The Experience and Meaning of Recovery-Oriented Practice for Nurses Working in Acute Mental Health Services:

A Hermeneutic Phenomenological Study

Bernadette Solomon

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Primary Supervisor: Daniel Sutton

Abstract

New Zealand mental health policy and service provision has shifted from a focus on the management of symptoms and risk to a broader focus on the recovery of psychological, social, cultural, and physical well-being. However, there has been growing concern that people accessing mental health services are not receiving an inclusive, recovery focused service; despite a recovery-orientated vision being integrated within national and regional service policies. There is much evidence to suggest barriers to recovery-focused service provision continue to exist. Current research indicates these barriers include the attitudes, skills, and knowledge of frontline staff, as well as issues with the system in which they work.

This study aimed to explore the experience and meaning of recovery-oriented practice for 10 nurses working in an acute mental health service. A phenomenological and hermeneutic lens was used to explore the nurses' experience of working in a recovery-focused manner with service users in the inpatient setting. Stories of practice were collected from the participants using an open-ended and conversational interview style. The transcribed narratives were then analysed to explore taken-for-granted aspects of working in acute mental health care and to uncover the meaning of being recovery-oriented in this setting.

The findings revealed that recovery-orientated practice is a challenge for nurses working within acute mental health wards. Although the experience and meaning of recovery-focused care varied from nurse to nurse, there were some common elements in the practice accounts. The accounts revealed the nurses' role in creating different therapeutic spaces to promote safety, relational commitment and healing for service users. However, the nurses faced challenges to recovery-oriented care, within the team culture and the broader service systems. The nurses were at times fearless in advocating for service-users and recognised that this was essential for developing recovery-focused services. The findings have implications for nursing practice, as well as training and service development.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

_____

Name: Bernadette Solomon

Date: 20th January 2019

Acknowledgements

I would like to dedicate this doctorate to my parents – James and Brigid McNulty – whom sadly are no longer here. You have always been my inspiration throughout my life, and will continue to be in the future.

Chapter 1: Study Context

Introduction

This study sought to understand how nurses experience and find meaning in recovery-orientated practice while working in acute mental health settings. The emphasis is on the collection of rich narratives from 10 nurse participants to uncover their lived experience of working alongside service users within a busy inpatient mental health service. It is anticipated that the findings will equip nurses, and other mental health professionals, with improved awareness about recovery-oriented practice within acute mental health settings. The insights gained highlight particular barriers and facilitators to working in a recovery-orientated manner and inform the implementation of specific practices, knowledge, training and leadership. A hermeneutic phenomenological lens was used in the investigation, with the main research question asked being: 'What is the experience and meaning of recovery-orientated practice for nurses working in acute mental health services?'

This chapter will provide an overview of the background context to the study. There are several key concepts within this area of exploration, and these will be defined and expanded upon. Firstly, there will be an overview of mental illness and how this affects individuals; following which, there will be an introduction to the notions of recovery and recovery-oriented practice in the mental health context. Further, there will be an overview regarding the inpatient context of nursing practice, followed by a reflective piece from my personal perspective as to what triggered my interest in this study. Finally, there will be an overview of the thesis chapters and structure.

Mental Illness

Mental illness affects hundreds of millions of people throughout the world, and is defined as being "characterized by clinically significant behavioural or psychological syndrome or pattern that occurs in an individual, and is associated with present distress" the definition furthermore states "it must be currently considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual" (Stein, Philips, Bolton et al., 2010 p.1760). Recent studies have indicated that the prevalence of mental illness is growing and people are living with a variety of conditions, with the most common disorders being anxiety and depression, schizophrenia, bipolar disorder, and alcohol and substance disorders (World Health Organisation, 2013). Mental illness currently accounts for about 13% of the global disease burden, with the World Health Organization

(2013) estimating that around 450 million people worldwide have a mental health issue and that depression alone is accountable for 4.4% of the global burden of disease. People with mental disorders often face severe and painful experiences, as well as disability due to mental health issues. They also experience disproportionately higher rates of physical disability and mortality (World Health Organization, 2013). For example, people with a diagnosis of schizophrenia and major depression are at 40-60% increased risk of dying prematurely compared to the general population; usually due to associated physical health issues that have been neglected. In addition, suicide is rated the second most common cause of death among the youth population worldwide (World Health Organization, 2013).

Mental disorder is common in New Zealand. The key findings of *Te Rau Hinengaro: the New Zealand mental health survey* (Ministry of Health, 2006), highlighted that around 46.6% of the entire population will experience mental health issues at some time during their lives. It raised concern that the prevalence of mental disorder in New Zealand (over a 12 month period, excluding a diagnosis of psychosis or schizophrenia), is approximately 20.7% (Ministry of Health, 2006). This survey also raised awareness around higher prevalence of mental health issues amongst Māori and Pacific persons.

Persons who are acutely unwell with mental health issues often display behavioural and emotional responses, which may affect their interactions with the everyday world, prove disruptive in their social interactions, and affect their inner wellness. It is increasingly recognised that supporting people with mental illness requires more than the reduction or elimination of symptoms. A focus on broader wellbeing and social participation is required to support recovery (Mental Health Commission, 2012; Ramon, 2018).

Recovery from Mental Illness

Recent conceptualisations of recovery in mental health services differ greatly from the traditional medical model as applied in Psychiatry (Anthony, 1993; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005). The medical model focuses on reducing and eliminating symptoms, and has been described as 'clinical recovery' (Slade, 2009). This perspective lacks recognition that the person may resume a full or 'normal' life once diagnosed, with or without the presence of ongoing symptoms. However, people affected by mental health issues have, over the past three decades, become more empowered and outwardly vocal in demonstrating their views about the reality of living with mental health issues and what recovery involves.

There are many variants and definitions of the term 'recovery' within service users' narratives; however, common themes can be identified and these emphasise the view that hope, personal responsibility, identity and meaning all play an important part in each person's journey (Slade, 2009). The most widely cited definition of recovery states it is:

> *A deeply personal, unique process of changing one's attitudes, feelings, goals, skills, and or/roles. It is a way of living a satisfying, hopeful, and contributing life even within the 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.* (Anthony, 1993, p.12)

This conceptualisation of recovery differs to that of 'clinical' recovery and has been described as 'personal recovery' (Slade, 2009). The notion of personal recovery broadens the sense of what is possible, and includes the belief that people can recover from mental illness in the presence or absence of symptoms, that the process is an active participatory event, and highlights strengths, hope, and self-responsibility within the process (Mental Health Commission, 2011). Arguably, it makes sense that services should listen to the voices of the people accessing care and draw on expertise gained through experience. This involves broadening the focus of services to support personal recovery, rather than only on clinical recovery, which has a narrow focus on the management and 'cure' of symptoms. The researcher predominantly positions and favours personal recovery over clinical recovery concept as it holds the values of lived experience, which aligns not only with the research question and informed the thesis, but also fits with the values and recovery focus that the researcher has strived to work alongside with service users in reality. However, arguably clinical recovery also is not dismissed by the researcher, as treatment modalities are often a necessary aid to recovery for service-users in practice.

What is Recovery-Orientated Service Delivery?

Since the early 1990s, the concept of recovery has developed to become much more than an understanding of each individual's personal journey. Insights into personal recovery as a process have led to recognition of the need for a broader range of resources and commitment from services to facilitate a journey from rejection and alienation to a sense of purpose, direction and a meaningful life (Perkins & Repper, 2003). A vision of recovery-oriented services has been developed and introduced into mental health policy throughout most English-speaking countries, with these countries having similar goals and priorities that embrace recovery-focused systems (O'Hagan, Reynolds, & Smith, 2012). One of the main priorities has been the drive to eradicate

discrimination and societal stigma. In addition, the need to improve access to services, embrace evidence-based methods, provide trained competent skilled staff, develop service user collaboration, and enhance links to health and social sectors has been indicated (Davidson, Tandora, Staeheli Lawless, & Rowe, 2009). This has involved a full governmental commitment to wellbeing, prevention strategies, and early intervention. The New Zealand documents that articulate the vision of recovery-oriented service delivery include the Blueprint for Mental Health Services I and II (Mental Health Commission, 1998, 2012a, 2012b). These documents support the concept that mental health is everyone's business, with health and social services working with service-users and their families to ensure practical changes in the way that services and society at large support recovery. In addition, *Te Hononga 2015* (Mental Health Commission, 2007) a mental health strategy to improve Māori mental health, and the framework *He Korowai Oranga* (Ministry of Health, 2014b), articulate the concept of whānau ora (healthy families) and includes mauri ora (healthy individuals) and wai ora (healthy environments) all of which support a broader approach to recovery for individuals with mental health issues. The current service development plan focuses on developing a capable and recovery-oriented workforce for New Zealand mental health services (Ministry of Health, 2018). The plan highlights the need to develop practice cultures where service-users and their families are valued; and nurses have the right skills and attitudes for recovery-oriented practice now and into the future (Government Inquiry into Mental Health & Addictions, 2018)

What is Recovery-Orientated Practice?

According to Davidson et al. (2009), recovery-oriented practice involves offering individuals with mental health issues a "range of effective and culturally responsive interventions from which they may choose those services and supports they find useful in promoting or protecting their own recovery" (p. 89). The core value of recovery-oriented practice is for nurses and other health professionals to recognise that people who experience severe mental health issues are simply 'people' (Anthony, 2004). This requires professionals to see the service user as the whole, unique person that they are, rather than an illness (Deegan, 1996). The literature also suggests that such an approach also requires clinicians to have the ability to hold hope for the individual in the expectation of having a good life, supporting and encouraging the person's resourcefulness, and empowering and supporting autonomy through collaborative decision-making (Deegan, 1996). Being present for the person and supporting their best life as they define it can reap positive rewards for all concerned (Slade, 2012).

Working in a recovery-oriented manner involves a shift in power and responsibility for nurses and other clinicians. The concept of the nurse being the 'expert' within the relationship is diminished as the person using services takes increasing control of his or her own recovery. Reflection, balancing safety and the need to take risks, and awareness of roles are helpful in supporting service users throughout all stages of recovery (Slade, 2012). However, recovery-oriented practice cannot be implemented using any one standardised approach, and is influenced by the practice context and the relational dynamics between individual staff and service users (Slade, 2012). Therefore, while principles for recovery-oriented practice can be described, how these are enacted in various practice settings needs further exploration.

Inpatient Mental Health Services in New Zealand

There are 20 District Health Boards in New Zealand, most of which contain mental health inpatient units attached to general hospitals. These units cater for between 12- 60 service users at one time. Most of the units in New Zealand have seclusion rooms and intensive secure areas. In addition, a significant percentage of service users receive compulsory assessment and treatment under the Mental Health Act (1992). The medicalised focus of care tends to dominate within inpatient settings with a primary focus on medication and containment. However, some additional approaches have increasingly been used within acute care, including talking therapies, advocacy, peer support, Māori health services input, sensory modulation and greater opportunities for staff to build therapeutic relationships (Sutton & Nicholson, 2011; Slade, 2012; Te Pou, 2010; Te Pou, 2013).

However, consumer feedback and research with inpatient staff reveals that acute wards are stressful and at times traumatic places to reside and work for service users and nurses' alike (Currid, 2008). The vast majority of clinical staff in New Zealand inpatient units are mental health nurses who are expected to manage the challenges of high occupancy rates, deal daily with the extra demands without extra resources, and provide care to service users who present with complex and often demanding behaviours that are associated with symptoms of their un-wellness (Cleary, 2004). Given that New Zealand has one of the highest rates of youth suicide in the world (particularly the Māori population), with high rates of seclusion and compulsory treatment (Te Pou, 2013), it is hardly surprising that acute mental health nurses and other professionals are often left struggling to adapt to changes of service direction and new philosophies that inform practice (Cleary, 2004; Williams, Haarhoff, & Vertongen, 2017). The need to reduce coercive practices, whilst supporting trauma informed care and remaining recovery focused, has been described as a constant challenge for staff working in under-

resourced mental health services (Delaney & Johnson, 2014). Unfortunately, coercive treatments remain embedded within acute mental health services, which creates barriers to recovery-oriented practice and power imbalances between service users and nurses (Cleary et al., 2018). It should be noted that acute mental health services in New Zealand have not been formally evaluated for nearly a decade (since 2006) and there is plenty of room to improve this area of service delivery for service users and nurses (Mental Health Commission, 2007), as there have been renewed calls for change in the service system from mental health staff, service users and families and the current national mental health inquiry (Government Inquiry into Mental Health & Addictions, 2018).

The Professional Context of Nursing Practice

Despite the shift to community and recovery-oriented care, there remains a need for acute crisis support when service users become highly distressed and unsafe to themselves or others. The guiding principles of the second Blueprint for Mental Health Services in New Zealand (Mental Health Commission, 2012) calls for nurses to engage in respectful partnerships with service users and their whānau and families. The document highlights that healthy relationships are key in providing positive outcomes for service users. However, it may be argued that acute inpatient services remain the most challenging, complex, and demanding areas for nurses to work in. These struggles may have a significant negative impact on how positive engagement, hope, empowerment, and recovery-orientated practice occurs in reality. The additional challenges associated with poor staff recruitment levels into mental health areas, and the ever problematic issue of mental health nursing being viewed as a less popular speciality than other areas of nursing, have led to this area of practice being seen as a less worthy or esteemed career option (Happell, Byrne, Platania-Phung, Harris, & Bradshaw, 2014). Therefore, the rate of stress, increased workloads, and shift work has taken their toll on front line acute nurses. Furthermore, the shortage of a trained workforce that represents the cultural diversity of New Zealand must be addressed to meet the health needs of the New Zealand people (Williams et al., 2017). Despite the often difficult power imbalance of working with people who are subject to compulsory treatment, it has been shown that it is still possible to support service users using respectful language, kindness, compassion, and genuinely listening to people's experiences within a busy acute setting (Te Pou, 2010). However, service users have vocalised that nurses working in these areas often lack 'humanity' and they want to be treated as an individual irrespective of how they have entered mental health services (Roberts & Boardman, 2013). As a profession, it may be expected that nurses should already be engaging actively in all

these positive attributes within their daily interactions, however, this is not reflected by service users who are ultimately at the receiving end of mental health treatment and service delivery (Rethink, 2012).

The aim of offering services which treat symptoms but also offer hope and support for service users to live a meaningful life, may depend upon whether nurses can engage in positive relationships with service users, rather than approaching their work with negativity and scepticism (Slade, 2010). The contextual factors within and beyond services have a significant bearing upon the acute nursing workforce and the profession as a whole. There is an ongoing need for strengthening nursing research and training that supports the profession, increases commitment to recovery-orientated practices, and drives positive changes in service delivery.

The Personal Context

I have worked in the mental health field for over 30 years, and over this time have listened to many 'voices' amongst mental health practitioners. I have listened to disparaging critical voices, and to the kindest and empathetic ones. Over time, I have realised how important reflection is in my life. The use of language is powerful, it can sooth or crush those around you. On reflection, I have a voice that is hopefully one that always tries to encourage and empower others. I gently listen to others, using active listening skills, and often use my voice to ask 'what would you like to talk about?', 'what are your hopes and dreams?' or 'what would it be like if whatever is worrying you disappeared tomorrow?' I personally feel a sense of value when others listen to me and reflect back an accurate summary of what I have talked about – without misinterpretation. This shows me that they have listened non-judgmentally and have not reached a biased or inaccurate representation of my thoughts or feelings.

I was invited and encouraged to become a Clinical Nurse Educator by a colleague who was leaving the position. My colleague enquired if I would be interested in a leadership role and stated they had "noticed my knowledge base, how well I worked with the staff and student nurses" in my other role as a lecturer and senior nurse educator. I felt that this would lead to a perfect opportunity to help support those student nurses whom I loved teaching and guiding, from being new graduates through to experienced staff who could then, in turn, mentor new students. The satisfaction of actually being part of this excited my senses.

My ongoing journey in education continues to shape my practice. The excitement of analysing newly found concepts shapes the way I deliver my education sessions. This

affects how I guide staff through their studies, and the satisfaction from feeling passionate, alive, and inspired when sharing and receiving new ideas.

The continuous journey that I have undertaken has brought a personal depth and understanding to the study, in terms of my passion for working in a recovery-oriented manner. My experiences, beliefs and values remain firmly and stoically service user focused. The ongoing and regular communications with those people who are in both community and inpatient acute settings, who are continuing on their recovery journeys, keeps me grounded firmly in the belief that the human spirit, often facing huge adversities and struggles, is one that can overcome such obstacles. I am often amazed and moved by the stories of recovery that I encounter, as well as the resilience of nursing staff over the years to keep showing care and compassion. These have been my inspirations to complete this study.

Overview of the Thesis

The emphasis on providing recovery focused services and a person-centred approach raises an important question. What is the experience and meaning of recovery-orientated practice for nurses working in acute mental health services? This question can be broken into two parts. The first addresses what are acute mental health nurses' experiences and what does it mean to work with service users in a recovery focused manner. The second is to identify elements in the context of the inpatient setting and within the nurse's own attitudes and beliefs that shape their experience of recovery-oriented practice. It was anticipated that exploring stories of recovery-focused practice, would reveal original understandings regarding how acute nurses work alongside service users in challenging circumstances.

This introductory chapter has provided a brief overview of the study, emphasising some important contextual aspects of how and why the subject is relevant to research and future practice. The future chapters scaffold onwards to demonstrate the research context, process and content. Chapter 2 presents a review of relevant literature pertaining to the research question. It highlights further aspects of the context in which the study sits and identifies the need for the research. Chapter 3 will discuss the methodology used, specifically hermeneutic phenomenology. Additionally, the study methods will be explained, including recruitment and interviewing of participants, analysis, and findings. The trustworthiness of the study design will also be discussed.

Chapters 4, 5, and 6 present the study findings. Excerpts from nurses' accounts of practice, along with my analysis, will be used to illustrate themes related to the

experience and meaning of recovery-oriented care. Chapter 4 highlights some core aspects of recovery-oriented care, Chapter 5 reveals how the nurses created different types of therapeutic space when working in a recovery-oriented way and Chapter 6 explores some of the challenges with using a recovery-oriented approach within the inpatient setting.

The final chapter, Chapter 7, brings together all the relevant findings. Key findings will be explored and highlighted and comparison of the study findings with the existing research evidence will be undertaken. There will be a final discussion on how this study has potential insights useful for developing acute nursing practices, research, education, and training. The thesis ends with a discussion of the study's strengths and limitations and a final summary reflecting on the study.

Summary

This study set out to explore the experiences and meaning of recovery-orientated practice for nurses working in acute mental health services. Stories of practice were collected from 10 nurses to explore what it is like to support recovery for people who are experiencing acute mental health issues. The use of a hermeneutic phenomenological lens allowed the collection and analysis of data to uncover what it truly means to work alongside those who require respectful support at a time when they are at their most vulnerable. Within the following chapters, I will unpack themes that were considered by the nurses to be at the heart of recovery-oriented practice. The study provides a picture of what recovery-oriented practice means to those actually working in an acute mental health service and informs the future development of nursing practice and inpatient care.

Chapter 2: Literature Review

Introduction

The following chapter provides analysis of the literature relevant to the implementation of recovery-oriented practice in acute inpatient units. Initially, the literature search strategy used and the outcome of that process is outlined. Next, the various definitions of recovery are explored. The background context of how a focus on personal recovery emerged from the service-user movement is examined, and consideration is given to the policies that were developed to better support service-users' recovery pathways. The review will then consider the literature on recovery-oriented practice, and the definitions and principles that underpin the practice. In addition, the literature related to barriers to recovery-oriented practices is examined.

In analysing the literature, it is important to consider what measures can be taken to influence and strengthen recovery-orientation in service delivery. There will be a review of the positive strategies already employed and supported by international and national recovery literature. There will be further exploration of the complexities of the nurse's role within acute settings and how nurses struggle to provide recovery-oriented practice. This includes the need to balance public protection with maintaining and raising good recovery-oriented practices and positive cultures within mental health settings. This is followed by an analysis of international literature that specifically focuses on nurses' recovery-oriented practice within acute mental health settings.

The chapter concludes by assessing the current state of the evidence in the field in order to frame the research question to be investigated in this study.

Literature Search Process

I specifically looked to the literature for perspectives on mental health nurses' experiences and understandings of working in recovery-oriented practice with service-users in acute ward settings. I made the assumption that this would yield personal accounts to provide insights and inform better understandings about what would improve recovery-oriented practice. My involvement in the world of education, particularly in my teaching role which covers recovery-oriented practice in mental health nursing, as well as my nursing role, relevant previous study, conference attendances, presentations, and continuous ongoing dialogue with colleagues and service-users, ensured that I already

had good access to literature and educational resources. Furthermore, manual searches were undertaken using references and included accessing health databases.

A literature search was undertaken specifically focussing on the following key words: inpatient OR acute psychiatric ward OR mental health AND nursing AND recovery-oriented practice OR recovery-oriented care. The health databases used included CINAHL, PsycINFO, and Cochrane Library. The initial search began with general mental health recovery literature, and was then filtered using more specific search terms that related to nurses and their lived experience of recovery-oriented practice. The parameters placed on the search included literature that had been published in the last 10 years and was in English language only. Some seminal literature more than 10 years old has been included in this literature review. This literature contains information related to the development of the notion of personal recovery and related definitions from leaders in the recovery movement and key policy documents.

Definitions of Recovery

Over the past three decades people affected by mental health issues have become more empowered and outwardly vocal in demonstrating their views about the reality of living with mental health issues. Through sharing their experiences of mental distress and personal recovery, service users and consumer advocates have been able to identify the differences and commonalities in their experiences. The following quotes succinctly articulate some of the key qualities and concepts expressed in the recovery literature. Patricia Deegan (1996), a well-known psychologist who has experienced her own recovery from mental health issues and hospitalisation, described recovery in the following terms:

> Recovery does not refer to an end product or result; neither does it mean
> that the person is 'cured'. It does not mean stabilisation or maintenance.
> Rather recovery is a process, a way of life, an attitude, a stance, and a
> way of approaching the day's challenges. (p. 92)

Another definition from Perkins and Repper (2003) stated that "recovery is not about getting rid of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning"(p .9). A definition of recovery commonly used within New Zealand was first articulated in the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998). This document defined recovery as the ability to "live well in the presence or absence of [one's] mental illness" (p. 1).

These definitions reflect much of what is written about recovery in the literature and indicate that recovery happens differently for each individual, is a non-linear and personal process, with the individual taking control and actively reclaiming his or her life. It is more likely to occur where communities are inclusive of those with mental illness (Ramon, 2018) and, importantly, where the person finds a new purpose and meaning in his/her life beyond the confines and impact of mental illness (Slade, 2012).

In a meta-analysis of recovery narratives and research Leamy et al., (2011) synthesised the key aspects of the recovery process as the developing framework that includes; "thirteen characteristics of the recovery journey; five recovery processes comprising of connectedness, hope and optimism about the future, identity, meaning in life and empowerment (giving the acronym CHIME)" (p. 2).

It is also important to acknowledge that the concept of personal recovery differs greatly from the idea of clinical recovery, which aligns with the medical model and focuses on reducing symptomology and improving basic functioning (Anthony, 1993; Cusack et al., 2017; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005; Wyder et al., 2017). The focus on clinical recovery alone has been criticised for being overly narrow, emphasising service-user's deficits without recognition of strengths, and failing to acknowledge the potential for living a meaningful life despite the presence of ongoing symptoms. This medicalised view of mental distress is believed to reinforce stigma that continues to be present in society and within mental health services (Mental Health Commission, 2009; Mental Health Commission, 2011)

With an understanding of personal recovery in place, it is important to set the study in context and look at how mental health service delivery has evolved over recent decades towards a recovery approach. This involves looking at relevant policy documents that have been produced internationally and in New Zealand.

