rowe, M. (2008). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. New York, NY: Oxford University Press.

Department of Health. (2011). *Framework for recovery-oriented practice*. Melbourne, Australia: Mental Health, Drug and Regions Division, Victorian Government.

Department of Health and Aging. (2013). *A national framework for recovery-oriented mental health services: Policy and theory*. Retrieved from http://www.ahmac.gov.au/cms_documents/National%20Mental%20Health%20Recovery%20Framework%202013-Policy&theory.PDF

Drake, R., & Latimer, E. (2012). Lessons learned in developing community mental health care in North America. *World Psychiatry*, *11*(1), 47–51.

Drennan, G., Law, K., & Alred, D. (2012). Recovery in the forensic organization. In G. Drennan & D. Alred (Eds.), *Secure recovery* (pp. 55–72). Oxon, UK: Routledge.

Guba, E., & Lincoln, Y. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 191–216). Thousand Oaks, CA: Sage.

Hadikin, R. (2004). *Effective coaching in healthcare*. London, UK: Elsevier Science.

Holland, K., & Hogg, C. (2010). *Cultural awareness in nursing and health care* (2nd ed.). Boca Raton, FL: CRC Press.

Horsfall, J., Cleary, M., & Hunt, G. (2010). Acute inpatient units in a comprehensive (integrated) mental health system: A review of the literature. *Issues in Mental Health Nursing*, *31*, 273–278.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal*, *311*, 299–302.

Leamy, M., Bird, V., LeBoutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*, 445–452.

Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, *311*, 109–112.

McLoughlin, K., Du Wick, A., Collazzi, C., & Puntil, C. (2013). Recovery-oriented practices of psychiatric-mental health nursing staff in an acute hospital setting. *Journal of the American Psychiatric Nurses Association*, *19*(3), 152–159.

Oads, L., & Anderson, J. (2012). Recovery in Australia: Marshalling strength and living values. *International Review of Psychiatry*, *24*(3), 5–10.

Onken, S., Craig, C., Ridway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9–22.

Patton, M. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Schubert, M., Clarke, S., Aiken, L., & de Geest, S. (2012). Associations between rationing of nursing care and inpatient mortality in Swiss hospitals. *International Journal for Quality in Health Care*, *24*(3), 230–238.

Shepherd, G., Boardman, J., & Burns, M. (2010). *Implementing recovery*. London, UK: Sainsbury Centre for Mental Health.

Stebbins, R. (2001). *Exploratory research in the social sciences. Sage university paper series on qualitative research methods, Vol. 48*. Thousand Oaks, CA: Sage.

Stenhouse, R. (2010). "They said you could come and speak to us": Patient's expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric and Mental Health Nursing*, *18*(1), 74–80.

Thomas, D. (2006). A general inductive approach for analysing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246.

Thompson, I. (2002). Mental health and spiritual care. *Nursing Standard*, *17*(9), 33–38.

Turton, P., Demetriou, A., Boland, W., Gillard, S., Kavuma, M., Mezey, G. et al. (2011). One size fits all: Or horses for courses? Recovery-based care in specialist mental health services. *Social Psychiatry and Psychiatric Epidemiology*, *46*, 127–136.

Whitley, R., Gingerich, S., Lutz, W., & Mueser, K. (2009). Implementing the illness management and recovery program in community mental health settings: Facilitators and barriers. *Psychiatric Services*, *60*, 202–209.

Woodbridge, K., & Fulford, K. (2004). *Whose values? A workbook for values-based practice in mental health care*. London, UK: Sainsbury Centre for Mental Health.