Historical and Policy Context of the Study

Historically, mental health services were based in large institutions and focused primarily on custodial care rather than medical or recovery-oriented care. In most Western countries from the early 1800s onwards, there was an increasing focus on segregating people with mental health issues from the rest of society within large and often rural asylums. The focus was on protecting the public from the insane and over time madness began to be understood as an illness, and experimental treatments were employed such as bleeding people and other inhumane practices, which often left individuals poorly treated and neglected (Bracken & Thomas, 2005).

The subsequent closure of these large asylums, and the changes towards deinstitutionalisation, was realised by most mental health inpatient. These units were subsequently attached to general hospitals in the 1960s (Gawith & Abrams, 2006) which led to an increased level of pharmacological interventions and treatment regimes, arguably, the overuse of psychotropic medication slowed the clients' ability to reconnect with others, creating barriers in their recovery (O'Doherty & Doherty, 2010). However, the eventual start of deinstitutionalisation in the 1980's and 1990's, began the slow journey towards significant steps in de-stigmatising mental illness, and the adoption of recovery practice and increased service-user participation (Gawith & Abrams, 2006). These traditions have shaped a lot of today's cultures and challenges in mental health services in providing recovery-oriented care; although recovery principles and practices have continuously been highlighted as areas for improvement within the mental health sector. With this in mind, the international policies that support recovery-oriented practice are explored in the next section. Following which, the focus turns to exploration of the New Zealand context and development of policies pertaining to recovery-oriented practice.

International policy directions that support recovery-oriented practice

Internationally, personal recovery and recovery-oriented practice have been identified as a priority in mental health policy and strategic planning. This section explores policy from the United States (US), Australia, and the United Kingdom (UK) to provide insights into the drive for recovery-oriented service delivery in the international context.

Government policy in the US has identified recovery as the "focus of a transformed system" and the New Freedom Commission (2003) stated that "for some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. Science has shown that having hope plays an integral role in an individual's recovery" (p. 5). US government policies have identified two principles of system transformation. The first of these is robust mental health services and treatment options that are consumer and family centred and offer meaningful choice to service-users. Second, there is an increased focus on enhancing and supporting the service-user's ability to build resilience, facilitate recovery, and less of an emphasis on managing symptoms. However, there are varying implementation pathways identified in differing states. Some jurisdictions appear more advanced in their progress, with California, Connecticut, New York, Massachusetts, and Georgia leading the way in supporting recovery and attempting to dismantle discrimination and negative attitudes towards service-users with mental health and forensic histories (American Psychiatric Association, 2005). The shift to embrace

recovery-oriented practice has continued to evolve in the US, with the White House calling for more policy reform to support mental health recovery through the initiative *National Dialogue on Mental Health* (Hoyles, 2013). This initiative was an effort to reduce stigma and support recovery by encouraging service users to reach out to mental health services if they need support and to access recovery tools and education.

Other countries, including Australia, have also been cognisant of the recovery approach and active in their participation and implementation of recovery-oriented practices. Australia has been promoting the implementation of a recovery-oriented mental health service since 1992. This has involved a series of five-year National Mental Health Plans. However, the Australian definition of recovery is scant: "these (mental health) services should provide continuity of care, adopt a recovery orientation and promote wellness" (Australian Health Ministers, 2003, p. 4). The method by which the policy is implemented is via a federal plan, which is then interpreted at a state level. Local and regional services show that encouraging recovery and anti-discriminatory practice needs to be led through challenging the organisational culture of services (Slade, 2012). These important recovery pathways have continued to grow in Australia via the implementation of a national framework that seeks to raise awareness and give practical guidance to practitioners and services. In particular, there has been a focus on how to develop recovery-oriented practice, and how nurses and other professionals can work to embed recovery focused philosophy within services (Commonwealth of Australia, 2013).

The UK is similarly promoting recovery approaches in practice, with an emphasis on recovery training for mental health nurses and allied health practitioners. Key policy focuses on the principles and values of using the recovery approach with priority given to "the expert patient, self-management and social inclusion" (Department of Health, 2006, p. 4). Recovery-oriented practices identified include; collaborative decision-making, providing optimism when working with service-users, supporting social inclusion, and enabling informed decisions (Department of Health, 2006; Gudjonsson, Webster, & Green, 2010).

More recently the UK has been advocating for the implementation of a service-wide Integrated Recovery-oriented Model (IRM) within mental health services (Frost et al., 2017). This IRM model is focused on health and wellbeing and social inclusiveness. By enhancing access to psychological interventions, it aims to promote hope, recovery, self-determination and agency and, importantly, active community reconnection. This way of working within an IRM model requires the collaborative working of all services; in particular, the inpatient and community services (Frost et al., 2017).

New Zealand policies that support recovery-oriented practice

During the mid-1990s, New Zealand mental health services saw a crisis of under-resourcing and the lack of community-based services following the deinstitutionalisation process (Gawith & Abrams, 2006). In response, a national inquiry into mental health services was conducted and the New Zealand government created the Mental Health Commission to act as a monitoring body and develop a vision for services, which was published as the *Blueprint for Mental Health Services in New Zealand* document (Mental Health Commission, 1998). It was in this document that the vision of having recovery-oriented services at a national level was first articulated. At this point mental health services became a government priority and significant funding was put into a national anti-stigma and discrimination campaign as well as into funding innovations in community services, particularly within the non-government organisations (O'Hagan et al., 2012).

The development of the Mental Health Commission and the *Blueprint* (Mental Health Commission, 1998) supported exploration on how best New Zealand might achieve effective service delivery for mental health and addiction problems. The new exploration and policy directives produced positive outcomes, including: specialist service provision (including forensic court liaison), advancement from institutional care to community, growth and development of non-government organisation led care and Māori mental health services (Ministry of Health, 2005).

The second *Blueprint for Mental Health Services in New Zealand* or '*Blueprint II'* (Mental Health Commission, 2012b) broadened the vision for services further, from supporting the recovery of those most disabled by mental health issues to improving mental wellbeing for the general population. This includes addressing mental health, addictions, and behavioural issues early and across the life span to enhance family relationships and prevent mental illness, addiction, and criminal justice issues. The document also promotes a focus on broader wellbeing and reducing stigma and discrimination within mental health services. This involves prioritising the development of meaningful lives for service users through social, educational, housing, and employment opportunities.

Since the 1990s, there have been many positive developments in New Zealand mental health services; both with the government's recognition of mental health priorities and the need for an approach that moves away from oppression of service users to power sharing (Slade, 2012). There has also been an increase in the range of services available, greater variation in the way services are delivered, and a broader focus on well-being and recovery; rather than simply reducing symptoms (Slade, 2012).

While New Zealand has been a world leader in its early adoption of a national recovery-oriented vision and taken steps in developing mental health services, some have argued that this vision has not been fully translated into service delivery (O'Hagan, Reynolds, & Smith, 2012). A shift in focus to personal recovery and wellbeing requires strong leadership across the whole service system, as well as in the community, families and whānau (Mental Health Commission, 2012c). It also requires a change in workplace culture, including more positive and less stigmatising attitudes towards service-users from professionals (Mental Health Commission, 2012d). Additionally, services must have organisational structures that support recovery-oriented practice and the development of a workforce that is competent and capable (Ministry of Health, 2018). New Zealand has the opportunity to learn from other countries' experiences. The efforts towards supporting recovery and recovery-oriented practices in other countries appear comparatively more robust. For example, in England there is a healthier budget directed towards recovery initiatives (Department of Health, 2006), Australia has a strong investment in peer workforce initiatives (Cleary et al., 2018), and some states of the US are leading the way with the elimination of seclusion with a focus on trauma informed practices (O'Hagan, 2008).

Recovery-oriented health reform in New Zealand has largely focused on delivering community-based services. Using outreach models, the emphasis has been on achieving life goals, such as obtaining housing and work. Acute mental health services are a pivotal link within the health service framework, as they are often the first to provide care when people become significantly unwell. Furthermore, the Ministry of Health (2018) has recently reiterated that New Zealand needs a workforce that is able to provide recovery-focused care when individuals are highly distressed. However, there remains uncertainty around how the principles of recovery-oriented practice can be successfully implemented and integrated into clinical inpatient settings (Kidd, McKenzie, & Virdee, 2014). The following explores the literature related to recovery-focused practice to highlight the general principles that might help to close the gap between the recovery-oriented vision and the reality of providing care within inpatient settings.

Recovery-Oriented Practice

Recovery-oriented practice requires nurses and other professionals to demonstrate genuine regard, based on respect, in supporting individuals to feel hopeful, and by recognising the possibility of wellness and recovery for service-users. This recovery-oriented approach also focuses on maximising empowerment and self-determination. The principles of recovery-oriented practice focus on the nurses' ability to support, be

involved, and genuine in their interactions with service users. It is vital for mental health nurses to offer hope and optimism along the individual's journey, and to embrace each service-user's uniqueness. It is paramount to offer choice, respect, and empowerment; and to work collaboratively towards best practice with each individual (Mental Health Commission, 2007). It is important to highlight, and understand, that these recovery approaches by nurses and others do not mean that all individuals will always feel hopeful or unrealistic regarding expectations. Rather, nurses acknowledge that individuals' expectations about themselves have an impact on whether they have positive or negative outcomes in their recovery. Yet, nurses often underestimate the strengths and resilience of those individuals with whom they work alongside. This may lead to service-users feeling hopeless and self-defeating (Slade, Oades, & Jarden, 2017).

Personal attributes that support recovery-oriented practice

Many consumer narratives of personal recovery have highlighted the importance of professionals who display certain personal attributes. These attributes include kindness and a positive, warm, and hopeful approach towards them (Slade, 2012). However, in contrast to nurses' personal and recovery-focused qualities, within mental health acute services there is an emphasis on professional accreditation, clinical competencies, and reaching system-focused targets. This proves significant in nursing practice development, wherein a 'gap' has been identified within service training, with little mention of the recovery, strengths, or person-centred approaches (Barker, 2001), or the acknowledgment of clients' own resourcefulness and decision-making skills (Cleary et al., 2018; Slade, 2012). This leads to the need to explore further how nursing competencies align with these ideals in practice.

Competencies that inform recovery-oriented practices

Nursing competencies are fundamental for nurses who work in mental health to acquire, and are what service-users want, which is the recognition of good ethical recovery care which has a strong focus on respect for autonomy and service-user's self-determination (O'Hagan, 2001). Furthermore, it is important that competencies inform good recovery-oriented practice, including the need for nurses to demonstrate the right attitudes, skills and knowledge base. This requires skills to critically evaluate their own practice.

Indeed, from a service-user perspective, it has been identified that nurses need to be more relational and listen rather than being process focused in their approaches (Cleary et al., 2018). This identified gap within acute mental health nursing has demonstrated the need for further education and training regarding how to be recovery oriented in practice, and led to the development of the 10 New Zealand competencies for recovery-oriented practice (O'Hagan, 2001). These competencies outline the attitudes,

knowledge, and skills that professionals require to support personal recovery in their practice. Within the competencies there is significant emphasis on understanding recovery principles in both a New Zealand and international context, recognising the resourcefulness of people with mental illness, using skilful communication styles, cultural awareness, knowledge, and support to actively sustain an anti-discriminatory culture, and to support families and clients to participate fully in their care at the service level. This set of competencies has been further supported by the report, *Let's get real: real skills* (Ministry of Health, 2008, Ministry of Health, 2018), which continues to create a framework for practitioners that underpins practical ways to support recovery-oriented practice in mental health services. Recovery underpins all of Te Pou's Real Skills outlined for nurses within the 'Let's get real' framework that informs recovery practices. These recovery guidelines need to be woven through mental health services, and practiced accordingly to improve attitudes and values towards reducing stigma. Further, it needs to be reflected clearly by those professionals who work, and are involved, in mental health services (Ministry of Health, 2008). However, it is not only competencies that are required to facilitate recovery-oriented practice, it is also vital that organisational change is put in place to further support service-users' recovery journeys.

These concepts, regarding the need for change, have been supported further by Sowers (2005) who recognised the importance of organisational change to facilitate client recovery and ensure recovery-oriented practice is utilised fully. Sowers emphasised the need to replace paternalistic approaches by professionals and move from a diagnostic or illness focus towards an empowering, hope-driven approach with a focus on each person's autonomy. He discussed the competencies and *Guidelines for Recovery Oriented Services* developed by the American Association of Community Psychiatrists (AAPA, 2001). These guidelines focus on the administration, treatment, and supports required to assist in transforming services towards a recovery-focused approach. Sowers referred to transformation of service delivery through the development of: vision statements; organisational resourcing, which included commitment to an annual budget; continuing education that ensured an understanding of recovery concepts; and adequate training for professionals that included core competencies. These guidelines include and align closely with the concepts of recovery within New Zealand competency frameworks, although it may be argued that New Zealand does not always adequately resource recovery training within the District Health Boards, which may be an area that urgently needs to be addressed to meet the ongoing recovery needs for supporting service-users now and in the future. The following section explores the importance of moving towards recovery-oriented practice and what current practices look like, and how to shift towards an inclusive and recovery focused service.

The shift from separateness to inclusiveness

In supporting recovery-oriented practice in mental health services, Smith and Bartholomew (2006) advocated that recovery principles need to guide professionals to work in partnership, respecting service-users' expertise and perspectives, and supporting them to act as experts on their needs, strengths, and goals. Additionally, the authors promoted the idea that all treatments should be seen as tools for use by service-users to be able to assist and manage their lives. These strategies support the current principles of recovery, showing a shift from separateness to inclusiveness and self-determination for service-users. Many mental health units have visions and mission statements, and policies and procedures, with rhetoric language regarding recovery; yet, often demonstrate practices entrenched in custodial and controlling practices. Smith and Bartholomew further recommended that to promote a positive shift towards inclusive recovery-oriented practice, there is a need to examine what actually happens within these services; to be able to see the reality of the situation in order to move positively forward in the future. Overall, the strength of nursing using recovery practices within a recovery framework is transforming the lives of many service-users who access mental health services. Mental health services are endorsing these practices because they work, and service-users have actively spoken out that it is what they need and want in supporting their recovery pathways.

Looking at alternative ways to support recovery-oriented practices, however, need not require literally 'reinventing the wheel' or creating new initiatives and ways of thinking. It is important to recognise that frameworks already exist within nursing that may be helpful in further embedding recovery-oriented practice in mental health services. Seed and Torkelson (2012) suggested that Orem's (1971) Self Care Deficit Nursing Theory (SCDNT) is aligned with recovery principles and may provide a framework for culture change in acute settings. Research has linked self-care abilities and competencies to enhanced recovery outcomes. Seed and Torkelson also suggested that the recovery principles that advocate service-users' autonomy and independence are intrinsic to the SCDNT and can be used as a theoretical structure to link self-care, self-management, self-esteem, and hope within recovery-oriented services. This involves a return to nursing roots, or going back to 'basics', by providing and delivering 'patient-centred' care. Care that focuses on building therapeutic relationships, being kind and empathetic as nurses, and anticipating service users' needs (Minton & Batten, 2018). The Tidal Model (Barker, 2001) is another nursing framework that explicitly aligns with recovery-oriented practice. Despite there being recognised competencies and principles for recovery-oriented practice, which align with nursing frameworks, barriers to implementing these within mental health services remain.

In summary, service-users have related that having nurses who are positive and hopeful in their approach towards them was a necessary attribute in nurses' provision of a recovery-oriented approach in practice. However, a gap has been identified in the provision of training to support nurses in acquiring the necessary skills to work in a recovery way. Nonetheless, the development of recovery competencies has been a positive step towards nurses being able to focus on being person centred, recognising service-users' resilience, working in partnership, and shifting the concept of separateness for service-users to inclusiveness which builds on empowerment and self-determination in their own recovery journey. As has been highlighted, however, barriers continue to exist that hamper the development of recovery-oriented practice within mental health services.

Barriers to Recovery-Oriented Practice in Mental Health Care

The literature describes numerous barriers to recovery; some internal to the recovering individual, such as lack of hope, and some in the environment, such as lack of work opportunities or social support (Onken, Craig, Ridgeway, Ralph, & Cook, 2007; Ramon, 2018). Barriers have also been identified within the mental health system itself, including the staff working in the system. This section of the review of the literature pertains to poor or discriminatory attitudes towards individuals who experience mental health illness. These attitudes are expressed both in the public domain and by the nurses and other professionals who have chosen to work alongside these individuals within mental health services. The impact of these types of attitudes and corrupt workplace cultures are indeed a challenge that needs addressing.

Attitudinal barriers

Members of the psychiatric profession have long shown poor attitudes towards people with mental illness, and it could be said that the opinion of the medical profession, in particular, can, at times, reflect society's discriminatory and stigmatising viewpoints (Hinshaw, 2007). The 20th century German psychiatrist, Emil Kraeplin, perceived the diagnosis of schizophrenia to have such poor connotations such that he named the disorder 'dementia praecox' or early dementia (Kraeplin, 1896a). Such hope-destroying perceptions have prevailed throughout history and have significant impacts upon service users and their families. This has exacerbated the 'learned helplessness' experienced by service-users (Deegan, 1992), which further disempowers them and their families.

Schulz (2007) noted that professionals are well informed about mental illness, but do not demonstrate positive attitudes and opinions about the illness or the people they are

treating. A study by Nordt, Rossler, and Lauber (2006) explored mental health professionals' attitudes towards people with schizophrenia and major depression. Interestingly, the survey compared the attitudes of mental health professionals with members of the public. A large sample of 1073 professionals and 1737 members of the public were surveyed about social distancing, stigma, and knowledge. The results showed there was no difference between professionals and the public in attitude in relation to stereotyping and willingness to closely interact with mentally ill people.

Rao et al. (2009) also examined and assessed stigmatising attitudes among health professionals directed towards people with mental health problems. The participants (n=108) were health professionals from acute and community mental health settings. The results showed that health professionals were comparable in attitudes with those observed in 800 members of the general population in an earlier study by Luty, Fekadu, Umoh, and Gallagher (2006). However, the data from the Rao et al.'s study highlighted that health professionals held more stigmatising attitudes towards service users from forensic secure hospitals than those admitted to an acute inpatient service with schizophrenia or an acute brief psychotic illness. The findings were consistent with other research, emphasising that clients with a forensic history are more stigmatised than clients from general psychiatry (Maden, 2007). However, in New Zealand acute mental health settings need to be open to accepting that individuals often bring their offending pasts with them, and nurses need to be aware that stigma by their own profession will have a negative impact on recovery for service users who access acute mental health units. Furthermore, nurses who show stigmatising attitudes and a lack of recovery-oriented practice for these individuals escalate further stigmatisation. These types of barriers to recovery-oriented practice will certainly have a negative impact for service users and may lead to service users feeling hopeless, disempowered, and let down by the system in which they seek help.

Interestingly, Rao et al.'s (2009) study highlighted a positive aspect, namely that health professionals were vastly more positive in their attitude when case studies depicted examples of successfully recovered clients within health care settings. This may have helped to reinforce that there is a human being with a history and a future who has shown resilience and has recovered well. Such a finding is important as it gives nurses and professionals hope in their work.

The significance of varying staff attitudes in relation to the level of clients' acuity or crisis, and their diagnosis, has been demonstrated (Munro & Baker, 2007). In particular, the diagnosis of personality disorder has been viewed in a negative way by professionals, with the borderline sub-type tending to attract extreme negativity and considered to be

different or difficult (Munro & Baker, 2007). One study by Lewis and Appleby (1988) showed that a diagnosis of personality disorder led to increased critical attitudes by psychiatrists. An alternative study, undertaken by Bowers (2002), involved nurses working in UK forensic hospitals (n=2503) and showed the existence of negative attitudes with terms such as 'evil' and 'monstrous' used for those with a personality disorder diagnosis. This is indeed a contrast to the positive nurse characteristics that are facilitators of recovery; especially nurses' use of self in supporting service-users to feel hope and safety in their space which enables recovery (Wyder et al., 2017).

Markham and Trower (2003) furthermore conducted a comparative study of the attitudes of 50 nurses towards clients with different diagnoses, which included schizophrenia, depression, and borderline personality disorder. Similar to the findings noted above, this study concluded that nurses were less empathetic and optimistic towards clients with borderline personality disorder. Interestingly this study highlighted that the nurses were additionally more socially rejecting of clients with borderline personality, and regarded them as more dangerous than other clients (Markham & Trower, 2003). This raises questions regarding the diagnostic 'labelling' of clients as a potentially damaging issue for supporting recovery and recovery-oriented practice. Although it has been recognised that service users with the diagnosis of borderline personality disorder believed that they benefited from knowing their diagnosis and were happy for staff to explain fully the diagnosis and treatment options available (Fallon, 2003), this type of negative labelling does not support a commitment to recovery-oriented practice. To address such a challenge, it is necessary to examine the part that health service workplace cultures play in creating look at negative attitudes around mental illness and the impact on recovery.

Corrupted cultures in health services workplaces
Research has continuously highlighted how barriers to recovery-oriented practices include poor staff attitudes and how negative team cultures are problematic in nursing practice. It has been identified how these negative attitudes and practices have a detrimental impact on workplace cultures. Indeed, this has been described as a "corruption" of workplace culture (Wardhaugh & Wilding, 1993, p. 5). Instead of focusing on the individual 'bad apple' (a bad or corrupt person in a group), inquiries have shifted focus towards the whole culture, which has become known as the 'rotten barrel' or a bad and corrupt culture (Bowie, 2010). These corrupted cultures are associated with particular features, including significant power divides and inequalities between service users and mental health professionals. In addition, this culture may be accompanied by a focus on risk management, being risk averse, and a culture of blame that further compounds stigmatising beliefs and may lead to rigid work practices that dehumanise

both the service users' and the professionals' existence (Cleary et al., 2013; Wardhaugh & Wilding, 1993; Wyder et al., 2017). The recovery concept being implemented by inpatient units is attempting to disentangle the concepts of risk and blame, removing the blame for service users' symptoms or illness (McKenna et al., 2014).

Smith and Bartholomew (2006) also highlighted a major obstacle to recovery-oriented practice as being the institutional legacy of medical and custodial approaches within hospital settings. Often nurses feel disempowered by the workplace cultures that they work within, and feel as mistreated and institutionalised as the service-users for whom they care. Therefore, it is imperative that any organisation intent on embedding recovery-oriented practice principles must be prepared to listen to, and acknowledge all, professionals at all levels within the system. This may prove a challenge for those nurses in management positions who may feel a sense of loss of status, or even fear the relinquishing of their power and status to others. However, this is a calculated risk that must be undertaken to improve future positive cultures and enable service transformation.

Changing cultures in acute inpatient mental health units may indeed prove challenging (Mental Health Commission, 2012). It has been argued that negative staff attitudes may be shaped by the combination of weak management structures, inadequate quality service systems, and a lack of training with little support in clinical supervision and peer reviews. In addition, where certain staff feel disempowered (and follow rigid hierarchal staff structures), these features may leave staff to cope with unresolved feelings that affect their self-esteem and have a negative effect on their job satisfaction. It may follow that staff attempt to restore their own self-esteem through the power of having access to, and control over, the lives of the service users in their care (Paterson, Wilkinson, & Smith, 2013).

This power may lead to an overuse of coercion, whereby staff use their position to act in a negative manner, and feel they have licence to over-medicate, restrain, and react by using counter aggressive methods, which are directed or displaced towards the vulnerable service user (Paterson et al., 2013). The long-term misuse of coercive practice and negative staff attitudes ultimately impacts on service culture and affects the introduction of recovery-oriented practices. Negative patterns of behaviour may become progressively embedded and passed on to new members of the team through 'modelling' behaviour. The pressure for new nurses to conform to the culture can be overpowering and can reinforce hostile relationships with other staff. This may cause counter aggression and enable the emergence of a new generation of staff who directly work in opposition to a recovery-focused service (Paterson et al., 2013).

Furthermore, evidence suggests that there are many nurses working in acute inpatient cultures, who believe that recovery concepts have no relevance to this setting (Kidd et al., 2014). Practitioners report that many service users are too mentally unwell and incapable of collaborating in their care. Nurses have overridden the views of service-users when they felt that the service user was insufficiently cognisant to make decisions regarding their own care. This paternalistic way of viewing service users is not strength based and clearly creates a significant barrier to hopeful, safe, and supportive recovery-oriented care (Cleary et al., 2018). Indeed, the role and contribution of mental health services to support these recovery principles is a step closer to reducing stigma. Recognising and reframing how service users are viewed by nurses and other professionals, and moving to view service users as people who are not merely onlookers in their care but in control of their own recovery, may help nurture and grow recovery-oriented services in reality (Davidson et al., 2009).

Many national campaigns, including the New Zealand 'Like Minds, Like Mine' campaign (Ministry of Health, 2007) have targeted anti-stigma strategies which encourage direct action to influence a visible societal and organisational stance to improve perceptions and eradicate negative public and professional views of mental illness. This includes an intended impact on society by promoting the concept of valuing and giving equal opportunities, without discrimination, to all people with mental health issues. This is often portrayed through media advertisements that frequently include famous celebrities talking frankly about how they coped with, and overcame, their mental health issues. By challenging previous negative views or assumptions (that the famous and affluent are resistant to mental illness), this media strategy may support and reduce the stigma attached to mental illness and help promote recovery and recovery-oriented practice both in the public domain and within mental health services. However, the challenge to promote recovery, and dispel the stigma associated with mental health, continues to be an ongoing struggle for service users, psychiatry, and nursing.

Overall, literature has highlighted that clients with mental illness are repeatedly seen by mental health nurses as having poor outcomes. Schulze (2007) suggested that psychiatry needs to take accountability for its role in reinforcing stigma. Stigma can also be reinforced by mental health professionals, who often have knowledge regarding mental illness, but do not always hold optimistic opinions about the diagnosis and the people they treat. Consequently, mental health nurses are placed in a position where they must explore their own attitudes towards mental illness, the cultures that they work in and the possibility of recovery, and help promote social inclusion and recovery within their practice. For this to be fully realised It will be necessary for nurses to have the right support to develop self-awareness around stigma and how their attitude plays an

important role in the way they provide recovery-oriented practice with service users. The outcome of such support would be for nurses to see their work as hopeful, and that they find satisfaction and meaning in their work (Wyder et al., 2017).

The Nursing Role in Acute Inpatient Wards

Being a nurse within an acute mental health unit can be both challenging and interesting, and a role that requires that nurses demonstrate skills that include having a good sound knowledge of physiology, health and wellness and disease knowledge, and nursing theories (which include the bio-medical, psychosocial, cognitive, and sociological models), to inform their nursing practices (Evans, Nizette, & O'Brien, 2017). The traditional expectations of nurses that work in acute mental health units range from delivering individual care to service-users, to using a crisis management perspective. The traditional nursing role also includes aspects such as using mental health assessment, the reduction or stabilisation of symptoms and discharge planning. Mental health nurses also engage actively in growing therapeutic relationships, and engage in using their therapeutic relationships with service users in various ways and situations, which may include administering medication or supporting service-users in distress (Fourie, McDonald, Connor, & Bartlett, 2005).

 Early nursing theorists were influenced by both psychology and social science they drew on these to develop nursing models. Hildegard Peplau (1988), a leader in the first generation of psychiatric nurse theorists, also outlined the importance of the therapeutic relationship. She highlighted that the nurse is the therapy, not the act of 'doing therapy' on the service-user. This was a major shift in thinking and practice for nursing, and aligns with the current recovery approach and practice within the current study. So too, another theorist, Phil Barker, alongside his collaborator Poppy Buchanan-Baker, developed a recovery focused model of care, namely the Tidal Model (Barker & Buchanan-Barker, 2005; Tidal Model, 2001). The key emphasis within this humanistic model was to look at solutions rather than solve problems. Furthermore, the tidal model also focused on being service-user centred, and encouraging the service-user and nurse to work in collaboration. Importantly, the model further recommended that mental health nurses are able to support service-users to find meaning in their experience and lives (Barker & Buchanan-Barker, 2005; Tidal Model 2000). Therefore, it might be said that the most important capabilities nurses need are advanced therapeutic skills, in which to connect with service-users and support their recovery pathway (Happell, Cowin, Rope, Lakeman, & Cox, 2013). The complexities of the nurse role within acute mental health services show how pivotal it is for mental health nurses to establish relationships based on trust and open communication. However, in reality, this does not always happen as providing

recovery-oriented practice can be challenging given the lack of time to apply the concepts of autonomy (McKenna et al., 2014), the acuity of an individual's presentation, and the balancing of risk versus recovery concepts. In a review of the literature, Wyder et al. (2017) discussed how nurses deliver care in acute inpatient mental health settings. Within recovery frameworks, the review found the role of nurses is one of a facilitator and enabler to allow service-users to take back their control and be an integral lead in their own treatment pathways. This approach can, however, be in conflict with the expectations of the service, so that nurses find themselves balancing recovery principles against the safety of the ward environment and the expectation they will seclude and restrain service-users. This constant experience of contrasting expectations puts a burden and increased stress on nurses, as they wrestle with how to be recovery focussed, reflective, and self-aware, whilst being 'pulled' in different directions emotionally and physically by these service expectations. These types of conflicting expectations may lead to role confusion and tension. The literature furthermore reveals that nurses are very aware of how negative workplace cultures affect their ability to deliver an optimistic and hopeful recovery-oriented practice, and how important it is to have safe, supportive teams and services that share a common vision about the care they give on the ward (Wyder et al., 2017).

Studies of Recovery-Oriented Nursing Practice in Inpatient Care

As outlined in the preceding section, acute inpatient mental health is a practice area that is often challenging for nurses to balance safety with supporting service user autonomy and recovery. This section reviews the available studies focused on nursing in acute inpatient mental health settings, and specifically the ways in which recovery-oriented practices are understood and applied.

Kidd, McKenzie, Collins et al., (2014) assessed the impact of consumer narratives on the recovery orientation of inpatient staff. This particular Canadian study used a mixed methods approach and an intervention which included a series of talks to staff (n=58) by 12 former clients. The speakers were individuals who had experienced psychosis at some point in their life journeys. The topic of these conversations included a large range of recovery-focused experiences such as the resources they utilised to facilitate their recovery, including positive support systems, and the importance of positive relationships with staff. The former clients also raised negative unsupportive experiences which included unprofessional behaviours by staff, bullying, and experiences of unfair seclusion processes. The outcomes of this study indicated several positives. First, it raised staff members' awareness of, and empathy towards, the former clients, an

improved 'sense of 'hope' for clients, and awareness of the impact that they have as staff. It highlighted "pride in doing a job that can feel like working all day and you don't see anything come of it" (Kidd et al., 2014, p. 224). In addition, staff responded well to the humanity and experiences of adversity of the clients. Staff recognised the importance for clients of having a human connection, which extended beyond daily nursing conversations relating to medication and symptoms. The overall value of these interactions highlighted the positive significance of connection beyond the margins of power divides that are often typical of service-client relationships. The study findings suggested that these insights may provide a shift in organisational climate to one that recognises resilience and focuses on the potentials and similarities rather than differences.

Another Canadian study by Chen, Krupa, Lysaght, McCay, and Piat (2013) developed recovery competencies specifically for inpatient services. The aim of this study was to understand how characteristics of the inpatient context influence recovery-oriented practice. The study involved interviews with key informants from three mental health inpatient services. Informants were recruited using purposeful sampling and included three consumers, three family members, two community mental health providers, and five service providers (total n=13). The interviews were semi-structured; and participants were asked about their views of recovery, what they felt was important to inpatient service provision, and what were challenges in demonstrating recovery competencies. All participants reflected a range of experiences with inpatient acute services. These interviews identified 'tensions' that included environmental and personal matters, and service providers' own tensions. The study created a competency recovery framework and the tension-practice-consequence model that emphasised the need for engagement and collaborative working relationships, warm and supportive communication styles, and the provision of choices based on individuals' needs. Furthermore, it identified the need to reduce tension through engagement as a paramount process to recovery. In addition, this study recognised that all daily inpatient tensions can be utilised in a positive way to open dialogue and provide a learning experience, and it advocated that the competency framework may prove invaluable to supporting education and promoting recovery-oriented practice (Chen et al., 2013).

Piat and Lal's (2012) qualitative study also focused on recovery in Canada; and it explored the service providers' experiences and perspectives on recovery-oriented practice. Sixty-eight participants were recruited from three geographical areas. This study was conducted using focus groups with service providers. The study found that challenges were highlighted in the implementation of recovery systems, including uncertainty around the meaning of recovery and the application to practice, and a lack

of leadership support and education. The study recommended that organisational and educational systems need to be in place to facilitate embedding a culture around recovery-oriented services and practices. These gaps were also identified, along with others, in an Australian study by Cleary, Horsfall, O'Hara-Aarons, and Hunt (2013).

Cleary et al. (2013) examined how the principles of recovery were viewed by nurses working in inpatient mental health settings. Within this study, 21 Australian mental health nurses were asked questions on a range of recovery-oriented topics. The findings of this study indicated that the majority of the participants understood that recovery is maintaining a state of wellness and includes social factors and self-esteem. Some participants focused more on a medicalised approach, such as medication and symptom reduction, which included improved service-user's behaviours. In addition, barriers to recovery focused on poor staffing levels, inadequate inpatient-to-community coordination, and poor community follow-up for clients being discharged, which led to service-users relapsing and returning rapidly back to the acute ward. Many staff recognised the need for interacting with service-users on a human level – being kind and positive, listening, and being hopeful. Emphasis on education about mental health and medication was also raised within this forum. This study discussed the many aspects of staff members' views on recovery in the acute setting; however, it provided only weak evidence to challenge and clarify the personal values and deep meanings that attach to how nurses experience working with clients.

Overall, the above studies reveal common themes related to the application of recovery-oriented practice within acute inpatient settings. The key messages include the importance of being empathetic, hearing service-users' stories, and recognising the need for nurses to be hopeful, recognise resilience, and engage with service-users on a human level. In addition, it was important that the barriers, within the context of providing recovery-oriented services and practice, were exposed. The nurses faced challenges in attempting to create therapeutic relationships with service-users, whilst being cognisant of the need to ensure safety of the service-users and others in their workplace. These studies discussed how poor staffing levels and lack of appropriate service direction and leadership needed to be addressed to support recovery-enhancing services in the future. This is an area that the proposed study aims to further explore.

The research to date suggests that there is lack of clarity about how the elements of recovery-oriented practices are applied for mental health nurses working in inpatient mental health care. The types of methods used to study recovery-oriented practice amongst nurses have included the use of focus groups, interviews, and brief surveys. Surveys of nurses working in this area indicate some common understanding of core

recovery principles, but there is very little research into nurses' lived experience of applying a recovery-oriented focus in the inpatient acute setting. One Australian study provided a descriptive study of nurses' experience (Cleary et al., 2013). However, the present study reported in this thesis, addresses a gap in the knowledge base as there have been no studies set in the New Zealand context and none that have used a phenomenological lens, which helps to reveal ways of being and thinking in the world. It also helps us to recognise things that are known, but are hidden or overlooked. Phenomenological narratives have a way of being challenging while provoking reflections and emotions. Thus, the current study provides an opportunity to explore and delve deeper into how nurses experience recovery-oriented practice, and the meanings that they make of their experiences within the inpatient setting.

Summary

Since the 1990s there has been a growing understanding of what facilitates personal recovery for people with mental health issues. This understanding has been translated into a vision for recovery-oriented services being incorporated in national policy documents, including New Zealand's Blueprints for Mental Health Services (Mental Health Commission, 1998, 2012). However, the vision has not been fully translated into practice and many barriers to recovery-focused care still exist, particularly within inpatient settings. Addressing the barriers and developing better evidence to guide the implementation of recovery practices is needed. Only then may the visionary ideals of current mental health strategies services be fully realised (Kidd et al., 2014).

While recent research has begun to explore the issues and the success stories of recovery-oriented practice within inpatient mental health services, gaps remain in the knowledge base. Previous studies have indicated that perceptions regarding mental illness continue to foster the beliefs that professionals may distrust and, at times, fear people experiencing mental health issues. Additionally, much of the literature on mental health nurses' attitudes and the implementation of recovery-oriented practice have predominantly used brief surveys as the method for gaining information. Little research has been conducted to identify the significance or meaning of recovery-oriented practice in depth and no relevant studies have been conducted in the New Zealand context. This represents a lack of knowledge with implications for both service user recovery and nurses' job satisfaction. Therefore, the research question that has emerged from the literature is 'what is the experience and meaning of recovery-oriented practice for nurses working in acute mental health services in New Zealand?'

Chapter 3: Methodology and Methods

Introduction

This study set out to explore the experience and meaning of recovery-oriented practice for nurses in an inpatient mental health service. The following chapter outlines the specific aims and design of the study. First, the relationship between the research question, study aims, and the chosen methodology are explained. Then the methodology of hermeneutic phenomenology, which informed the study, is introduced and key philosophical notions outlined. The discussion then moves on to the research methods used, including ethical considerations, researcher pre-understandings, participant recruitment, data collection, and analysis. Finally, the ways in which the trustworthiness of the study was maintained are described.

Aims of the Study

In the previous chapter, the review of relevant literature highlighted several studies that explored how nurses understood and applied principles of recovery-oriented practice. The findings of these studies revealed themes related to aspects of recovery-oriented practice as well as facilitators and barriers to using the approach across mental health settings. However, these studies primarily used descriptive methodologies and methods such as brief surveys, which lacked depth in relation to capturing the experience and significance of practice. Additionally, few studies explored how nurses experienced and engaged with service-users specifically within inpatient mental health settings, and no studies of this nature were conducted in New Zealand. Therefore, to address this gap, this study set out to answer the overarching question of: What is the experience and meaning of recovery-oriented practice for nurses working in a New Zealand inpatient mental health service?

There are several elements of interest within this question, which are captured in the study aims:

- To explore nurses 'lived experience' of recovery-orientated practice within a New Zealand acute mental health service.
- To explore the nurses' experience of specific barriers and facilitators to recovery-orientated practice.
- To capture something of the overall meaning or significance of recovery- oriented practice for the nurses.

The study question and aims served as a guide for choosing an appropriate methodology and method for the research. To address the need for a more in-depth focus on the nurses' lived experience of practice, a phenomenological approach was chosen. Phenomenology aims at gaining a deeper understanding of everyday and taken for granted experiences (van Manen, 1997). The phenomenon of interest in this study was the practice of recovery-oriented care, which nurses do not generally stop to reflect on in the busyness of each shift. Furthermore, the addition of a hermeneutic lens supported the research to go beyond descriptions of lived experience to *interpret* the meaning of that experience, using philosophical notions (Heidegger,1927/1962). Therefore, a hermeneutic phenomenological approach was identified as being well aligned with the aim of exploring the nurses' experience and the associated meanings. While the exploration of recovery-focused care is not new, this study aimed to extend what is understood by describing and interpreting the meaning of the nurses' lived experience in greater depth. In the following sections the methodological foundations of the study are further explained, including key notions underpinning the study design.

Philosophical Underpinnings

A hermeneutic and phenomenological approach guided the study design. Specifically, the writings of the German philosopher Martin Heidegger (1927/1962) and the Canadian scholar, Max van Manen (1990) informed the research process. The following discussion outlines the philosophical underpinnings of this methodology and shows how these have informed the methods used. It is important to note that this study was conducted in the context of a professional doctorate, a qualification aimed at being applied and practical in nature. Therefore, unlike a PhD, the emphasis is less on a deep reading of hermeneutic philosophy, but on bringing a phenomenological and hermeneutic 'lens' to the research questions and analysis.

Firstly, it is important to understand and define what is phenomenology and hermeneutics within the context of this study. Husserl (1907) described phenomenology as the study of the 'lifeworld' – the world as we immediately experience it pre-reflectively rather than as we conceptualise, categorise, or reflect on it. The goal of phenomenological inquiry is to gain a much deeper awareness and understanding of our daily experiences. Phenomenology is quite different from other forms of research, in that it moves away from current ways of thinking, for instance around theoretical and technical concepts. Instead, it connects more to our direct conscious experiences. These experiences can be explored philosophically or even poetically, to try and capture something of the essence of the phenomenon of interest (van Manen, 1997).

The hermeneutic aspect of the methodology is the interpretive element and is pivotal to Heidegger's philosophical view of phenomenology (1927/1962). The term hermeneutics comes from the Greek word *hermeneuein,* which is translated in English as 'to interpret' (van Manen, 1997). Phenomenological hermeneutic inquiry is underpinned by the assumption that there is no single reality that can be understood objectively, and that we are always interpreting and making sense of our world through our engagement in it. van Manen (1997) suggested there is a need to determine, through questioning, the essential nature of lived experience, a way of being in the world, stating:

> A phenomenological concern always has this twofold character: a preoccupation with both concreteness (the ontic) as well as the essential nature (the ontological) of a lived experience. Phenomenology is not concerned primarily with the nomological or factual aspects of some state of affairs; rather, it always asks, what is the nature of the phenomenon as meaningfully experienced? (pp. 39-40)

This approach is, therefore, more concerned with how something is in the world, rather than what it is (van Manen, 1997). However, we can never get to one single essence of a phenomena, we can only uncover taken for granted aspects, which are overlooked because we are so caught up in the everyday movement of life (van Manen, 1997). This approach to phenomenological inquiry propels the researcher to be orientated to the lived experience of the study participants, to be able to show genuine interest, to be able to ask 'what is that like?' The aim of this type of research is to avoid generalising, as this may prevent the researcher from developing understandings that focus on the uniqueness of each person's human experience (Magrini, 2012).

van Manen (1990) made the clear distinction between 'problem' and 'mystery' and suggests that phenomenology focuses more on mystery than problems. Problems require solutions and methods that get outcomes and results. Whereas a 'mystery' requires original and meaningful questions and remains open in the inquiry. It was anticipated that a focus on meaning and remaining open to the nurses' experience would help to uncover some of the taken for granted and overlooked aspects of working in a recovery-oriented manner within the inpatient setting. The phenomenon of interest within the present study therefore was 'the nurses' experience of recovery-oriented practice in an acute mental health service'.

Hermeneutic Notions

As phenomenology is the conduit through which to gain a better understanding of everyday experiences, hermeneutics provides a lens through which the meaning of these experiences are interpreted. The analysis within this study used the notions of Heidegger (1927/1962) and van Manen (1997) to add depth in making sense of the nurses'

experience. The following gives a brief overview of some of these notions and how they are important to the nurses and their experience of recovery-oriented practice within this study.

Dasein and Being-in–the-world

Dasein is a key notion in Heidegger's philosophy. This is not always an easy notion to define but, putting it very simply, it means 'being there'. Heidegger (1927/1962) argued that humans are not distinct from the rest of reality but part of it. Thus, Dasein is about being there, present, available, existing in both time and space (Inwood, 1997). It is all encompassing, as we are part of the world in which we interact every day, and cannot step out of it completely. A related notion is that of 'Being-in-the-world' (Heidegger, 1927/1962). The hyphens in this term reflect the notion that our being cannot be separated from the world in which we exist. The term also refers to the *ways* human beings exist, behave, or are involved in the world. There are many different 'modes' or ways that we can be-in-the world, and these are influenced by our mood and the situations we find ourselves in. For example, within this study there might be certain ways of Being-in-the-world that the nurses' stories reveal, some that support recovery and other modes that do not.

Being-with

The notion of 'Being-with' (Heidegger, 1927/1962) refers to "who it is that Dasein is in its everydayness" (p.149). Heidegger (1927/1962) rejected the notion of Dasein being an 'I thing' but suggested that we are primarily a "Being-with-another" (p.163). Heidegger highlighted what he meant by "Others" a term he often interchanges with the word 'they' (das Man). Heidegger explained:

> By 'Others' we do not mean anyone else but me - those over against whom the 'I' stands out. These are rather those from whom, for the most part, one does not distinguish oneself - those among whom one is too…By reason of this with-like Being-in-the-world, the world is always the one that I share with Others. (pp. 154-5)

Thus, our 'world' consists of those people we engage and share experiences with. The world of inpatient mental health nursing consists of being-with service-users and their families in distress as well as nursing colleagues who have shared understandings and practices. In this manner, they share with others by being-in-the-world with them and present to their experience.

Mood and Thrownness

Heidegger also introduced the notions of state of mind, mood, and thrownness (1995). A state of mind is translated to say 'a human is always found somewhere' (a location)

whether or not they are aware of it (their mood or state of mind). This is what Heidegger referred to as living in the world, how we sense how we find ourselves and in situations, indeed it gives us a sense of belonging in the world. A related notion to state of mind is the 'mood' that we find ourselves in. Heidegger discussed the notion of mood in relation to how we are in tune or 'attuned' with the world around us. Through our bodily or embodied attunement, our fundamental mood reveals our relationship to the world at any moment. If we are anxious, the world may be a threatening place, if we are depressed, the world may feel meaningless or like it is closing in on us.

Our way of Being-in-the-world is shaped by our mood, but also by the situations we find ourselves in. Heidegger referred to this situatedness as 'thrownness', in that we are thrown into particular contexts historically, socially, culturally and geographically. Despite having little choice about the times we were born into and many of the situations we find ourselves in, Heidegger contended that an 'authentic human is free' and this is characterised by the ability to 'be'. He suggested that humans are not only confined to the present time, but can project into the future, by having an awareness of our actions and the possibilities that arise with any situation. Heidegger's definition of what it is to be human, implies that while we are 'thrown' into particular contexts, we can also choose how we respond and shape our own destiny in some way (Heidegger, 1995). These notions of mood and thrownness are relevant to the way nurses' find themselves in a particular context within the inpatient unit. They are often literally 'thrown' into unpredictable situations with various expectations and pressures to manage risk and complete certain tasks, but at the same time remain attuned to the possibilities for supporting recovery and healing for service users.

Lifeworld existential: guides to reflection

All phenomenological research involves explorations into the world as we experience it in everyday life and situations. The next section explores some essential themes of lived experience or 'existentials' that help inform this study. As previously mentioned, the aim of the study was to reveal or uncover the experience and meaning of recovery-oriented practice for nurses working in acute mental health services. van Manen (1990) discussed four core aspects of Being that are fundamental to all human experience. The four themes (known as lifeworld existentials) have been instrumental in guiding my writings and have been used in my reflections within this study. They include: lived space (*spatiality*), lived body (*corporeality*), lived others (*relationality*), and lived time (*temporality*).

The first of these themes, *lived space*, is 'felt' space rather than calculated or mathematical space which is measured in length, height, and depth dimensions (van

Manen, 1990). It refers to the feel of a space that we occupy. It may be that we feel safe and cosy in one room or situation, or vulnerable and fearful in another. Indeed, van Manen (1990) suggested that "we become the space we are in" (p. x). The lived space is important in this study, as the changing work cultures, environments (often confined and at times coercive), and space within which nurses' and service-users come together is a central theme within many nurses' stories revealed within the current study.

The often-fluctuating experience of *lived body* is another central theme within many of the nurses' stories from within the data. It refers to the fact that we are always bodily in the world, the subtle signals of how we relate to the individuals we meet in daily life always reveals something, even if we are trying to conceal how we feel. This becomes apparent within this study, in particular with nurses being attuned or experiencing embodied knowledge (Merleau-Ponty, 1945/1962) as they respond to service-users intuitively.

The theme of *lived other* refers to the relationality we maintain with other people in the interpersonal space we share with them (van Manen, 1990). This relationality can fluctuate depending on mood, where we are, what we may be doing, and how we engage interpersonally. The notion of Being-with is closely related to lived space and lived body and as the later chapters will show, engagement with others was an important feature of the nurses' experience.

The final lifeworld existential discussed by van Manen (1997) is *lived time* (temporality). Rather than clock time, which is objective and generalised, lived time is subjective and influenced by our specific mood and thrownness. For example, when we are having fun, time flies, but if we are waiting, time drags. van Manan (1997) suggested that lived time is "our temporal way of being in the world" (p.104) and also includes the relationship between our past, present and future. According to Heidegger (1927/1962) our past and our possibilities for the future come together in our present Being-in-the-world. Thus, for nurses in acute mental health settings, their previous experience shapes their attunement to current practice situations, which in turn shapes their understanding of possible responses and projects them into the future. The nurses' accounts in this study revealed aspects of their lifeworld, and the four existentials were evident in their Being-with service users in distress.

Research Methods

In the preceding sections the methodology and philosophical notions guiding this study were explored and discussed. The second half of this chapter shows the particular research methods that were utilised. van Manen (1990) suggested that the methodology

of phenomenology aims to reduce the influence of pre-conceived ideas saying it "tends to ward off any tendency towards constructing a predetermined set of fixed procedures, techniques and concepts that would rule-govern the research project" (p. 29). While Gadamer (1976) suggested that the method of phenomenology and hermeneutics is that, there is no method at all. Therefore, there are no set or prescribed procedures or expectations to produce specific repeatable results in a scientific manner.

However, van Manen (1997) has proposed 'six steps' or themes, for conducting hermeneutic phenomenological research. These 'steps' are broad principles which allow for flexibility in how the research is conducted, but provide a guide for elements of the research process. In line with avoiding a rule-governed approach, the steps are interchangeable, and allow for movement between the detail of specific stories and the overall phenomena of recovery-oriented practice. These general principles have been applied in the interviewing and analysis within this study.

The first of van Manen's steps refers to *turning to the nature of lived experience*. Everything we do is directed in some way towards understanding and interpreting the things that are of importance to us as humans. Within this particular study, this is namely the experience and meaning of recovery-orientated practice for nurses working in an acute mental health service.

Step two, *investigating experience as we live it*, relates to methods employed to investigate the lived experience. van Manen (1997) asserted that one must investigate rather than simply gain knowledge through books or through third party communications. This relates to being experienced (like the nurses who participated in this study) and having lived a life deeply and fully; all of which helps the researcher to explore the lived experience in some depth.

Step three of van Manen's (1997) framework involves *reflecting on essential themes*. This involves being able to be deeply reflective and grasp what the stories of experience reveal to uncover themes that point to something of the essence of the experience.

Step four, involves the process of *describing the phenomenon in the art of writing and rewriting* (van Manen, 1997). Through this process of descriptive writing and interpretation, the intention is to make visible the feelings within and significance of the participants' experience.

Step five, *involves maintaining a strong orientated relation to the phenomenon* (van Manen, 1997). As a researcher it was important to have a strong attachment to the study and remain focused on the research question throughout. This was a challenge, as I found myself often getting side tracked into other areas pertaining to recovery. I needed

to keep grounding myself and continually orienting back to the nurses' experience of recovery-oriented care.

Finally, step six involves *balancing the research context by considering the parts and the whole*. This principle focuses on the researcher's ability to "constantly measure the overall design of the study/text, against the significance that the parts must play in the total textual structure" (van Manen, 1997, p. 33). In other words, each individual account of practice needed to be considered in its own right, but also in relation to the thesis as a whole. There was a constant movement between each part and the whole story of recovery-oriented nursing in the inpatient setting. As the data was read, reflected upon, and reconsidered in the present study, it became evident that despite the use of these guiding principles, there was no structured start or finish to analysis in the traditional sense. In phenomenological research, understanding is always 'on the way', and a final point or essence is never achieved (Heidegger, 1927/1962). Reflection and interpretation will be ongoing and more insights into the nature of recovery-oriented practice will be revealed beyond the conclusion of this thesis. The following discussion sets out the application of these principles in further detail, specifically in the sections related to data collection and analysis. First though, the methods related to ethical considerations, presuppositions and participant recruitment will be outlined.

Ethical considerations

The protection of the nurse participants was a key ethical consideration in this study. Nurses who are employed in small acute inpatient services and work in close-knit teams and communities are open to the risk of privacy being breached if ethical considerations and processes are not followed carefully. In addition, there was potential for emotional or sensitive experiences and information to emerge for the nurses as they reflected on their work with service-users and the impact of inpatient team culture and other pressures. It was therefore necessary to gain relevant consent, ensure protection from harm, risk minimisation and maintain confidentiality at all times, as well as avoiding coercion or any deception throughout the entire study.

To ensure participation was voluntary and based on an informed decision, an intermediary colleague (the ward manager) gave potential participants verbal and written information about the study. Initially, the intermediary informed the nurses of the study by placing a poster on the notice board in the ward office. When interest was expressed then an introductory letter outlining the aims and process of the research was sent to the potential research participant, along with an attached consent form (see Appendices A and B). It was clearly emphasised that participants had the right to withdraw their consent from participating at any stage of the research. In addition, there was a 'cool down' period

of at least a week, before the researcher contacted the potential participants. This ensured that each potential participant had time to reflect on and digest the introductory letter. Interested participants were then asked to sign the consent form regarding their participation, including the recording of their individual interview.

Although no issues arose, if any concerns from the participants had arisen during the research process, the researcher would have responded immediately, as well as seeking other supports as relevant. Protecting the anonymity of the nurses involved keeping all personal data and materials in locked storage or passcode protected electronic files, to prevent the disclosure of personal data beyond the study supervisors and myself. The nurses were given pseudonyms to protect their identity, which were used in presenting the data. It was also important to provide opportunities for participants to check and verify the transcription of their narratives and to ask for any inaccurate or sensitive information to be removed from the data. The Auckland Ethics Committee (Appendix C) and the Auckland University of Technology Ethics Committee (Appendix D) granted ethical approval for the study. Additionally, a locality agreement was secured from the District Health Board in which the inpatient unit sat.

In addition to the above ethical considerations, the researcher was mindful of the concept of Tikanga, (the indigenous reference Māori of values and ethics). Because the service in which the study was located had relatively high proportions of Māori service users and staff, it was important to ensure that views of Māori nurses were captured and analysed with a Māori worldview in mind. Before the study began, a hui (meeting) was sought by approaching the Health Board's Māori representatives to discuss the study and the possible impact on Māori. Cultural consultation and supervision for the study were then accessed through Dr Barry Smith (Te Rarawa, Ngāti Kahu) and Phyllis Tangitu (Ngāti pikiao, Ngāti awa, Ngāti ranginui, Ngāti haua).The use of cultural consultation and supervision aligned with the Treaty of Waitangi principles (Hudson & Russell, 2009). These principles ensured inclusion of *partnership*, through full consultation with tangata whenua in relation to the study aim and design, and utilising cultural supervision in the data analysis. Another principle of the Treaty of Waitangi, included the important notion of *participation*, this was carried through the purposive sampling of the Māori nurses on the ward, to ensure the voices of Māori nurses were represented well. The final principle of *protection*, involved the respect and value that was placed on the stories of Māori nurses and the integrity of these stories being maintained in the analysis through checking interpretation with the participants and through cultural supervision. Additionally, the study outcomes are to be shared with transparency and clarity with Māori stakeholders.

Assumptions and pre-understandings

Early in the development of this study, it became clear that it was going to be important that I reflect on how my own assumptions or pre-understandings might influence how I ask about and interpret the nurses' experiences. To assist with this, one of my supervisors offered to interview me to help me recognise the influence of my own experiences and beliefs regarding recovery-oriented practice within acute mental health settings. My personal life and my career as a mental health nurse were indeed experiences that influenced my belief system and assumptions prior to starting this research. Some of these beliefs were acquired through reading literature pertaining to nurses and their recovery practices in mental health. Consequently, I expected that nurses would relate how little time they had to spend with the service-user, and expected to hear stories of the nurses being burnt out and not really caring as much as they once did. Looking back, that interview enabled me to reflect on these matters and revealed that I held particular assumptions and a somewhat negative bias about nurses' ability to be recovery-oriented in the inpatient setting. I was then able to manage this assumption and remain open to other types of experiences within the nurses' stories. I realised over the time of the study that, in reality, these nurses showed passion and extraordinary care while working alongside service-users within acute care. Furthermore, I totally underestimated the power and value of nurses simply Being-with service-users, and the importance of reflection within their work. I had taken these aspects of practice for granted and been focused on the issues that were more explicit in everyday practice of the new nurses that I supervised or supported. What I learned from these reflections assisted me to be more attentive and open to the nurses' actual lived experience and the meaning in their stories.

Participant Recruitment

The sampling for the study focused on recruiting up to 10 nurses from the acute mental health ward of a New Zealand District Health Board. The research office within a District Health Board was contacted for approval to approach and discuss the research with the clinical nurse managers within the respective hospital. I began the participant recruitment once the District Health Board had approved the study and the recruitment methods. I asked clinical nurse managers to act as intermediaries and inform all the nurses about the study. The intermediaries made the staff aware of the opportunity to participate in the research and were provided with copies of the participant information sheet to distribute. In addition, there was a poster displayed in a communal area informing staff of the research project, outlining its purpose and requesting for those interested to contact the researcher (see Appendix E). When nurses expressed interest, the researcher provided further information verbally and answered any questions they had

about the study. When the volunteers wanted to proceed as participants, the researcher asked them to sign a consent form and arranged a time for an interview. The inclusion criteria required the participants to be:

- A registered nurse, holding an annual practicing certificate, and conversant in the English language.
- Employed by the District Health Board and working directly with service users in the inpatient mental health service at the time of the study.
- At least one year plus post registration. The first-year post training can be fraught with new experiences and knowledge building. It was reasoned that after their first year, the nurses would be better prepared to discuss recovery-oriented practices and have a range of practice experiences to draw on.

Study Participants

Ten participants took part in the study and all were registered nurses from the same inpatient service and all offered to share their stories without reservation. Eight of the participants were women and two were male, with ages ranging from their late 20s-50s. Three of the participants identified as being Māori, with the rest being of European descent. Seven of the participants had nursing experience of 20 plus years, some with over 30 years as nurses. Overall, the majority had vast experience of working in acute mental health settings. The three remaining nurses were relatively new, having completed their new graduate nurse training in the previous year. The mix of ages, gender, and ethnicity of the nurse participants provided a rich range of experience, reflections and viewpoints regarding recovery-oriented practice within the acute mental health setting.

Data collection: Conversational interviewing

In-depth interviews were conducted as a way of meaningfully exploring each nurse's unique lived experience. It is common in phenomenological research to use a 'conversational' style of interview to remain as close to the participant and his/her experience as possible (Grant & Giddings, 2002). During this data collection process, I applied van Manen's (1997) principle of '*Investigating experience as we live it*' to guide to the questions and style of interview. I tried not to make the interview overly structured and endeavoured to keep it an open conversation throughout. This informal style of interviewing assisted me to capture specific accounts of the phenomenon of interest. Therefore, the focus was on eliciting the nurses' stories of particular events or experiences, which they viewed as being recovery-oriented. Within the first interviews I

was overly concerned to ask all the questions that I had laid out, and was rather nervous in my interview style. However, once I relaxed, I was able to focus on listening and being present with the nurse in front of me. In this particular method, I had a number of questions that were 'open-ended' to allow the participants to reflect and to share their personal stories in conversation, which seemed to work well. This was a positive way to obtain a rich quality of views and experiences (Burnard, Morrison, & Gluyas, 2011), which I feel helped to yield a deeper meaning in the data. Types of questions asked of the nurse participants included:

- What does recovery mean to you?
- When you hear talk of the need to practice using a recovery-oriented approach, what memories and feelings are triggered?
- In what way do you feel you support client recovery?
- Tell me about your experience of recovery-orientated practice with a client.
- As you seek to practice recovery-oriented care, what helps or hinders you in achieving that goal?
- Can you tell me about a specific example of recovery-orientated practice?

All the interviews were recorded on a digital recorder and professionally transcribed for analysis. This included having a transcriber confidentiality agreement put in place.

Data Analysis
The transcribed data were analysed using step three of van Manen's (1997) framework; '*Reflecting on the essential themes which characterise the phenomenon*'. The focus here was on using a reflective stance and uncovering emergent themes within the stories of recovery-oriented practice, with the aim of capturing something of the meaning or essence of the participants' lived experience. van Manen (1997) suggested that phenomenological research aims to uncover or re-establish a connection with original experience, a deep questioning, a level of mindfulness, and a depth of meaning within everyday matters or practices.

I began the process of data analysis by examining and listening carefully to each individual nurse's story. I then spent time reflecting upon relevant statements, phrases and accounts, which were extracted from the transcribed interviews. I also spent a lot of time removing data that did not relate to recovery-oriented practice. In addition, I learnt it was important to keep an original record of each of the nurse's transcripts to return to as a whole. As time went by, I would go back to find these transcribed conversations and find that they continued to reveal more to me as the findings unfolded. This return to the

original transcript helped me to ensure that I had understood and captured elements of the stories accurately, separately and within the whole (Adams & van Manen, 2017).

Following on from this process, I turned to the 'meanings' that were emerging from each nurse's account and across the conversations with different participants. I began the formation of thematic groupings and analysis to communicate the phenomenological – ontological understanding of their lived experience. To help me with focus, I created a mind map of how I perceived some of these thematic groups would look like overall (see Appendix C). I also found it useful to keep a table of each of the nurses' stories, concepts, meanings, and possible phenomenological significance, which enabled me to stay focused on key insights in relation to the research topic (see examples in Appendices F and G). I found that it was helpful to be able to relate back and check that I was going in the right direction, while respectfully representing the nurses' stories. Staying with van Manen's (1997) aim of "thematic understanding" (p. 79), helped to identify commonalities from the participants' transcripts, as well as any variations within the data.

Validation was required to explore and check theme construction and then organise these into an incorporated description of the phenomenon in question. This involved an iterative process of writing and re-writing interpretations of the nurses' stories. The writing of phenomenological description, according to van Manen (1997), "strives for precision and exactness by aiming for interpretive descriptions that exact fullness and completeness of detail, and that explore to a degree of perfection, the fundamental nature of the notion being addressed in the text" (p. 20). I also used direct participant quotes to illustrate the themes and this added richness and rigour to the study. This reflective process assisted me to remain thoughtful and cognisant to data analysis, and enabled me to understand each participant's world and personal meanings in relation to his or her individual stories and recovery-orientated experiences. In addition, it was important to ensure that the data collection and analysis always related back to the nurses' experience of recovery-orientated practice. Participants were kept informed about the research during the analysis and initial findings were shared with the nurses.

Trustworthiness

In this study, the term trustworthiness has been used to represent the rigour of the study's process and content. Koch and Harrington (1998) suggested that trustworthiness in qualitative research needs to be transparent, reflecting the quality of the methodological thinking and the researcher's decision-making. Common themes pivotal to trustworthiness in qualitative research include; credibility, transferability, dependability and reflexivity (Koch, 2006; Koch & Harrington, 1998).

The methods that I used to promote the trustworthiness of this study included the following aspects;

- Use of reflection on the entire research process. This included the use of a reflective research diary. In addition, I recorded my thoughts, feelings, and observations during each stage of the study. This aspect shows reflexivity within the process

- I sought participant feedback and validation throughout the process. It was important to involve participants in the process, to show transparency and inclusion of their stories, which included the audit trail from the beginning to the final research findings. Their feedback and views, and perceptions were then incorporated into the 'themes' clusters accordingly. Here the dependability aspect of this study is thus highlighted.

- Peer review and supervision. Inter-rater peer review was incorporated in this design; the researcher approached a colleague who had experience in qualitative research. My analysis was furthermore discussed and interpretations were compared with my supervisors.

- Keeping an audit and data trail, helped support dependability. It was necessary to provide evidence for every phase in developing the themes and subsequent findings. The process of this study was audited in various ways. As mentioned, a reflective journal or research diary was utilised. In addition, supervision session notes and all feedback from sessions with the supervisors were kept to reflect upon and use within each stage of the study. These were invaluable when thinking and reflecting back through the themes within the study. The interpretation of the data were also made clearer by the ongoing writing and rewriting of findings. van Manen (2014) suggested that the methodology of phenomenology requires this back and forwards of writing, in order to do "justice to the fullness and ambiguity of the experience of the lifeworld, writing may turn into a complex process of rewriting" (p. 131).

I have undertaken this research for many reasons. However, an important motivation was the discovery that there was very limited literature pertaining to the lived experience of recovery-oriented practice for acute mental health nurses and none using a phenomenological approach or within the New Zealand context. My personal hope is that this study will be of interest and of value to nurses who work in mental health services and are striving to use recovery-oriented approaches. To ensure transferability in the study, and considering that nursing research in this study is tied implicitly to nursing practice, I feel it was also important to also give consideration to readability. I aimed to present the study findings with enough description to allow nurses and other health professionals to decide whether the participants' experiences are in line with their own (Pereira, 2012). Furthermore, I have continually met and engaged with fellow

researchers, who were using hermeneutic phenomenology, to think about and explore the concepts and notions regarding the use of phenomenology. I also felt it was vital to keep my study 'alive' and real and therefore presented the study to other nurses in various settings. In doing so, I have been pleased to have received the 'phenomenological nod' when sharing the preliminary findings with nursing colleagues, which indicates that the findings resonate with other nurses' experience.

Summary

This study used a phenomenological hermeneutic lens to explore mental health nurses' experience of recovery-orientated practice within an inpatient setting. This approach involved gaining insight into 10 mental health nurses' practice experience through conversational interviews. Interpretation of the transcribed interviews was conducted through an iterative process of careful reading, reflection and writing to uncover key aspects of the nurses' experience. This chapter has described the link between the hermeneutic phenomenological approach and the methods of collecting and working with the data as well as maintaining trustworthiness by using a reflective and transparent approach. The potential benefits of the study include providing rich narratives of the nurses' experience to reveal to strengths, limitations and challenges of current practices in relation to supporting recovery. In addition, the findings may prompt action to develop new strategies to support recovery-focused care and improve inpatient services. The following three findings chapters present the nurses' accounts to illustrate key aspects of their practice within acute mental health services. The sharing of these nurses' experiences begins to uncover something of the meaning within their practice, as they work to support service users' recovery.

Chapter 4: Core Aspects of Recovery-Oriented Practice

As discussed in Chapter 2, in recent decades people with mental health issues have become more vocal about their experiences of recovery, providing various perspectives on the process. Similarly, the nurses who participated in this study had varied perspectives on what recovery and recovery-oriented practice involves. However, within the nurses' accounts of supporting recovery some common aspects of practice stood out as being core elements. This chapter introduces these core elements and provides brief excerpts from the nurses' stories to illustrate the subthemes. The findings chapter following this one will then illustrate the participants' experience of applying these elements in the creation of therapeutic spaces. The present chapter begins with a discussion of the nurses' focus on supporting recovery through "working collaboratively". The discussion then examines the significance of "knowing the person" and "looking beyond the service user's diagnostic label", to see individuals in the context of their lives and not just the diagnosis. Following on from this, the notions of "focusing on strengths" and "finding personal meaning" are presented. Finally, "instilling hope" is shown to be paramount in supporting service users' emotional well-being.

Working Collaboratively

During this study, it was evident that the nurses' accounts of recovery-orientated practice focused on 'working with' rather than 'doing to' service-users. In New Zealand, the climate of mental health services encourages the involvement of service users in their own care, drawing on their own knowledge and experience in planning treatment. The nurses' stories reflect this approach and suggest that using a collaborative approach had a positive impact on the service-users' experience. In the following narrative, one of the male nurses, Arron, begins by discussing his understanding of what recovery-oriented practice is and its meaning for him. He talks about collaboration and self-reflection as important elements:

> *Everyone deserves a chance regardless of how long a patient's been treated and has not responded, we need to take a different approach. So, I suppose you know as far as a recovery model goes, I mean you are looking at the hierarchy of needs…. are we going through the basic needs etc***. Are we working with the client? Are we working collaboratively?** *Or are we sort of dictating what needs to be done? Are we looking after ourselves or are we trying to sort of you know work with a client?*

In the situation described by Arron, he comes to the realisation that when service users do not respond to treatment, an opportunity opens up to do things differently, which necessitates a change of approach. Arron describes the need to question whether, as a nurse, he is truly working in a collaborative manner to identify and meet the service user's needs, or simply servicing his own. For nurses, there are clear expectations to fulfil, with an emphasis on engaging collaboratively, but at times, a more directive approach may be required. Therefore, the capacity for self-reflection and working alongside service users to help them articulate their needs, from basic survival to higher psychological and social needs, appear to be important aspects of supporting recovery.

Similarly, Anna discusses her understanding of recovery-oriented care as working with service users to identify and meet their needs:

> *Recovery [oriented-care] for me predominantly **is working with** the patient to help them recognise their illness and find a way that we can help them. Not just through medication but through all other avenues to give them back a quality of life, which they can take forward.*

Anna's description stresses the importance of working collaboratively to support service users in understanding the nature of their distress. She also suggests that working alongside individuals provides a conduit to explore alternative ways in which to support their recovery. There is a recognition that medication alone is not an adequate response to restore quality of life, whereas collaborative decision-making allows choice and increases the likelihood of finding the best way forward. Providing education on the nature of their 'illness' and the options for support available opens an opportunity for service users to regain a sense of control over their situation. Therefore, working collaboratively is a way of Being-with service users that opens space for greater shared understanding and future possibilities. However, this requires a foundation of *really knowing* the person and his or her family.

Knowing the Person

The nurses' accounts indicate that really knowing who each service user is, as a person, is critical to recovery-oriented practice. All participants described relationships with service users that were long-standing and were built through spending time and effort in getting to know the individual over multiple encounters. This involved 'Being-with' in an authentic manner that benefited the service user; rather than looking through a solely clinical lens. The following excerpts from participant accounts show how 'knowing the person' provides a positive platform for building strong relationships and supporting

recovery. In the following excerpt, Deb, an experienced nurse, describes the pivotal role knowing the person plays in supporting the recovery process:

> *So, I guess what recovery means to me…, for me it is around the patients that I work with… 'have they achieved their goals or not'? I guess it is what it means to the client's family…, yeah. 'Cause I don't really see it for myself what recovery is. It is **about knowing the client and what they are normally like**, **what they normally achieve, what they normally do, what do they want to get back to**? …And [then] setting those small goals to achieve that.*

In this account, Deb describes how it is important to develop knowledge of who the person is, beyond the context of the inpatient unit and their crisis. She cannot know what recovery is for each individual without an understanding of his or her past and desired future being-in-the-world. This understanding develops through being-with the person and working collaboratively over time. By focusing on the service users' typical ways of being before their crisis, Deb understands what their 'baseline' for wellness might be, what is important to them and perhaps what types of support might be helpful. Understanding the person's previous lifestyle and routines, provides a starting point for shaping future recovery. This needs to be determined by the individual and family, rather than a nurse though and Deb recognises that this can be a delicate process requiring small steps. Ultimately, an understanding of the person's past way of being and desired future creates a space in the present for setting and achieving relevant goals.

Similarly, Anna discusses how knowing the person and building a therapeutic relationship is a primary aim of recovery-oriented practice. She identifies that the pacing of this process needs to be foremost in her mind while supporting service users. She also highlights the significance of recognising different cultural needs, specifically when working with Māori service users.

> *Especially with the Māori culture... I had to learn fast that [recovery-oriented practice] is done at a completely different speed, [that] before you even start … you need to get **to know their family … You get to know the patient** before you even start looking at why they presented to the acute ward!*

Here Anna indicates that learning what works for people of cultures different from her own is an important aspect of recovery-oriented care. In particular, she describes how she has learnt that she needs to take a more mindful and slower approach when first getting to know Māori service users. Anna understands that for Māori, knowing the person means knowing their family (or whānau) first. She suggests that connecting in Māori culture requires an investment of time to meet and get to know each other before any therapeutic interventions begin. This awareness allows Anna to engage at a deeper,

more meaningful level. In summary, 'knowing the person' involves both temporal and spatial aspects of Being-with service users. It involves attunement to the person's lived space and time, through being present and building connection at their pace, but also understanding how their past and possible future being-in-the-world shape their current goals and care.

Looking Beyond Labels

Another aspect of recovery-oriented care, closely related to knowing the person, was the nurses' ability to look beyond the person's diagnosis or label, and see his or her issues holistically. This was a particular aspect of practice that was highlighted as a challenge for the nurses, due to the dominance of a medical approach within the inpatient setting. The focus on diagnostic labelling and a prescriptive approach to treatment meant the nurses had to broaden their awareness to other aspects of the service users' issues to support recovery effectively. Furthermore, the participants also suggested that the negative attitudes of some staff members led to other stigmatising labels being placed on service users, such as 'attention seeking', 'dangerous' or 'manipulative'. As discussed later in Chapter 6, one impact of these labels was the disempowerment of service users.

In the following excerpts, the nurses discuss how they needed to look beyond the service user's diagnosis or label, and focus more broadly on the service user's life as a whole. Carole, a senior nurse, describes how she views the person holistically:

> *It's looking beyond 'diagnosis' or labelling…It means **working with the whole person** and looking **at their whole journey** rather than just illness and symptomology really. So, for me it is about establishing a relationship with the person and looking at their whole life and their holistic health and what they want or don't want.*

Here Carole identifies how looking beyond the label brings the broader picture into focus and puts the current distress into context. By moving the focus away from the symptomology, she is supporting the service user to identify their wider needs and promotes service user led outcomes. By looking past the label, Carole shows awareness of the power of individuals with lived experience to shape their own life, even in times of distress.

Another nurse, Pat, discusses how she too goes beyond labels and works in a recovery-oriented manner. She indicates the need to broaden the focus to the social context of the person's life and understand what is behind the mental distress. She also highlights

the lack of understanding and stigma faced by service users, and her sense of frustration is evident:

> **People come from families with violence and all that kind of stuff** and it is like, 'how can other people treat other people like that'? Why does that [happen]?… **I suppose 'Why'? is my big [question]**, **'Why is their mental health [like this]?'** 'Why do people, shy away'? I have worked with people, they just want someone who is going to sit and listen and understand their journey and not go; 'Will you just stop'? I have heard people go, 'Oh just get over your mental health [issue]', or 'Just stop your drug addiction'.

Here, Pat recognises individuals' past and current context and the impact experiences such as trauma may have on their lives. Pat feels it is imperative to be less judgmental towards service users and focus on understanding their experiences rather than labelling or dismissing them. Pat emphasises the need for nurses to sit, listen and validate the person's experience to support his or her recovery.

In her narrative, Rae discusses how looking beyond the symptoms and taking a long-term view is an important aspect of a recovery-oriented approach. Her approach also involves being collaborative and empathetic:

> Recovery, for me is about balanced empathy. It's about being directed by the client and their family. It's all about **looking past the acute episode, and I actually think it requires working outside of the episode**. So what I mean by that is, I think a true recovery approach would be that we communicate what we do in our part with the client, and then the **recovery approach keeps going from that point onwards – to the community**.

Like Carole, Rae shows her ability to look at the larger picture; she 'works outside of the episode' looking beyond the crisis, beyond the symptoms and labels towards a life in the community. She focuses on forward thinking and communicating with the service user to play a part in moving the person beyond the distress to the life he or she wants.

Looking beyond diagnostic labels is an aspect of recovery-oriented practice that puts service users' current distress in context, by 'looking at their whole journey'. Similar to *knowing the person* it links past, present and future, but in this instance, the focus is on understanding the origins of the distress and moving past the distress, rather than who the person is and their past and possible future being-in-the-world. A further aspect of recovery-focused care that is important to both *knowing the person* and *looking beyond labels* is the practice of focusing on the person's strengths.

Focusing on Strengths

The nurses reported that recovery-oriented care involved a shift away from focusing solely on fixing service users' deficits towards identifying and using their strengths. This shift challenged the traditional approaches where the role of the service user is a passive receiver of treatment rather than an active agent. For example, in the following narrative Tui talks about what recovery-oriented practice means for her and she discusses the use of a strengths-based approach:

> *For me it means doing whatever I can so that the patient or the client that I am working with can achieve or do whatever they **can to make themselves stronger**…this is part of a recovery model. **Its strength based**, ah... (the nurse was thinking) was that what I was doing? And it will take for someone to say something and then you launch into this conversation and you think, 'ah, was I doing recovery[-oriented care]'? I was just doing what I think is best working for my relationship with that patient towards becoming better, being comfortable, and it is really small steps, on the acute ward*

Here, Tui commits herself to supporting service users by engaging in a strengths-focused way of working, helping them to recognise and build their strength and resilience. She also indicates that in acute services this is achieved through taking small steps rather than great leaps towards recovery. Additionally, Tui somewhat surprises herself when reflecting on her approach. This is quite a beautiful moment where Tui realises that she has been actively 'doing' recovery-oriented practice, without conscious efforts to do so. This indicates that supporting recovery is just what nurses do – a sometimes taken for granted aspect of good nursing within the inpatient setting.

Finding Personal Meaning

Finding personal meaning in life is a task all human beings face, whether it is in the presence or absence of mental health challenges. However, crises and extreme mental distress disrupt everyday meaning structures, such as beliefs, identity, roles and relationships. This can lead to service users questioning themselves and their relationship with the world around them. How service users make sense of their experience is important, as it can determine their understanding of what they are recovering from and what they can hope for in the future. The nurses' accounts suggest that a key aspect of recovery-oriented care is facilitating meaning making with service users.

In the following excerpt, Marama discusses how being recovery-oriented involves recognising the uniqueness of each individual's pathway.

> *It is a very personal, it is personal to each individual and what may be seen as you know recovery for one person can be quite different for somebody else…*

Marama's account highlights that the meaning and process of recovery can look very different for each service user. Recovery pathways are deeply personal, have no guidelines, guarantees, or set rules, but Marama appears open to working with the uncertainty and differences. She continues to discuss how supporting recovery involves helping service users to gain a sense of meaning and purpose in their lives:

> *So recovery to me means enabling or supporting the patients to be able to **find some worth in life**, something that they can…, a goal they can work towards, so that they can **find some meaning in their lives**.*

Finding personal meaning through setting and working towards goals, which Marama relates to here, shows how she values her own role as a recovery guide. She is constantly enabling the service user to identify or seek their worth in life. This ability to gently guide, rather than 'fix' the issue, highlights the services users' strengths and empowers service users in their recovery.

Similarly, in his narrative Matt discusses the importance of supporting individuals to find personal meaning and engage with life in the way they want:

> *It is about the person being able to cope again, to be able to function again; to be able **to live a life that they feel is fulfilled again**. Yeah, it is more about… not necessarily getting them to…what is perceived as normal, but what they feel is **their ability to carry on with a life that they want**.*

Here, Matt suggests recovery-oriented practice involves supporting people to live a fulfilled life. This might involve helping someone to cope and function at a certain level, but it is not about achieving what others might view as a 'normal' life. The excerpt indicates it is necessary to work with service users to identify what a fulfilled and a meaningful life is for them. Helping service users find meaning in their distress and purpose in their life requires nurses to step back from 'doing' or 'fixing' issues. Finding personal meaning in and beyond the crisis also opens up a space that brings hope for a better future.

Instilling Hope

The final core aspect of recovery-oriented practice highlighted in the nurses' accounts was instilling hope through their work with service users. Hope is a word that reflects the belief that things can change for the better. It is rather similar to the word faith; they are both simple words but with deeper meanings and are powerful elements of recovery. An example of instilling hope is found in Marianne's account of recovery-oriented practice. Here she talks about some of the hope inducing messages she communicates when she is working alongside service users.

> *I mean recovery, guess I've learnt over time it doesn't necessary mean getting rid of or having no symptoms, do you know what I mean?*
>
> *I guess for me as a nurse it is really supporting people. Like giving that sense that **this will get better**, and you may not know to what extent, **but we are here together, working together**, **we will get through this**. It is not going to be as bad as it is at this point, **there will be some relief**, so that sort of **sense of hope.***

The nurses' accounts, such as Marianne's, indicated that instilling a sense of hope is fundamental to supporting personal recovery. Marianne suggests that instilling hope involves really Being-with the person, getting alongside them and communicating a belief in his or her capacity to get through the distress. She also gives a sense that she will not abandon the service user; that she is going to be there no matter what happens. This gives three important messages; that the service-user has unwavering support, that there will be some relief from the pain and that a better future is possible. The nurses indicated that they were able to hold on to this hope when service users could not see a way through the crisis and had lost all belief that recovery was possible.

Summary

When asked what recovery and recovery-oriented practice meant to them, the nurses in this study provided varied descriptions, with no two accounts being the same. However, there were some clear themes or core elements across the accounts, which have been briefly outlined in this chapter. It was heartening to hear these 'front line' acute mental health nurses talk about recovery as a real possibility for every individual that they worked with. The accounts also showed how passionate the nurses are about working collaboratively with individuals and supporting them in their recovery. These findings highlight the significance of collaborative engagement, really knowing the person and seeing beyond their distress to their broader life context, focusing on their strengths, facilitating meaning making and providing hope for a better future. To do this the nurses

needed to be self-reflective, have the capacity to step back and see the broader picture, get alongside people and help them articulate meaningful goals and take small steps towards these. The following chapter builds on this overview of the core aspects of recovery-oriented care by revealing more of the nurses' practice experience in utilising these elements to create different types of therapeutic space.

Chapter 5: Creating Therapeutic Spaces

Introduction

This chapter provides further exploration of the nurse participants' experience of recovery-oriented practice. In particular, the interpretation of the nurses' accounts reveals different types of lived space that the nurses created through their care. These therapeutic spaces were formed between the nurse and service user and held particular significance for supporting recovery. van Manen (1997) described how lived space can be difficult to capture in words and unlike dimensional space, it is something that is felt, but not usually reflected on. The telling and presentation of the nurses' accounts allows some reflection on taken for granted aspects of practice. The stories show how nurses in acute mental health settings use their intuition and a sense of dwelling within the world of relationships to create shared meaning and support individuals in their recovery. These intuitive practice experiences relate to the philosophical notion of embodiment. Discussions of embodiment and embodied knowledge are found in the works of philosophers such as Heidegger (1927/1962), Merleau-Ponty (1945/1962), Dreyfus (1991), and Benner (2000) and are pivotal to the phenomenological viewpoint on what it is to be a person. Embodied knowledge refers to the phenomenon of knowing how to 'do something' automatically and without deliberation. This type of knowledge seems to be imprinted in the body. It has been described by Merleau-Ponty (1945/1962) as "knowledge in the hands" (p. x) which is not explicit or conscious, but is recognised by the body or through the body when it is practiced or experienced. Merleau-Ponty (1945/1962) also referred to it as "knowledge bred of familiarity" (p. 144). The nurses within this study spoke about how they often work instinctively with individuals. They gave examples of how they use intuition as an important part of their practice and skill set.

The phenomenological notions of lived space and embodied or intuitive knowledge play a significant role in the following narratives. First, the notion of lived space helps us to understand how nurses open up different spaces when supporting service users, showing *what* they are creating. The second notion of embodied knowledge shows something of *how* the nurses create and work within these spaces. Therefore, the way in which the chapter is constructed reflects the interplay between these two concepts. While the main section headings reflect the concept of lived space, the concept of embodied knowledge or intuition is threaded through the sections. Additionally, the core aspects of recovery-oriented practice discussed in the preceding chapter are also essential elements in creating the different types of therapeutic space.

The chapter begins with the practice of *'creating safe space'* and examines how nurses manage and support individuals who are in crisis or are experiencing distress. This includes an exploration of how Māori nurses create safe space within their work. Then the chapter moves on to consider the practice of *'opening relational space'*, to create connection and shared commitment over time. Humour and play feature within the nurses' stories as sharing humorous moments opens space and can strengthen relationships. Finally, the last section explores the practice of *'providing healing space'*, which supports service users to process their loss and trauma.

Creating Safe Space to Manage Crisis and Distress

Inpatient nurses work with people who are often at their most vulnerable, highly distressed, and at risk of harming themselves or others. Therefore, working within an acute mental health setting is demanding, and frequently requires nurses to use their ability to connect and manage crisis and distress. In the following accounts, nurses describe different aspects of how they work alongside service users and create a sense of safety when faced with challenging situations.

Matt describes his engagement with a young man who was picked up by the police after an urgent call from the public, where he was described as being 'disorientated and psychotic' and walking on a busy highway. The crisis team felt he needed to be formally assessed given that he was presenting as a danger to himself and others:

> *[I said to the police officers] 'Please take the handcuffs off', I was quite relaxed with him and suggested that we have a cup of tea and a chat and see how I can help. I sort of was able to then take him off and we completed the paperwork, taking him out into the ward and introducing him to one or two of the other patients, and just started showing him the general environment and made him feel relaxed.*

Matt describes a situation of supporting a young man on admission, where he recognises the service user's hyper-vigilance and potential vulnerability. Matt works to facilitate a sense of safety and trust by shifting from a custodial orientation (requesting the removal of handcuffs) to offering a warm drink, and by 'Being-with' the distressed service user in a calm and relaxed manner. He also uses the distraction of completing paperwork and then orientates the young man to the ward environment. The account suggests that Matt attempts to communicate some understanding of the lived space of the service user. His actions and tone also communicate that the ward is a safe and supportive place.

The participants' narratives suggest that effectively supporting people in the acute stages of their recovery requires a particular attunement or intuitive awareness. Another story depicts one such experience and its meaning for a senior nurse, Rae:

> *I actually use sitting in close proximity as a form of touch, cause, yeah I actually think for me that's almost more intimate than being a fair way away from someone and just talking you know. On the positive side of things, I think if people are really sick you might see it, in that they present as calmer. I used it this morning on a man with a diagnosis of bipolar, who I didn't know and really it could go either way, so you've got to judge that. But I'm a pretty brave practitioner, so, I just sat beside him and I said, 'look I know that you think that the police and the [gang members] have been after you', and he could have exploded but he didn't. So then I know whether I'm going to be able to de-escalate him, 'cause it gives you lots of pointers, their reaction, where they are at. For me, it is part of my assessment. So then, I thought okay, he is okay with me being, you know up in his grill, so he'll be okay if I take his bloods, he'll be okay if I do his ECG, so let's try that, so we did that and I didn't really talk much 'cause he was quite elevated. I just stayed, did what I needed to do and just said, 'yes' or 'no' or 'hmm', just acknowledged him.*

Here Rae reduces the space and distance between herself and the service user, connecting by understanding his experience of feeling persecuted and continually assessing his responses sensitively. Her experience and intuition tell her that it is safe to continue with further procedures, whilst she continues acknowledging him and validating his perspective. The phenomenon being shown here relates to lived space; not only the physical proximity, but the emotional proximity or attunement that Rae demonstrates as she sits alongside him – she sees it as a form of touch – or getting 'in touch' with what sort of 'space' the service user is in. Indeed, the space where we find ourselves has an impact on how we feel and depending on our mood, what we are attuned to. In essence, we become the space we are in (van Manen, 1997). As Rae gets in touch with the service user's lived space, her calm presence and acknowledgment of his vulnerable state reassure him and evoke a sense of safety.

Similarly, the concept of intuitive embodied knowledge can reveal itself by the use of actual touch as well as physical presence. This is shown as Rae continues her account:

> *I actually use touch a lot, but... I'm careful in what I do. So if I think someone is really unwell and or I think It might escalate them or they're quite disinhibited or maybe if they're quite psychotic or, and agitated I might start by perhaps just touching them on the arm once. I actually use that as a bit of a litmus test, or I'll just touch their back, just briefly and see how they respond. Clients will tell you when they don't want to be touched, and if I have I'll apologise, I'll say 'look I'm sorry, I didn't, you*

know I didn't mean to get into your space', but on the positive side of things, I think if people are really sick you might see it in that they present as calmer.

Here Rae is using her past experiences and intuition to connect with the service-user. By introducing touch, she is once again reaching in to his lived space and supports him in his distressed state. She is very careful to use touch in neither an aggressive nor an intrusive manner, demonstrating a 'tactful' approach (van Manen, 1991). Rae uses touch as a 'litmus test' to gauge where the service user 'is', psychologically, in his world at that moment in time. She is also self-aware and her orientation and tact towards the service user shows how important it is to know oneself and recognise that the other is a separate 'self' (Smythe & Norton, 2007). This is significant for Rae in understanding that the service user's concerns, feelings, and needs are as yet unknown. She needs to provide a safe space for him and waits patiently and intuitively for him to open up and reveal his world.

Like Rae, Pat recognises the importance of managing her physical presence in creating a safe space:

I think even just sitting down [is helpful]. There is no use someone sitting down … and you're standing up - well go and sit down next to them, you know so you're not towering over anybody, or I kneel down. Someone's sitting on a chair I'll kneel down beside them and I might put my hand on their knee, just an instant, or their arm…, just to say 'I am listening', 'I care', 'cause that expresses how I am feeling. For me doing that expresses how I am feeling, so that's done with a smile, you know, the whole-body language…

Here Pat supports individuals by adjusting her body position to be at the service users' level, showing a genuine respect, letting them know that she is committed to listening and cares about their experience. Like Rae, Pat shows the need to reach out to service users in distress physically and emotionally. As she moves her physical position, she also shifts her stance from power over the person to being present with. She is aware that by getting in touch with the person, she opens up the possibility of him being 'touched' by her smile or her sense of care. By her tactful presence, she too opens a safe space for the service user to reveal something of his experience.

A further excerpt from Rae shows the power of relationship in helping manage people's distress. She does this beautifully by providing a calming and trusting presence and this helps to alleviate the distress of the service-user.

Then we had a review and he, yeah he got really elevated, pressure of speech, he was really labile in the review... with the doctors yeah, and

he said 'right I'm out of here, I am terminating this, I don't like all these questions, da .. di.. da .. di.. da ..', getting all red faced about it. I just padded the chair and I said to him nicely (cause we kind of wanna be at the same tone), 'come and sit, come and sit with me Bert (Pseudonym). I just want to talk to you about a couple of things' and … I think because of how I treated him beforehand …he responded. Now I knew that I had a chance there, yeah I felt good about it and actually I think the doctors were quite surprised. I'm not sure why? But I felt good because he didn't get so distressed and what it facilitated was him sitting down and he was able to talk about what brought him in here. So, for me that's a good outcome for him.

Rae ensures that her interaction with Bert is one that focuses on being alongside him when he is getting distressed. She uses a level tone, signalling the importance of setting the tone and drawing the service user into her physical and emotional space, where he can trust it is safe. Because Rae has provided safe space previously, she does not need to reach out here, but invites the service user into her calm space, which he accepts and becomes less distressed. This opens up an opportunity for the service user to feel that he is being listened to and it is safe to express his thoughts and feelings calmly.

Rae also describes how nurses can work together to create safety in crisis and the importance of being attuned to each other as well as the service user's lived space:

They [nurses] will try everything, the decision won't be made quickly, so they'll try different practitioners in the room. When I'm watching them I notice how they change their body language a lot, those senior nurses that have worked together a lot, they have almost have a ... what I would call an intuitive form of communication when the situation is really acute. It's almost like a stage where they know how and when to de-escalate. They seem to know when it's one persons 'turn'. I think this is number one for me – my experience of seeing recovery team working. It's amazing how much time is spent with people – to avoid seclusion.

Rae gives the sense of being somewhat awe-inspired by the amount of time and energy given to supporting a person in distress and avoiding the use of seclusion. The flexibility in the use of de-escalation techniques is acknowledged, as nurses 'try anything'. At the heart of the practice is the teamwork used to keep the service user safe. She talks quite poetically about an unhurried 'intuitive form of communication' and the unspoken 'thread' of connectivity between the two nurses. She relates that as she watches this type of communication, she feels it is 'almost like a play on the stage' where they move in and out, each knowing their parts without having discuss what to do next. They work together to create a safe space in which to manage the individual's distress in that moment. The key emphasis here is that they have learnt to be-with people and each other in a way

that is responsive to the unfolding distress and creates and sense of safety and supports recovery.

There are often times when nurses need to manage service users' distress by using their skills to de-escalate potentially dangerous situations and avoid potential harm. The following story from Pat illustrates this on one particularly busy day on the acute ward:

> *Once with our young one [service user], was not in her room, but walked down to the TV lounge, and I thought 'what's up'?, [It was] the way she was walking, um [she] went down and grabbed the cord of the mouse, she was going to take it back to her room. I'm glad I followed that up, you know followed her to see, she didn't know I was following her, I just kind of stood back, waited 'til she got there and had enough time to see her take the mouse out of the computer with the cord from the computer. So, yeah it is kind of all that, and you get to learn that I think there up on the ward, you do learn that.*

Here Pat describes using her observations and embodied knowing, which is acquired through time spent on the ward. She 'knows' something is not quite right, in the way the service user is walking and also understands the significance of the computer cord as a tool for self-harm. Here Pat did not explicitly think or reason about what was happening, she followed her body's cues and moved towards the service user discreetly. This intuitive experience aligns with Heidegger's notion of attunement, in that Pat is 'tuned in' or present to the service user's vulnerability and helps to maintain her safety. Heidegger (1995) used words such as *verstehen* 'to understand' or 'to know one's way around' in relation to this embodied knowing, borne through experience.

The nurses also indicated that sharing some of their own vulnerability helped to increase trust and support the development of safe space. In her account, Carole talks about how her own experience of physical vulnerability can help in creating safe space:

> *Well mostly it [my disability] works in a positive way, even in terms of, you know, some people sort of question my safety working on the ward in a wheelchair. Actually I think mostly it is a positive thing, because, you know, I have helped to de-escalate big burly guys that are going right off. I've never felt [unsafe], well probably not any more unsafe than anyone else.*

Here Carole rejects the notion that her physical impairment is unsafe or viewed as a weakness in a ward setting. She argues that her experience of being in a wheelchair can actually have a positive effect in de-escalating situations as she is less threatening and she has to rely on her ability to use relational connectedness. As she continues her account, Carole relates how her experiences of being honest and, at times, the use of boundaries are important:

I think it is being really honest and saying that you know it is not acceptable to be threatening to staff, and also acknowledging how angry and hurt he was, but yeah, but can we talk about this and talk about it somewhere where it is safe for everybody? So I think honesty is always really important and saying what's acceptable and what's not.

In this account, Carole creates safety by acknowledging the service user's emotions and being honest, whilst also placing necessary parameters around what behaviours are acceptable and what are deemed unsafe. The service user's fears and power inequalities are something that Carole seems to understand, and she is able to enhance the safety in the relationship using transparency and through building trust. She also indicates that creating a safe space allows the possibility of moving beyond touch and embodied communication to talking through the situation verbally.

Carole's account highlights the need for honesty, trust and straight talking. The following excerpts from Arron's narrative reinforce how language use is important in creating safe space and managing distress:

Simplicity (of language) definitely makes a lot of sense. You know, cutting out academic language, medical jargon is not going to help. So, keep the language simple, keep it to the point and move on. So, I suppose it is 'keep it simple' to connect with others.

…He has come back in today, you know his mum is saying he won't get out of the car, I just went out to the car, and spoke to him like I normally would and there was no issue.

Arron describes how he finds a stronger connection develops between him and individuals when he uses less medical jargon. 'Speaking straight' seems to be more helpful in forging honest and transparent relationships that support individuals when they are in crisis or distress. It seems that connecting to the service user using plain language in an uncomplicated fashion assists in creating a space for the service user to understand and trust the nurses' intentions.

Carole describes her experience of working with another highly agitated service user and further shows how trust opens the way for dialogue:

*It was someone that's been in the ward quite a few times and so I've had contact with him over several admissions and we've always got on really well. Well, something triggered him one day and he was very threatening and very intimidating, but actually it was [the senior manager] who came up to the ward and him and I managed to talk [the service user] into coming into the interview room and discussing it with us. He still did go to seclusion, but he **walked** into the seclusion room with the staff, whereas I think we managed to de-escalate enough that he did that,*

> *whereas prior to that he was very threatening and was going to take some of the staff out.*

Here Carole describes how past positive interaction had created a feeling of trust for the service user. She recognises his level of agitation and works to facilitate a sense of safety. By entering the interview room the service user demonstrates his trust in Carole. She works with her colleague to create a safe space, where he can talk about his experience. Through this process his agitation and arousal reduces enough to avoid hurting himself or anyone else. Even though seclusion is used in this account, through her trusting relationship Carole averts the traumatic use of force or further escalation for the service user.

The Māori nurses in the study indicated that their culture and use of language is one of the most important elements when building connections and creating safe relational spaces. The words and phrases used by the Māori nurses often reflected a collective or family-focused approach to connecting with others. For example, Pat shows the importance of connecting with not just the individual, but with whānau (family) members to create a safe space.

> *[There's an] old Māori lady on the ward, so I call her Whaea, and say 'Kia Ora' to her and things like that and acknowledge her whānau when they come in. I introduced myself [to the whānau]. I wasn't nursing her then, but said 'I have nursed mum' and I said 'I would like to introduce myself' and went around to do that. So, it's any whānau that comes in there, you know, because it is scary for everyone that comes in there, scary for our clients being in there too. Actually, around all the clients I'm always 'Kia Ora', on the ward, that's me and my Māori background.*

Here Pat recognises that her use of Te Reo opens up a connection that creates a safe and calming influence for service users and whānau through language. In addition, Pat's practice of making sure that she introduces herself is a process of *whānaungatanga* (connecting) that enables the exchange of information to support relationship building (Struthers, 1999). Pat takes time to greet individuals and ask where the person is from and to find significant connections, including the fact that she has nursed their mother previously. This opens space for a conversation or sharing of backgrounds that is reciprocal, which in turn builds trust and a feeling of safety for the service user.

Overall, the nurses' accounts revealed that a key aspect of recovery-oriented care within the inpatient setting is creating a sense of safety in the midst of distress and crisis. Safe space was developed between nurses and service users through using a relaxed and calm tone, orienting the person to ward environment and getting 'in touch' with the person's lived space. Through their calming presence and straightforward honesty, the

nurses were able to establish the person's needs, the boundaries of acceptable behaviour and a level of trust. This relational safety supported service users to open up and begin talking about their experiences. The importance of straightforward language and the use of Te Reo and connection with Māori whānau were also highlighted.

The process of getting alongside service users to create a sense of safety also reflected some of the core aspects outlined on the preceding chapter. These included working collaboratively, knowing the person and looking beyond labels to understand and manage the distress. Once immediate distress had been reduced and a safe space created, the nurses were able to work with service users in ways that further opened up the relational space and created a shared commitment.

Opening Relational Space to Create a Shared Commitment

The nurses' accounts suggest that their relationships with service users grew through connecting to each other in various ways. This involved active participation of both parties to build and maintain a shared commitment to the relationship and to recovery. In her account, Carole describes a personal 'shift' in her thinking around how she sees Being-with and supporting service-users within her practice:

> *[Now I am] …actually focusing on the relationship, because before it was more about me being nice, and being a nice person, being gentle and being caring, and I saw that as building a good relationship. Where actually now with the model of care [a new model introduced to the DHB] to sit down and look at the model with the patient in front of me and say this is a **commitment** between the two of us, and this is about **our** relationship…. Because then I am taking more responsibility that I am going to **work with** them.*

Here Carole describes a change in the way she develops commitment within relationships. The importance of taking time to work collaboratively shows a willingness to let go of traditional medical and nursing roles. This highlights a shift from taking responsibility for the service user and caring *for* them to taking responsibility for facilitating a partnership. This approach forms the foundation of opening a relational space that supports equality and working together as a choice, rather than the nurse having all the power. This is important for creating a shared space that allows the rhythm and pace of the relationship to evolve in a way that supports recovery.

For Rae, having a previous relationship with a service user when he was very unwell, creates a commitment that is ongoing and shows itself some years later when they meet again.

So there I was, you know beside the bed, he couldn't drink, so I was lifting his head up, you know he was nearly catatonic. Well we have a really amazing therapeutic rapport now and it does make me wonder… I wonder if not having that ability to carry on the therapeutic relationship directly afterwards, for however long the one on one, does affect how deep your rapport is with someone. You know when you take them through that dark place and you've had that really close professional rapport and you come through the other end and it hasn't been intermittent like we kind of do now. I think if you were [working] in the recovery model, wouldn't it be appropriate to have someone walking alongside you when you're that sick, when you're in that darker place? It's part of what rewards us as nurses too I think, you know satisfaction. I think you go, 'yeah, I did good there'.

Rae's account suggests that being a consistent presence and walking alongside others through their most distressing or difficult times is an important aspect of recovery-oriented practice. She also identifies how rewarding the experience of a committed relationship can be, with a sense of achievement in helping service users to come through the other side of their darkest times. The sharing of some of the most difficult times in another person's life inevitably creates a deep bond between the nurse and service user. Similarly, an account from Marianne demonstrates the importance of the bond that is created through the building of shared experiences over time. She describes the sharing of memories with a service user, which solidifies the trust and commitment between them:

I nursed him in Starship [children's' hospital] when he was 13, 14 and he remembers other nurses there and we've had lovely conversations around what this nurse is doing. One nurse used to have quite an interesting dress sense and we've been talking about him and having quite a few laughs and he remembers me taking him to radio lollipop…

Within this narrative, Marianne recalls how a young service user remembers her and they re-connect through their shared experiences. In reminiscing and sharing laughter, these moments play a significant part in reinforcing strong bonds and a feeling of humanness within the relationship. It highlights the common ground rather than differences between them, which helps to open up a relational space that is supportive of recovery.

In addition to building up and recalling shared experiences, the identification of shared interests appeared to be an important aspect in the nurses' practice. For example, Anna shared the following account:

He reminded me of my grandfather, we'd sit because he wouldn't talk about it [suicidal feelings] … a religious man who had these thoughts

about suicide. He was in because of an overdose, so when he first came in [to the ward] he wouldn't discuss what his thoughts were to anybody. So, it was a case of just sitting there and talking about old cars and old-fashioned things like hobbies, and he liked his garden, so I talked about my garden … it was nothing medical… I brought some old magazines of old cars, because I knew he loved them and my partner and me race, so we talked about that, and the garden and I tell him about my chickens.

Here, Anna again reinforces the importance of finding common ground, as she connects with the service user through shared interests. Talking about ordinary topics such as gardening or old cars opens up a space to know each other and provides a starting point for building trust and commitment. Anna and this older man slowly build their relationship one step at a time until he is ready to open up and talk about his inner thoughts and painful experiences.

Another way in which the nurses created shared space was through humour and a sense of playfulness. Within the narratives, the participants repeatedly spoke about using humour to gain connections and release tension. However, they also revealed a strong sense of awareness regarding the need for sensitivity and the right timing and type of humour in relation to the situation. They referred to the danger of inadvertently using inappropriate humour, which would diminish others and close relational space.

Marianne, a senior nurse, shares how she uses humour in a therapeutic way to release tension within challenging situations on the ward:

I actually use humour a lot, in a respectful way. Yeah I have had some really funny situations where we have just ended up laughing even - and it sounds terrible - even in restraint. We ended up… I said 'ah, for goodness sake', you know, 'I said look at us, look at my pants' and she [the service user] giggled, and then I giggled and we both and of course it just, you know… dissolved and somehow broke the tense moment.

Here Marianne intuitively de-escalates the situation by making a humorous observation regarding 'their' situation. It draws her seamlessly to a connection, even in the middle of a physical restraint. In the words 'look at us' she sends a message of togetherness that supports the service user and opens up the relational space. She manages the balance of maintaining safety, while shifting her attunement from the distress and power over the service user, towards 'Being-with' her. Marianne transcends the oppression and tension in the situation with a human approach, using humour to highlight shared experience.

Humour seems to play an important role in Marianne's identity as a nurse, as the following story reveals. Using the conduit of creativity in music and singing this story

shows her experience of supporting another service user with a cultural support person (whai manaaki), in the Intensive Psychiatric Care (IPC) unit:

> *…so, what we do as a team is try and break up the monotony of being in IPC for Alan [the service-user]. So, Henry (the whai manaaki) came in with the guitar and said to Alan – come on make up something to sing, so Alan sings:*
>
> *'I'm Alan, I am stuck in IPC' you know it was just a little ditty, but it was quite funny and we were all laughing at that. I think for me, you've got to use humour.*

Here Marianne recognises the tension of being confined and the service user's lack of autonomy and choice in his present situation, may be lessened by connecting through creating a sense of belonging and shared humour. The use of humour connected both Marianne and Alan to experience something very 'human', natural, and respectful. For Marianne there seemed to be a release of tension for her, and a sense of being able to be a great connector and communicator as a nurse. Overall, it seems that the humour and singing opens up the relational space by providing Marianne and Alan a different way of relating to each other beyond a focus on safety and symptomatology.

There were also accounts of nurses using humour when service users are also experiencing active symptoms of psychosis. For example, Rae reflects on how at a sensitive moment she found the use of humour helped her to forge a deeper relational space:

> *On this particular night I was on shift with him [service user, Sam] and he comes out with this big smile and just, cause he does his own thing, was responding hard out to himself [experiencing auditory hallucinations and responding both verbal and non verbally]. And he has this coffee. I said to him, 'ah, geez thanks Sam, I was wondering when you're going to bring me a coffee', and, he looked at me -between responding to me and responding to his voices - and then a couple of minutes later he came back out of the kitchen area and he made me a coffee. It sounds really terrible, but sometimes you're not quite sure to drink certain things patients make, but I had to. I just had to do that, cause well I asked for it and, so that makes you feel, yeah, it makes you feel like you've got a connection there, that you're able to crack a joke, and he took the joke, but actually went the extra mile and he made that drink. So that's our running joke when we see each other.*

Within her account, Rae reveals how a playful request for a coffee opens up relational space and a shared commitment with the service user. This type of playfulness and asking the service user to do something for her could be seen as a 'risky' practice, especially when working alongside someone who is experiencing active symptoms of

psychosis. However, it is possible that Rae was able to read the situation due to her knowledge of and previous connection with the service-user. She also recognises that being able to reciprocate is important in recovery, as service users need not be limited to always being the recipients of care, but are able to care for others too. The use of a playful and humorous approach opened up this opportunity for reciprocation. While Rae's initial reluctance to drink the coffee is indicative of an underlying prejudice about Sam's ability to attend to hygiene, she prioritises her relationship, and preserves this over her hygiene concerns. She indicates a sense of commitment to put any of these feelings aside due to Sam making such a thoughtful gesture. Once again, these stories show the opening of shared space, in which commitments to a relationship can form. Humour connects the nurses and service-users in a shared momentary experience that is very 'human' and forms a binding between their being-in-the world (Heidegger, 1982).

Māori ways of opening relational space

The opening of relational space and formation of commitment takes different forms and several of the nurses challenged traditional relational boundaries in their efforts to develop trusting bonds. The Māori nurses in particular focused on meeting cultural and spiritual needs as much as achieving clinical tasks. In her account, Tui shows how her cultural background assists in opening shared space and building commitment through language and song:

> *This particular patient was on the ward for quite a long time, [she had a diagnosis of] …paranoid schizophrenia, an older Māori lady. She would hold the Bible with her quite a lot, and I went over to talk to her one shift and she was listening to the radio, she was listening to the Māori station one night. She said, 'sing me a song, sing me a song, sing me a waiata [song] Tui'. I sort of went, 'oh crikey' I've got to think of one and I was sitting there trying to think of a waiata. Anyway, I quickly pulled out my phone and had a quick look and…I started singing this waiata, and she started joining in and we sang a few little waiata together. It just helped her sort of calm and build that relationship.*

The calming influence that Tui provides through waiata illustrates how the use of shared language and song can create strong threads, not only between two people, but also to cultural meaning and a sense of safety. The account underlines the significance of cultural connection and a having support from people of your own culture in recovery. Tui shows her commitment to the relationship and to supporting the service user's cultural needs by singing and having a conversation or 'korero' in Te Reo. While singing

to service users is not a typical intervention in clinical training or practice, this seems particularly powerful in opening shared space and creating a bond.

Pat too describes how she creates relational space using her cultural norms and shared cultural connections.

> *To the boys [I say to them] 'which one of you's wanna get up and come and help me do the laundry, come on, who's not doing anything?', you know, 'oh yeah miss', you know things like that. Like, 'come on'. I ask 'have you been in and tidied your room?' I mean it is the same as **how I would talk to my son**, kind of thing with these young males. One client last night, all of this food on the floor, I said 'would you do that in your whare [house]?', the answer was 'yes' he would, and I said well, well I won't be coming to your whare I said...*

Here Pat likens her style of communication with young Māori service users to being a mother and talking to her own whānau. The account highlights how Pat treats young men as family and shows how she expects a collective commitment to keeping the ward in order. This does not always involve being gentle and has an element of 'tough love' as Pat demonstrates a directness in her communications. However, this expectation of shared responsibility subsequently opens up opportunities for the young men to contribute to the ward environment. As described previously, providing opportunities to be an active contributor rather than a passive recipient of care appears to be an important element of recovery-oriented care. The exchange of energy and care present in shared practical activity is a further way of creating relational commitment and a sense of belonging. With the focus on the activity rather than the verbal exchange of conversation, this may be a less threatening way to build a shared space for the young male service users.

Pat discusses the importance of touch and physical connection in Māori cultural norms. This applies not only in creating safe space as illustrated previously, but also in maintaining relationships:

> *I have always been a touchy, touchy person. I've always cuddled and kissed my friends and my family and stuff… It's a big thing in Māori culture. Whaea, she's the nanny and she is used to that, [as a Māori woman] and that's 'Kia Ora Whaea', and she will come to me and give me a cuddle like that, so it is just knowing those ways you know.*

Pat is comfortable in getting physically close to the people she is working to support. This reflects her focus on building shared space and commitments that are similar to family-like relationships. Pat approaches her work with this older Māori woman in the same way

as she would approach caring for an older relative, as part of her whānau. In the following excerpt, she goes on to discuss further interactions with the same woman.

> *I told her I was sorry that I was running late 'Pat she said I don't even have a watch, so I don't know'. 'No' I said 'that's delightful', I said 'I'm sorry' I said 'got stuck into my notes', 'that's alright' she said, 'I could have been sitting up here till midnight'. I said 'no, I would've been in before that'. She put her knitting away, 'right it is time for me to have a moe [sleep] now', I said 'great', go for my cuddle, she always gives me a cuddle when she goes to sleep, 'I love you Pat', and you know what, I say it back, '**I love you too**'. Why not, I don't see anything wrong with that.*

Using words to express love is not usual for most nurses. Traditionally this might be perceived as unprofessional and overstepping professional boundaries. However, Pat's honesty and open expression seems to create a human connection that far surpasses most boundaries as she as opens space for sharing platonic love. Indeed, Pat's manner of treating individuals like her own whānau creates warmth and a strong sense of commitment within the relationship. To show genuine affection, physically and verbally, seems natural for Pat within her practice. However, while her practice stretches traditional boundaries (of being part of a Western, medico-legal tradition) she has also learnt to discern how to use touch and physical presence therapeutically.

> *I've learnt that you can't just go up and cuddle everybody…you know I would like to give everyone a cuddle in the ward, but there is some that don't want to be touched at all, um so that's what you have to learn.*

Pat describes how she is careful in her interaction here, she gauges how, where, and when she uses physical presence and touch within her practice. She is aware that not everyone responds the same to physical touch. She endeavours to commit herself to treat every service user as a unique individual who may or may not share the same values, beliefs, values, and experiences as other Māori.

The sharing of distressing experiences, good memories and common interests, humour, practical activities and also touch, culture and love were shown to be important elements of opening up relational space and developing a commitment and bond over time. By nurses focusing on the relationship, working collaboratively, and by really knowing the person, and seeing beyond the label, seemed far more important than 'fixing' service-users or their problems.

Providing Healing Space for Processing Meaning and Loss

Whilst sharing elements such as interests, humour, activities and love opens up relational space, the participants also recognised that recovery from mental health issues often involves addressing loss, trauma, and trying to find meaning in personal experience. Service users may feel that they have lost a part of who they previously were, or feel stigmatised by society and others due to their mental health issues. Individuals may also find it very hard to find professionals to trust, if there is no one with whom they can identify or have a sense of shared experience. The nurses' accounts indicate that the formation of both safe space and a shared relational commitment are important foundations for opening up healing space where meaning making and processing grief and loss can occur. A story from Anna illustrates the importance of recognising how loss and trauma affects individuals, in this instance a young man who reacted violently when distressed.

> *He was quite scared; his antisocial behaviours were quite extreme at times. He assaulted his parents and then the only person that would always stand in his corner passed away while he was on the ward. That spiralled him out of control again for a few more months and he became even harder to manage, cause he was grieving, but because of his diagnosis he grieved in such a, what is the word I'm looking for, an antisocial way. You see he couldn't express his grief. The only way he could express it was to really give the nurses a hard time, which was counterproductive because the people that didn't care, didn't care even more.*

Here Anna shows her ability to understand the service user's experience and his reaction to the loss of a loved one. She 'looks beyond the label' of his diagnosis and the associated symptoms to the underlying causes of his behaviour. She sees his struggle to process the grief and the transference of his feelings of loss and fear into anger and rage towards others. As the account continues, Anna shows that because of this understanding, she is able to open a dialogue to begin talking about the issues.

> *We did build up quite a lovely relationship you know, a working relationship with his wellness. So, when he came into the ward and he was acutely unwell, I was always asked to go and sit with him and talk to him. I always could manage to get that window of opportunity in that time and he would respond to me, might have only be for 5 or 10 minutes, but we'd build up that trust. Again, I think it is just that trust thing, he knew that when I was speaking to him, and quietly he was functioning quite highly despite his manic-ness, and he somehow knew that I could manage to calm him down.*

Even in the midst of the service user's manic episodes Anna has the foundation of a safe and committed relational space to create brief but fruitful 'windows of opportunity' to talk things through. Recognising the violent behaviour as an expression of grief and responding accordingly, allows the creation of this healing space where it is safe for the service user to express his feelings and grieve for his friend. It is the recognition of trauma, pain and loss that is the first step in creating space for healing in the nursing relationship.

Carol also provides an account of how she recognises the impact of trauma and helps a service user process his painful experiences:

> *It is quite interesting, the fact that I'm in a wheelchair, because people find that a positive. It often opens doors into discussing how it is coping with a trauma or a something and so that often really helps to break down some barriers because they perceive that I understand where they're coming from, even though you know it's a completely different situation. I had a guy recently who had previous physical traumas where he had actually lost a leg as a teenager and then he had quite a few incidences of grief where he had lost family members and a son and stuff. So, he sort of opened up quite quickly to me about his traumas and how difficult it was for him to adjust and come to terms with the loss of his son, hmm. So, for me it's around interacting them with them on that personal level rather than just… the depression.*

This story shows how Carole is able to open up space for dialogue, this time through the shared experience of physical impairment. With this shared experience, there is a sense of a deeper understanding of the significance of loss at a very personal level, even though the service user's situation is different from her own. Rather than simply focusing on mental health symptoms of depression, she looks beyond the label and attunes to the grief associated with multiple losses. This trauma-focused attunement allows a healing space to form, where the service user tells his story and in doing so begin to process the trauma. Therefore, as well as *looking beyond the label*, creating healing space involves *supporting meaning making* as a core aspect of recovery-oriented care.

A previous account from Anna showed how discussing shared interests opened up relational space and built a commitment. The following account shows the result of this connection and the importance of consistent presence:

> *I knew I would never get anything out of this man [emotionally] if I went straight in and start asking questions… we didn't talk about his suicidal thoughts, **it was just about spending time listening to him**. Then one day we were just sitting there, he was having a low moment, and he suddenly started talking about his thoughts, about his family and*

> *wanting to die, It seemed that he was desperate to talk to somebody;*
> *it was like opening his soul to the devil.*

Within this story, Anna shows how the shared space of common interests becomes a healing space through the time she spends Being-with and really listening to the older man. It is in the demonstration of her commitment that Anna creates the trust required for the service user to reveal his inner most thoughts and feelings. The opening of relational space allows the man to also open 'his soul' and release what he has been so desperate to share. The excerpt suggests this is a cathartic experience, which helps with not only the release but also the processing of deeply painful emotions.

In one final excerpt, Anna provides a further example of how she provides a healing space for making meaning.

> *[I'm working with a] lovely Māori lady, who is very unwell at the*
> *moment. I continue to encourage her even though her stories are to*
> *her not way off this planet, but to anyone else coming in seeing them*
> *would be way off this planet. So I, I go along with her stories and say*
> *'how does it make you feel?' and she talks of 'the Lord and Dad's right*
> *there, Papa's right there', so I say hello. So um, I don't know how to*
> *put that into words… we talk about her journey, that's right.*

Anna does not judge or challenge the content of the service user's beliefs, but encourages her to tell her story and talk about the feelings behind the beliefs. Anna understands there is meaning in what the woman is saying, even though others would see it as part of a psychosis. She recognises the need of the service user to be able to connect to her ancestors and supports her spiritual and cultural identity, whilst reducing her distress and bewilderment. This gentle way of working seems to create a safe space where meaning making can take place, including connecting with loved ones who have passed away. In this way a healing space is formed between the nurse and service user, where life can be discussed and some sense can be made of the 'journey' she has been on. This is a different process than that of a medical approach where symptoms are assessed with a clinical eye and the subjective meaning of states that are considered extreme or unusual are not typically explored.

Relating sensitively to individuals and creating a space for healing appears to be paramount to recovery-orientated nursing practice. This involves recognising the impact of trauma and loss on service users' emotion, beliefs and behaviour. It also involves looking 'beyond the label' to avoid pathologising service users' distress, grief or belief systems. In addition, the accounts show how nurses can draw on their own loss or past trauma to attune to the vulnerability in others and potentially use these meaningful experiences to connect with service users through trust. Ultimately, creating healing

spaces requires consistent presence and listening for the deeper significance of service users' experience and stories. In providing this support, the nurses opened the opportunity for service users to process painful thoughts and emotions and to find meaning in their life journey.

Summary

The nurses' accounts indicate that recovery-orientated practice within the acute inpatient setting involves building relational space that is first and foremost safe. The nurses needed to be able to figuratively, and sometimes literally, hold service users gently during crisis and distress. However, at times maintaining safe space also requires honesty, straight talking and setting boundaries about what is acceptable. The nurses' stories also show how opening up relational space allows the development of a shared commitment. The bindings of commitment were created through sharing experiences, including going through challenging times, exploring common interests, humour, touch, engaging in practical activities, sharing cultural beliefs and practices and platonic love. At times, there was a need to let go of traditional roles or stretch traditional boundaries to open up relational space. The relational space became healing when there was real trust and service users were able to share and make sense of their innermost thoughts and feelings. This supported the expression and processing of personal meaning, including painful emotions arising from trauma and loss. Having explored these key areas of relational space, the following chapter will now focus on how nurses strive to find the space for recovery-oriented practice within a challenging mental health system.

Chapter 6: Barriers and Enablers of Recovery-Oriented Care

Introduction

There are various challenges for nurses when working alongside individuals who enter the mental health system. Some of these challenges derive from the nature of mental health nursing, and the fact that it carries a historical stigma. Other challenges arise as nurses find themselves having to contend with ethical dilemmas and risk-averse systems, which create a paradigm trap between, on the one hand, using coercion and, on the other hand, creating space for autonomy and supporting service users with recovery-oriented practices.

This chapter draws on stories from the participants, showing that, for many nurses, it is not always easy to identify or recognise a recovery focus in mental health services. It appears that nurses themselves frequently struggle to find the words or identify the actions they take to make meaning in their practice. They find it hard to explain how they embed their recovery practice into reality when working with service users. The nurses who were part of this study repeatedly downplayed how they practiced recovery; often they vocalised it as 'simply just normal practice, just part of what we do'. So, how do nurses recognise or find the space to work and find meaning around their recovery practice in the acute setting? In this chapter, the nurse participants talk about their experiences of the institutional and system factors that can hinder or support the embedding of recovery-oriented approaches.

Many of the following stories show what Heidegger (1927/1962) would have called deficient modes of care. It must be recognised that care, concern, and solicitude have deficient modes as well as positive ones. These deficient modes close down, rather than open up, safe, relational, and healing spaces. The notion of deficient modes of care reflects a lack of care and concern for the other. Some of these deficient modes of care are shaped by historical aspects of ward culture, which are still present within team practices, and others involve external processes, such as the systems within which nurses' work. However, both make the embedding of a recovery-oriented process a challenge.

A key phenomenon shown in the following stories is how nurses' prejudices influence and affect their fundamental attunement or mood. Attunement is an important aspect of recovery-oriented practice, and it is reflected in how responsive a person is to another's emotional needs and fundamental mood. A nurse's ability to be present and actually 'be-with' service users in their distress may be restricted by their assumptions about who the

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service users are and what they need. A fear-based attunement narrows their perspective towards physical risk and the need to maintain full control over what happens to both the individual and the ward. The cumulative effect of deficient modes of care appears to be inflexible, narrow and risk averse practices.

To begin, this chapter will explore deficient modes of care, and how these impact on service users and acts as a barrier to the nurses' recovery-oriented practice. Next, there will be examples of how the broader systems impact the nurses' ability to be recovery-oriented within the workplace. There will be some illustration of the external and institutional barriers, and exploration of the tensions that arise within the ward culture. Lastly, the chapter presents nurses' accounts that reflect how the changes, growth, and learning that they have experienced acts as an enabler and builds recovery-oriented practice.

Team Culture and Deficient Modes of Care

In their interviews, nurses provided detailed accounts of recovery-oriented practice. However, the participants could also readily identify instances of practice that were not recovery-oriented. These deficient modes of care are highlighted in the following accounts of practice and serve to uncover some of the challenges that exist in maintaining a recovery orientation within inpatient mental health services. As the stories in this section show, at the heart of these practice issues is the misuse of staff power, which reduces service user autonomy and dignity. The nurses talked about both the internal team culture and external system challenges that they faced, and reported several situations where they observed the misuse of power through neglectful or coercive practice.

The accounts begin with descriptions of non-recovery-oriented practices in the admission process, affecting service users' rights and cultural needs. Then the stories highlight the prejudice of a senior nurse, the impact of negative language, coercive and risk-averse practices, and the consequent disempowerment of service users. Overall, the accounts show the need for a recovery-oriented approach from the point of admission onwards.

The following narrative from Carole describes how challenging it is to be recovery focused when processes impede engagement with service users. This becomes especially challenging when interfacing services are seemingly not recovery oriented:

I did have a client recently who wasn't happy with their whole admission process and he felt that he was sort of admitted against his will in a way. He was told by the crisis team to come up to the ward and 'have a look and see what you think' and then was told he was being admitted and when he said he wanted to go home to his nana's [he] was then put under the Mental Health Act. So, he said he totally lost faith in the whole mental health service and would never ask for help again. So, I called the District Inspector on the weekend to come and talk to him about it. I felt really sad that he felt duped and he hadn't agreed and hadn't really understood what was happening. I think if there had been a lot more conversation with him and the nana, I think a win-win could have been arranged where he could have maybe, you know, had leave overnight or even leave for the weekend and come back on Monday. He wasn't threatening suicide or anything. So I don't think there was enough conversation with him and the family to try and get a win-win.

Carole discusses her feelings of sadness and frustration about the coercive manner in which the individual has been misled by the crisis team and has been misinformed about his rights. Her perspective is that this situation may have been avoided if a more collaborative approach had been used. This would require the involvement of family and some negotiation regarding leave. Carole understands these external constraints create tensions between the service user's rights and legal processes, and supports the service user by arranging a meeting with the District Inspector. This potentially creates a safe space for the service user to have a voice, and supports the principles of autonomy and the service user's right to be informed within his treatment pathways.

It is clearly not always straightforward for nurses to find the right balance between safety and being able to support service user autonomy. The question of whether nurses have to accept deceptive and coercive practices or, indeed should offer support by creating a space for informing the service user of their rights, is an ethical dilemma. The difficult decisions that arise from these dilemmas may confuse and influence nurses' judgements, thereby having a negative impact on decision-making and outcomes for the service user. Overall, the deception involved with this service user and the closing down of dialogue on how to manage the situation caused insurmountable distress for the service user. This, in turn, led to the service user losing faith in mental health services and reduced the likelihood of future engagement. However, despite these external interfaces making recovery difficult, by arranging a meeting with the District Inspector Carole takes positive steps to correct a situation outside of her control, and move towards practice that better aligns with her vision of recovery.

The significance of failing to create a safe space on admission is also highlighted in the following account from Tui. In this instance, the service user's cultural needs require greater attendance:

> *I walked around the corner and saw that this young Māori boy, Hemi, was trying to escape. He just darted past me and ran for the conservatory, and, I think a nurse said, 'stop him, stop the door, don't open the door!' Anyway, it was too late, everybody went running out there, ah, 'what's going on'? 'Ah he's just been admitted, he doesn't want to be on the ward, we need to go in and restrain him'. His Dad was there, I was trying to get an understanding about what's he here for, but obviously in the heat of the moment you're just not going to know that. You have to take what your colleague is saying and go with the decision (to restrain him). There was a partial restraint, he was brought back inside, and then he started saying, 'I don't even know who you guys are, why don't yous introduce yourselves, all I asked for you guys is to introduce yourself' and 'what I am a doing here?' And the Dad was trying to calm him down and he was quite upset. He went back into the whānau [family] room with his Dad and not long after he came walking out. … So he went in freely to the whānau room, 10 minutes later I happened to be walking to the dispensary and he come up to me and said, 'You didn't even welcome me here, why didn't you even say anything? You're Māori, that's all I wanted you to do'.*
>
> *I find myself questioning and thinking 'maybe he is just probably playing the Māori card?' But it wasn't that at all, but I won't have that conversation with other colleagues. It is just, 'okay, we just get on with the shift' sort of, you know, but then I will do a karakia [prayer] myself, I might walk around and if it is a bad shift I am forever doing the karakia to myself, you know, please guide me, please guide the patients, look after us all.*

In the previous chapter, the need to create safe space in the midst of crisis was highlighted as being essential to recovery-oriented practice. However, here a deficient mode of care is revealed through Tui's narrative, which shows how the accepted culture within the unit and the internal process limits the creation of a safe space. Subsequently, this has extremely negative consequences for the service user and staff. Instead of feeling cared for and safe, the service user and staff are caught in a cycle of escalating defensiveness, which shuts down rather than opens up relational space. Here the overall focus is on physical risk and containment; in the midst of this focus, the service user's cultural needs are overlooked and, consequently, a culturally safe space is not created. Tui reflects how being culturally aware and providing a suitable welcome for the service user and his whānau may have delivered a better, timelier outcome. In addition, Tui indicates that she does not feel sufficiently safe to discuss the need for cultural responsiveness within her team. This suggests that, to make culturally safe spaces for

service users, nurses also need to feel safe to express and live their own cultural practices. Tui is left to find her own way to deal with this dilemma, and privately says karakia (prayers) to keep her safe.

In another account, Tui shows how opportunities to open a relational and healing space can be missed through pre-conceptions about who service users are and what they need. This may involve a narrow focus on controlling agitated behaviour, and a lack of attunement to the lived experience of the service user. Tui, a relatively new nurse, relates how another more senior nurse's viewpoint affected her:

> *Yeah, [The senior nurse said] 'Gosh she's back again. Another one, smoking all that synthetic [cannabis]', you know, she comes in, 'ah you just medicate her, and that's usually the good way that she responds in 48 hours. She will be a 24-hour admission, so just get the medications into her, and make sure you keep on top of it. Have you medicated your patient? Have you given the night medications to your patient? I don't want a noisy night'. I don't know if it was my [Tui's] inexperience being new, still classing myself as new, 'they know better, they've been here long enough, they have seen all this before' in terms of the colleagues, yeah, but does that make it right? I always question that; does that make it right what I've done with my patient? Does it make it right what she's done with her patient?*

Here Tui observes how the senior nurse's pre-judgement or prejudice shapes her attunement to the service user and what the service user needs. The focus on using medication to sedate the service user and have a quiet night means that the nurse is not attuned to the underlying pain and distress the service user is experiencing. Indeed, it is a revelation for Tui that a quiet night shift, with little bother and no noise, is the priority over the needs of the service user. Tui questions the senior nurse's narrow focus on sedating the service user to reduce the noise on the ward. The senior nurse's stigmatising pre-conceptions about what the service user is like and what she needs shuts down the potential space for relational practice and healing. Here, also, the acceptance of such a hierarchical structure is evident. For Tui, there is an acceptance that the senior nurse is more knowledgeable. This can often be seen in nursing as accepting the prerogatives of those higher up in the pecking order. There is an obvious tension for Tui in the challenge between what she is asked to do, based on her senior's prejudice and position, and her own understanding of what is right and how to provide safe and recovery-oriented practice. This tension and lack of recovery-focused guidance leaves Tui doubting herself and her practice.

The importance of creating a safe space in the context of medication use is also raised in the following account from Marama. A deficient mode of care is demonstrated both in

the coercive way that medication is administered and how language is used by nurses. Language use influences how service users are perceived, and subsequently how their treatment unfolds.

> *The statements [from staff about the service user] are generally anything that might sound threatening, 'this person is threatening', and 'this person is non-compliant'. To me that is a custodial term, you know, for me it is, why say this person is being non-compliant with their medications instead of saying this person hasn't been very cooperative when it's time to take their meds. So even just in the language and the way that it is portrayed can have that negative rub off on, on the handover to somebody else. So if it is somebody that has negative recovery principles, then I don't see that there is going to be any favourable outcome before you even get started! For me the frustration is more about the treatment of the patient because straight away it's like, is this person ever going to get a chance here? Is this person ever going to be put on a road of recovery here, or what?*

Marama's frustration around the nurses' ingrained attitudes, negative language, and coercive behaviours towards service users is clear. The experience leaves her feeling almost hopeless about the possibility of recovery for the individuals being discussed by the staff. This story again highlights how internal processes affect the experience of care for service users. It shows how the influence of attunement to mood and understanding, underpins the discourse in this situation. Once again the evident lack of attunement and negative attitudes bring about these deficient modes of care, where the nurses are attuned to risk and compliance rather than creating a safe space which supports relational connectedness and the healing of the service user. Marama identifies how negative language about a service user may influence the receiving nurse or shift to absorb an unfavourable perception of the service user and continue to shut down the relational space and hope needed for recovery. Marama highlights the importance of recovery-focused language when interacting in all situations with both her colleagues and service users. The sense of hopelessness that Marama feels leads her to start questioning how any individual can have a positive future when nurses fail to be supportive at a time when the service user is most vulnerable.

Ultimately, Tui and Marama's stories show how the nurses' stigmatising assumptions and attunement shape their understanding of what is needed and the discourse through which that understanding is communicated. The assumptions shut down the possibility of alternative ways of understanding the service user's situation, and their discourse does not allow a space for dialogue and shared understanding with the service user.

The nurses' accounts suggest that an understanding of the power dynamics within the ward is important for recovery-oriented care. Here, Pat talks about her observation of how service users may feel disregarded and disempowered while on the ward:

I mean because it is a whole [bad situation] to be in those four walls, continuously, day in and day out. The client can have so much to say as they like, but at the end of the day it's the doctor whom actually makes that decision. Here [the service user may state] 'well no I don't feel well at the moment'. [So the doctor says] 'I am going to keep you here for longer'.

Pat recognises how disempowering it must feel to be a service user within a mental health unit and she goes on to describe how internal challenges within the multidisciplinary team play a part in contributing to deficient modes of care. Indeed, nurses can increase rather than relieve that sense of powerlessness:

There's no consistency in her [the service user's] care, some people give in and some people don't. There is no consistency with her and sometimes it is a power trip when they don't give in and when they give in it is just like they don't care. It's like a power trip (the staff) sitting in the office all shift, cause 'I am the nurse and I don't have to go out there' basically. 'I'm the nurse and I can sit here in this office all day'. 'I'm the one that's got the freedom; you're the one that's locked away, so I've got a power trip on you.' It's like that with our clients. That's not me that does that. As a nurse, I totally disagree with that!

Here Pat expresses a resolute sadness and anger about being part of a team that shows a lack of consistency and commitment in their approach towards service users. It not only reflects part of an entrenched historical internal challenge for Pat, it also does not sit well with her own values and her support of recovery-oriented ways of working. In this particular story, Pat highlights how the nurses fail to see the vulnerable and powerless situation the service users are presently in. On account of the inability to recognise this vulnerability, they are not open to hearing the 'call to care' and can withhold care in order to maintain or increase the service user's vulnerability.

In another account, Anna reflects on how she has observed some of her colleagues being apathetic and displaying negative attitudes towards service users:

*You take people out for walks, or you take them down to sensory modulation, and a few of the members of staff just, their words not mine, 'I just can't be arsed, **can't be bothered with it**, because he won't thank me for it, **he doesn't care**'. I just kept thinking, well this person, once you sat down with him, was quite scared. His antisocial behaviours were quite extreme at times.*

Here Anna shares her experience of how negative attitudes and cultures shape behaviours. She acknowledges that there are internal challenges within the team. Anna suggests that her colleagues have failed to recognise the service user is afraid and grieving the loss of his friend. Being able to recognise how parallel processes play out within team dynamics can have either a positive or a negative impact on how nurses deliver recovery-oriented practice. Within Anna's story there seems to be a parallel process where, ironically, the nurses do not care because they believe that the service user does not care. However, they have failed to see or hear what the service user cares about, his lost friend. Here the nurses are not 'called to care' for the service user because they cannot see beyond his challenging behaviours to his vulnerability and, specifically, his grief. Ultimately, Pat and Anna's stories both show a deficient mode of care, and that having 'power over' others can have a negative effect on service users. The inability to fully address the issues around power and attitudes means that the "deficient modes of care" remain a challenge to recovery-oriented care.

The nurses' accounts suggest that a focus on physical risk and maintaining power over service users may lead to narrow and inflexible ways of working with individuals. Arron describes observing a colleague closing off relational space through rigid practice:

> *One example was where somebody [a service user] who was quite loud was experiencing some hallucinations and one of the staff members went out [to the medication room] and took out some pills and an injection, told the client, 'take this, you're going to take that', [with] no explanation why they were doing that, no reflection how the client was feeling, no discussion how you're feeling, no exploration, no assessment, it was 'take this or take that', as simple as that.*

In the previous chapter, opening relational space to create shared commitment was shown as an important part of recovery-oriented work. Arron's story identifies that for this service user there is no opportunity for developing a shared commitment, with no choice or treatment options made available. The nurse's narrow and inflexible responses close down what might have been a safe and relational space for the service user to have a voice, a space that might provide hope and healing.

In another account, Matt describes his experience of inflexible and risk-averse practice, and the possible impact for service users of this.

> *It was late at night and one particular young lad wanted to go out for a cigarette [and] staff felt that it was best to… well that he was after the time when you know it was deemed appropriate to be going out for a cigarette. If he would've just been escorted outside you know in an enclosed environment to have a cigarette, he would have been more than happy, come back in and gone to bed. But because the nurse in*

charge deemed that she knew best and that the policy was… you are not allowed to go out after 9 o'clock for a cigarette, you know it is for your own safety. You know and he was basically coming back with, 'well I'm over 18, it is not illegal to have a cigarette, it'll help me calm down, you know I'm quite happy to go out in the courtyard and have one with the nurse, with me, you know why not just let me, rather than telling me I can't'. [The nurse in charge] said 'because that's not policy, policy says that, you know you're not allowed to have one'. And it resulted in a couple of windows being put through [smashed], a door being smashed and the police being involved. All this over two minutes you know of allowing him just to bend a rule.

Matt reflects on how services continue to be driven by inflexible rules and regulations. In Matt's narrative, power and control play a negative role in a situation where ward 'rules', and policies around smoking, in particular, often cause conflict for service users. Matt relates that this experience frustrated him hugely and feels the incident could likely have been avoided. The lack of negotiation, the lack of empathy and the rigidity of this charge nurse's stance served only to inflame the situation, with no explanation around what 'safety' might mean in terms of the service user or the ward. For Matt, simply being more flexible could possibly have created a more favourable situation and assisted in growing relationships rather than diminishing them.

Unfortunately, such medically focused and process-driven services continue to be at risk of putting an exaggerated focus on rules within the acute setting, which often neglects to allow a relational space. This is shown in the ways through which nurses' practice becomes inflexible. Deficient modes of care have shown themselves in various ways within this theme, from nurses using coercive and deceptive practices, to dismissing cultural and emotional support for service users who need it when they are at their most vulnerable.

Having considered nurses' stories that have focused predominantly on how external barriers contributed to deficient modes of care, the next section turns to an exploration of the wider systems-level barriers that shape deficient modes of care.

Service Systems as Impediments to Recovery-Oriented Practice

The reality for nurses working in recovery-oriented practice requires them to deal with the challenge of system-related pressures. These external factors inevitably have a significant impact on service delivery and how teams manage to work within these systems. Heidegger discussed the notion of 'thrownness' through one part of Being-in: Befindlichkeit (Heidegger's term for the ontological side of "mood"). This is, for these

nurses, literally the experience or state of "how they find themselves". From the perspective of an ever 'moving forward' Dasein, this state of mood is the 'past in the present', and the previous moments continually 'throw' us into the mood we now occupy (or, in the nurses' experience, the mood they occupied).

In understanding the nurses' narratives that help identify these system constraints, it can be seen that the nurses' past way of Being 'threw' them into the current way they find themselves. The narratives demonstrate that the nurses cannot always control how they feel in the present moment, but can only try to 'project' themselves into a different mode of being in the future. Thrownness can be understood as the "past-for-the-present", the current way our history and experience places us in the world. Furthermore, the impact for nurses finding themselves thrust and thrown into unforeseeable circumstances may have a positive or negative effect on their mood. The mood that follows may in turn play an important part in the nurses' ability to feel attuned and able to be-with the service-users and each other.

The ever-increasing resource constraints, high ward occupancy levels, and high service user acuity often affect nurses' moods and bring pressure and complications to acute inpatient services. These challenges may cause relationships between nurses and the systems within which they work to be problematic. The significant constraints and barriers nurses face in financially stretched services mean that the time needed to build relationships is difficult to secure, making recovery-oriented practice a real challenge. The nurses' accounts indicate the key challenges involve increasing demands with reduced resources, issues with continuity of care and discharge, and tensions around legal and procedural expectations. Each of these challenges is discussed in the following sub-sections.

Increasing demands and lack of resources

Within acute wards, there are increasing expectations from government and mental health services for nurses to respond promptly to new government directives. While in principle these directives are both necessary and recovery-oriented, the nurses' narratives suggest they are caught in the challenging position of facing increased demands to improve service delivery, while not being provided with adequate resources to meet these new demands. In the following narrative Anna discusses how she experiences the impact of these demands, an example of which is the zero-seclusion project within acute services:

> *We had a particularly hard year last year and the year before for some reason. It was constant, we were full [up to the maximum numbers of service users on the ward]. It was a lot of pressure on all the staff, [with*

the lack of] resources, also with the use of seclusion because there was a big push on de-escalation, so the pressure was on us even more to manage [service users] without putting them [in seclusion]. The only time they were in seclusion was when they were a risk to themselves or others.

Anna finds herself thrown into a situation where she needs to get the right balance between supporting the service users' right to be safe in the least restrictive environment while managing the growing demands of an increasingly busy ward. Not only are there expectations to reduce seclusion use, but Anna goes on to raise concerns regarding the increased admission rate (due to a growing number of youths engaging in synthetic drug misuse). This increase in admission rates creates pressure and increases difficulties for nurses in providing recovery-orientated care, due to the rising numbers of individuals needing access to beds for treatment:

We found last year we had to do a lot with young people and synthetics and 'P' and you need to give those people a period of low stimulus in a confined space where they're safe.

A further excerpt from Deb's account echoes this issue with drug and alcohol misuse, as well as the increased demands of supporting people with cognitive impairment:

Well since when I first started, they seem to be a lot more complex, a lot of drug and alcohol issue. Low IQ seems to be quite common at the moment as well, cognitive stuff.

A common theme that emerged in the nurses' accounts was one of having to meet these increasing demands in the context of low staffing levels. In her account, Deb voices her concerns about the lack of prioritising and resourcing of staff, and how the focus on observation affects the way in which nurses provide recovery-focused care.

It's the lack of resources. It takes you away, off the ward into that area away from your primary secondary patient. With the changes [trying to reduce seclusion and restraint] there is lots of constant watches on the ward, so there is lots of C-levels, so when you've got 4-5 C-levels on the ward, your whole shift is relieving staff for their breaks. You get so caught up in that, making sure that everyone has their breaks, always relieving, someone is always relieving, and then that also takes you away from sitting and being with your primary and secondary patients.

Deb finds her experience of her senior role is one of constantly attempting to meet the systemic needs of service (resourcing, skill mix) whilst balancing challenging resource issues and meeting expectations. Deb explains how difficult it is for her, juggling the safety of the service users and staff whilst feeling frustrated in being unable to just 'be-with' service users in a meaningful way. Her connection to both the service users and

the staff whom she leads is through her constant watching and supporting of others. However, Deb attempts to support the trust and partnership in working relationships through her generosity in relieving breaks and by adapting her approach to support each service user's different and changing daily needs.

It is common for casual nursing staff to be asked to care for more services users per shift than the regular nursing staff. The increased caseloads often prove challenging for these casual nurses and reduce their ability to be recovery-focused in their practice, as highlighted in the following account from Pat:

> *Being a casual you just get more clients [and] because you get more clients you don't have enough time to sit and korero [talk] with your clients. I'd rather be out there with my clients, but sometimes you know you can't be. Also, there is not enough staff on the ward so you can't leave the ward, so that means they [service-users] are shut down all night, not being able to go outside. It's very hard, very hard for the clients, absolutely I feel for them too, what are we going to do about it?*

Here Pat voices her concerns that there may be a negative impact for service users due to shortfalls regarding staffing levels. There is an expectation that she should provide recovery-oriented care despite an increased caseload, which reduces the time for building relational space with service users. The staff shortage also has a significant impact on her ability to accompany service users off the ward, which limits their access to more open physical spaces as well.

Rae also identifies how system barriers such as poor resourcing in acute settings create complexities in staffing and impacts nurses' safe practice:

> *I don't know whether we manage things so well from a **resource** point of view, because we still have the same model of nursing where [we are allocated each shift] 5, 4 or 5, clients each. So, if you get an admission and you don't seclude them, and we go 'that's one and one' [where a service user is on a constant observation with an allocated worker]. I mean what do you do? It's hard to be responsive to that.*
>
> *I wonder if we have the capacity to resource it and what I mean by that is, we use support workers [not registered nurses]. It's quite an ethical issue too as well as a legal one, is we have in our policy one-on-one intensive nursing, and I've actually said this, it is not one-on-one **intensive nursing**. After that event at the beginning where you de-escalate and you don't seclude, to be one-on-one with someone means they have a support worker in there, that does not always mean there is a nurse*

Rae's emphasis is focused upon the lack of registered nurses to carry out special observations with service users who have been de-escalated earlier, but remain a high risk (whilst not requiring seclusion). Rae highlights that shift patterns have not changed over years, whilst resourcing constraints are ever increasing. Both situations are incompatible with responding to service users' needs. The lack of resources and the lack of qualified nurses impacts and becomes a challenge on the ward.

In addition, Rae raises concern that there may be a negative impact for service users from not having a trained nurse available when 'one-to-one' constant observations are utilised. This observation raises the need to provide and actively create a safe place for service users, whilst protecting the service user's rights and access to appropriate treatment.

Furthermore, Rae regards what she experiences as both an ethical issue and a legal issue. For Rae, there is a sense of unease about this experience. She questions whether it is appropriate (or ethically right) to use the policy wording 'intensive nursing' and yet, due to resourcing issues, supply a support worker for the task. The support worker usually has to spend many hours (and commonly the entire shift) engaging with what may be a very distressed service user, whilst not always having the full training to be able to identify or recognise changes or to assess the need to make changes quickly. Once more, this narrative highlights the point that resourcing barriers challenge nurses to provide recovery practice in reality. The lack of resourcing of nursing staff on the ward ultimately takes the focus away from Being-with individuals and enabling a therapeutic space in which to work.

The ongoing lack of resources, strict budgeting, and stretched staffing levels shape the nurses' attunement to just observing multiple people, rather than being-with and creating a safe space for individuals in distress. This in turn drives narrow and inflexible ways of responding. Matt, for example, reflects on how he views services as becoming more focused on finances than care. He describes how resources are being monitored more closely and how this experience has affected him:

> *My personal thought is it is financially driven, it's money orientated, it seems to be creeping in more and more into nursing, into healthcare you know, and that happens all the time that I've been a nurse, it seems to become more and more the pressure around money, pressure around budgets, [and] seems to be higher than it was before. I mean I know there is… well there is a huge difference between the English health service and the New Zealand health service, you know, in… the British NHS was sort of government funded, whereas a lot of the funding here is private and not quite the same. I never ever felt that we*

> *were in an industry where you can validate it with pound, shilling and*
> *pence, it's never been a money profession for me you know!*

Matt's reflections regarding the increasing pressures around budgeting, resources and funding are made via comparisons between the United Kingdom and New Zealand health systems. The frustration that he evidently expresses is linked to his experience that the focus of nursing has evolved into prioritising the management of financial constraints over service user care. Matt suggests that his journey as a nurse was not led by a strong financial need, as this creates a lack of flexibility and space to care within his job. Matt suggests that a focus on efficiency, cutting costs and managing with larger caseloads should not be the primary goals of mental health services. Indeed, perhaps a focus on being efficient makes the focus of practice narrower and less individualised.

Problems with discharge and continuity of care

The nurses' accounts suggest that issues with discharging service users and the lack of continuity of care are also problematic for nurses working in acute services. The increasing burden of these types of challenges seems to cause the nurses to feel stuck and hopeless about facilitating relationships and processes that are healing. Indeed, it appears to affect the relational and physical space for service users in such a way that the ward becomes a space of entrapment rather than enablement. These deficient modes of care are significant in that they create barriers to providing recovery-focused practice, as illustrated by Deb in the following narrative:

> *I definitely say a barrier to us is around the relationship between the ward and the community, and it is something we really find quite difficult at the moment. I feel like we come up with all these plans and all of these kind of commitments and then we end our relationship and because they're in an acute phase, they [the service-users] are only there for 14 days, that relationship ends and then you know, where's the follow up? It doesn't feel good that you are sending this person out, you've worked so hard with, to someone that they haven't even met [the community keyworker], or haven't developed that relationship with. Sometimes they need them, but if that relationship is not developed, then that is when relapse tends to occur, they do tend to bounce back quite quickly [to be readmitted to the acute ward].*

In the previous chapter, opening up relational space was highlighted as being important in supporting recovery, and the nurses discussed the need for ongoing relationships. Here, Deb suggests that the system does not support continuity of care, which in turn does not allow the consistency of relationship, which is vital for recovery-oriented practice. Due to such inconsistencies, and early discharges, service users have a tendency 'to bounce back' to the ward quickly after relapses in their mental health.

A related issue is described by Marianne, who speaks about the challenge of managing service-user discharges effectively, while continuing to support service users in a recovery-oriented manner:

> *It's purely around bed pressure. It has been over the last few months you know when you've got fifteen in the ward and people need to be admitted and I just yeah. I mean I've had situations being on the afternoon shift and we've taken people to Recovery Solutions [supported accommodation] 9 o'clock at night and it is not, it's not okay, you know, it doesn't feel right, doesn't feel very supportive. So, I think, but we're getting better at sort of getting people out so we've got space, but you can see people [service-users] are quite sort of taken back and quite anxious about it and you are managing with what you've got really.*

Marianne relays the challenge of the rapid turnover of service users on the ward. Marianne expresses the difficulty of managing this situation; yet still being able to find the space to support and connect fully with service users. Her reflection is focused on making a somewhat unreasonable compromise between juggling ward capacity without the support of resources, whilst perhaps sacrificing her needs and her commitment to being able to connect fully with each individual. She seems eager and willing to want to work in a recovery-orientated manner; however, she feels frustrated and powerless to fully engage due to the increasing expectations and demand for beds. The rising feeling of frustration for Marianne shows how these somewhat challenging expectations of her role and services have a negative impact on both her and the service users. Marianne feels that a lack of continuity of care is evident; she feels that, due to the lack of support and resources, service users' values are being ignored. Furthermore, Marianne feels she is in a dilemma of not being able to support service users' recovery whilst they experience raised anxiety levels in being moved rapidly out into a community setting with little or no warning.

In another account, Matt describes working in an under-resourced area of health and seeing how a lack of continuity creates barriers to recovery-oriented practice. Under-resourcing has a negative impact on service users because it is not possible to discharge them from acute settings:

> *A recent example was one particular lady who, because of lack of resources in the community, was trapped on the ward for long periods of time, has not been able to be moved off and every placement that has been suggested because of resources has fallen through and unfortunately, she's wrongly placed sitting on an acute admission ward, to the point now where she sees it as home. You know that's again not specifically for here, because I have seen that you know in other areas*

*and other places. Patients, you know, because of complex needs they have ended up trapped basically in that **limbo** of you know sitting on an acute admission ward treating it as their home, when you know no one should have to treat that environment as their normal home environment!*

Matt discusses his experience of this particular individual having a lengthy stay and its negative impact on her wellbeing. Matt expresses how he feels incredulous that the situation has prolonged the service user's discharge. What should have been a relatively short admission is now holding back this individual's wellbeing, creating institutionalised behaviours and patterns of being. In turn, this creates barriers for her returning to the community and leading her life independently. It seems that both the service user and Matt are stuck, feeling hopeless within a cycle that may lead to a shutting down of relational space and reduced recovery practices due to the lack of resources available.

Deb also raises concerns related to delayed discharges on the ward, which have a negative impact both on the service user described in this account and on Deb's ability to provide recovery-oriented practice:

And the other thing that takes up a lot of our time is patients on the ward that don't need to be there. So, accommodation issues, we've got one client on the ward at the moment that's been there for 3 years. And lot of that stuff is around because the environment doesn't suit her, she is in an environment where it changes constantly, she needs to be more in a stable environment with ID [intellectual disability]. That she is taking up so much of our nurses' time, because of her behaviours and it takes us away from spending time with our patients as well.

I start getting really frustrated with the system more than with the client. You know I can't understand why she's not been moved into a more appropriate place. I mean she is not actually all that difficult to nurse as long as you've got consistent care, with ID which is like anyone with ID. And now 3 years, that's the stuff I get really frustrated with, is like why is this still ongoing? You know, why, we've got families making complaints, we've got patients making complaints, it's not therapeutic!

Deb continues despondently,

Sometimes I probably feel like I can't be bothered anymore, I give up with the hope, and it's like, I'm just going to get through the shift. I don't really care, I am just going to try and get through.

Deb discusses her experience and frustration at the system more than with the service user. She is venting about inappropriately delayed discharge systems, and she voices her anger and frustration at the lack of a therapeutic environment for this individual, that it is not recovery-oriented. Deb attributes part of the blame to the lack of consistency in

care, poor resourcing, an unsuitable environment, and lack of access to appropriate housing for this particular service user, who cannot be discharged to an appropriate place in the community. Deb also describes the impact of this situation and how the lack of resources leads to service users and their families making complaints. In turn, Deb feels this has impacted upon her feeling a sense of hope; she identifies feeling despondent and becoming automatic and lacking any enjoyment in her work. This experience that Deb has spoken about seems to amplify the need for change in the system to provide more resources for service users in supporting their recovery and their swift reintegration into the community.

Tensions of legal and procedural expectations

The Nurse participants identified resource challenges to a recovery orientation within team practices. They also shared their personal stories of how they moved forward towards resolution by managing practice tensions and addressing some of the challenges that working in acute mental health often creates. Recovery-oriented practice within nursing requires meeting such challenges whilst working within services that have tensions and constraints. Some of these tensions involve coercive practices, in particular around medication, and the further tensions and challenges that they bring subsequently to nursing practice. However, nurses show determination in facing these challenges daily and facilitating change in service systems where possible. The nurses' accounts, brought together in this section, show how they view and attempt to address such practice challenges.

Marianne talks specifically about working with individuals who are placed under the Mental Health Act and the tensions and subsequent challenges that she has experienced, for both service users and herself as a nurse:

> *When you've got people under compulsory treatment orders and you know, they must take this medication, and then they have some real valid concerns about that medication. At times there may be very little negotiation around the Olanzapine depots and things like that. I think sometimes you can feel quite conflicted, because in a sense you want people to be able to have a say, an input in their treatment, but then with the constraints of the Mental Health Act and being under compulsory treatment it can be quite limited, you know what I mean. I have had people that don't want to be on Clozapine because they can't stand the thought of having a monthly or weekly blood test the rest of the time, they're on it. I guess it is around balancing for people like you know, people have to be informed and know what the risks and side effects are.*

Marianne talks frankly about some of the barriers for individuals who are placed under the Mental Health Act by psychiatrists. She reflects upon the internal conflicts that she encounters in being part of a multidisciplinary team hierarchy, and within her career as a mental health nurse. Marianne opens up about how challenging it is for her to accept that service users seem to have little power or experience little negotiation (from the medical team) around their treatment options whilst being contained under the Act. Furthermore, by recognising that service users often have little negotiation or power whilst under the Mental Health Act, Marianne is able to show genuine empathy for what is happening for the individual. She also demonstrates awareness of the need to provide recovery-oriented practice that shows respect for the service users' autonomy. In addition, Marianne recognises the need for a considered balance in treating service users' distressing symptoms alongside the service user's autonomy and choice of treatment.

Another nurse, Rae, talks about an experience where she found that service user autonomy was lacking. It was a distressing and challenging incident for her and an individual in relation to forcing medication on a service user. Rae shows here how there are times when challenging a difficult situation may be necessary:

> *One significant incident for me which I remember with great clarity, [from] when I was a young practitioner, was being asked to lie a client on the floor and (forcibly) administer Epilim syrup. This client wasn't on high levels of observation and I just followed my instinct and just said 'no'. After this event I reflected on it, I was pretty angry at the time, it was actually directed in the notes. I recall that I spoke about it to others in the team. I said this person is not in seclusion, they're not being C-levelled, they are on an open ward. I spoke about it not being safe [practice] either for her [the service user] or for me, you know there just wasn't any negotiation. It was almost like being asked to violate someone in some way, which isn't like me, that's probably why I was so angry! Also, because I had worked really hard to get the rapport that I had, it hadn't been easy. So yeah, I was particularly stressed about that. I remember being stressed and upset about it. It was like taking a friend, and saying excuse me but I'm going to lie you down on the floor [and force you to take medication]. It was just odd, it was so out of my frame of reference.*

Rae reflects on this story and finds herself continuing to struggle today to comprehend how such inhuman practices could be part of the practice of a caring mental health service. She reflects on how a service has shown disservice and non-recovery-oriented practices, the opposite of recovery principles which advocate kindness and negotiation towards treatment options for each service user. It also shut down the opportunity for creating a safe space, which would have allowed the building of a relational space for

both the service user and Rae to work with. In addition, Rae speaks of the word 'violation', and how she found a connection with what may have been deemed quite a distressed service user. Here Rae is recognising the coercive practice and challenging these procedural expectations and refusing to do what was asked. In addition, the distress that the service user displayed almost mirrors Rae's distress. The impact of this situation on Rae has caused her trauma and ongoing distress which seems to have continued to affect Rae greatly through her career. Rae has never forgotten this disturbing experience and the impact of the coercive and challenging practice that she witnessed. Rae tried to address and manage the tensions here by standing firm in her beliefs, and having no part of this type of coercive practice or the negative impact would it would have upon the vulnerable individual involved.

Rae's account goes on to describe how this disturbing incident continued to escalate after she had made a formal complaint to the mental health services regarding the incident:

> *There was a massive kickback and actually a lot of senior nurses said that to me at the time, 'it's not worth it, just do what you're told', but I've, I mean, I've never believed in that. I think the culture was, it was medically driven... I think it was also his [the psychiatrist's] cultural background, so in his cultural background you know, women were quite subservient, and that was quite a theme, but the care was medically driven. We had a lot to do with clients, but we didn't really have a say, unless you could be quite clever and quite academic, yeah, and that was more about the consultant, because he was a real academic, so learning how to speak his language. That was back in 1996.*

Rae's experience of this incident (the use of unnecessary forceful and disempowering behaviours and attitudes) enables her to recognise and reflect on these types of cultures within mental health teams. This highlights how the hierarchical system and expectations are very strong, and has significant power over nurses. There seems clearly to be an expectation for nurses that you 'just do what you are told'. There is an expectation that nurses are expected to follow procedures and Rae even mentions in the preceding account that to force medication 'was directed in the notes',

Indeed, Rae further recognised that she would need to change her approach in order to reach and connect with the psychiatrist. Here Rae articulates how she managed to find her voice, by engaging and learning how to articulate in an academic manner with the psychiatrist in moving away from a traditional nursing and gender role. Here Rae indicates she has changed how she vocalises her concerns, to present them in a more academic way that will make the psychiatrist listen to her. This in turn enables Rae to feel a sense of being heard and validated, which may be the catalyst for Rae to also

enable service users to find their voice in a safe space. Here there seems to be some indication of a parallel process. It is parallel in the sense that Rae wanting her voice to be heard, whilst ensuring safe practice, is also what service users may want. Recovery in practice, for example, being validated and having a voice, is what service users want, and it reflects the same principles that nurses also need and want to see in their practice.

Building Recovery-Oriented Practice

Despite many of the challenges discussed in the previous stories, many of the nurses within this study spoke about their experience of positive change towards recovery-oriented practice over the years. The nurse participants spoke about how they recognised a change in both attitudes and practice, observing how they and their colleagues have become more recovery-focused over time. They also described how being hopeful and positive in their approach helped support service users but also each other.

Shifting focus from clinical management to supporting recovery

Reflective practice is an integral part of working as a nurse. The ability to hear service users' experiences better informs changes in practices. The accounts in this section show nurses recognising the need to shift their focus from clinical assessment and managing risk by using power and coercion, to providing a positive experience during admission, which helps to stop the cycles of distress and disempowerment. The nurses focused more on the relationship, and sharing power through working collaboratively and providing opportunities for learning about managing distress and developing meaningful insights. The following nurses' narratives indicate they have seen a cultural shift towards these ways of working:

> ***I mean from right when they come into hospital that you make sure that they have a good stay*** *because you hear a lot of patients come in and say, ah, man, you know years ago it was horrific. They didn't realise that things have changed quite a bit now... (Deb)*

> *When you have been in mental health nursing for so many years and seen so many different scenarios with people presenting as such then you see them many years later and then they have turned into vagrants etc., it puts back that picture in your mind:* ***How can we stop that cycle and how can we improve someone's life? (Arron)***

> *I think a lot of our clients coming to the ward see it as being a negative, it is negative, like there are times where they have to come and they don't want to be there.* ***How can we make it more positive so that***

> *they actually get some meaning or new insight from their*
> *experience on the ward? You know, like what do they gain?*
> *(Marianne)*

Marianne talks about enabling and empowering a service user to recognise change and obtain new insights into their treatment, whilst supporting a recovery approach by creating a space for meaning and service users' growth and learning in supporting their self-management.

The nurses' accounts suggest that the change in focus towards a recovery-oriented approach has led to a discernible change in practice, as Deb continues to describe here:

> *I also see a change in myself is that I am not so focused on getting a*
> *mental state [assessment] from the patients, yeah. It used to be for*
> *me all about getting a mental state but also assessing risk, and making*
> *sure that everyone was safe, so I was very focused on that.* **Now I am**
> **actually more focused on having a good relationship with the**
> **patient**, *which if you have a good relationship you actually get the*
> *same information, probably get more, yeah.*

Deb highlights how her way of making change grows and opens up a space to engage in collaborative relationships and connection. She describes how sharing experiences supports a more recovery-oriented approach with individuals. For her, this has been the catalyst that has made a positive change in her working practices. A change that allows Deb to feel not so driven to keep rigidly to the ward assessment process.

In practical clinical work, collaborating with individuals with lived experience often creates a feeling of optimism for both the service users and nurses. Here Aaron and Carole each relate how they understand this:

> ***It's about working collaboratively.*** *…the recovery model is not about*
> *you know, organising something for them. You both have to work,*
> *problem solve, sit down, have time, negotiate it and then proceed*
> *forward. (Aaron)*

> *I think we (nurses) are getting better because of the team reviews and*
> *things like that. Now they do involve the family more and do talk to the*
> *client and ask what they want and how they are… I think we are more*
> *client focused and more into what they [service users] want and*
> *supporting their journey. (Carole)*

Arron seems to recognise the significance of using a collaborative approach in his work. Here he is also using negotiation and goal setting to move forward in preventing a 'downward cycle' to help prevent the service user 'slipping through the gap in services'. Furthermore, Arron identifies that, by early intervention, using both knowledge and

communication skills, and by connecting to service users in a recovery-focused manner, this approach would be likely to assist in better health and social outcomes.

Carole is reflects on the positive changes she has observed over her years as a nurse. She is talking about her experience of change, which for her includes an important change regarding the service users and their families, by involving families more and creating space for service users to have more choice in decision making roles. Creating a feeling of positivity and hope regarding such favourable changes, in turn opens up the space to enable or create a hopeful environment, whilst supporting service users' recovery. Carole is cognisant of the nurses' power whilst working on the ward, and how the need for balance and providing the space to talk about service users' collaboration and advocacy, begins to grow a more positive environment in which to support service-users and support good recovery-oriented practice. Here Marianne shows how she connects through being collaborative in her approach:

> *You can do a lot of **education around symptoms,** like really sort of basic stuff, early warning signs and things like that. Sometimes I ask that to people [service users]. I say 'is there anything that's been a bit of a "light bulb" moment for you while you've been here? You know, 'is there anything that you didn't know before about yourself that you do now'? I mean one lady said to me, she said she felt she now had better control over what was happening for her because she understood it more.*

Marianne shows how she is able to connect and support educative skills in a more collaborative manner with one particular individual. Here she is supporting this individual's development of self-management skills to help increase the service user's skills and confidence in managing her own health. Supporting self-management is a central clinical contribution to recovery.

The need to recognise and support recovery-oriented practice

Nurses talked about how they thought that mental health services appeared to be more open and receptive to embracing recovery practices. However, developing a focus on recovery may be resisted by parts of mental health services. It is a long way from being perfect, and it has been demonstrated it is necessary to move away from a traditional medical focus, towards a more 'human need' recovery-focused service (Onken et al., 2007; Slade, 2012). Therefore, this section highlights how nurses make recovery-oriented practices more explicit. They share their stories of their recovery practices, whilst exploring how these practices apply within the team. Additionally, they discuss how important it is to have training to support the application of recovery-oriented

practice, and how vital is it to have the right nursing support structures to provide mentorship and role modelling for new nurses.

Marianne explains how change has occurred for her over time, and her perspective on this:

> *When I did my training, we didn't really talk about recovery, it was just, so it was sort of quite a new concept when I began working here in a sense...Yeah, I mean it may have always been around, but it seemed more, **there is more talk about it now** than there was back then.*

Marianne reflects back on her experience about the silence or the lack of 'talk about recovery' that was evident during her nurse training years ago. The concepts may have been there, for example, supporting clients' choice; however, she is acknowledging that there has been a positive change over time. Her knowledge around recovery for service users in today's mental health services has grown positive changes in practice, in comparison to the past practices. She mentions that there is an element of recovery being 'alive' today, awakened from a shadow of recovery in the services in the past, by nurses acknowledging and discussing recovery and how this might look in reality.

Marama also recognises the need for a change to take place in mental health services, one that would create a space for education, for nurses in particular, in raising awareness around what recovery looks like and how to practice this in reality with service users:

> *[I wonder] Do people [nurses] really know what recovery even looks like? You know where you get this whole education about, also patients need to be in some control of their own recovery, which is fine to a point, and I agree with that, but **do we know what it is as the clinicians delivering it? Do we actually know ourselves and are we supporting patients to recognise that for themselves?** Because sometimes in their un-wellness they're not going to recognise it, but we should be able to!*
>
> ***I think if we set up the sort of training** that includes all of that kind of stuff then it can get clinicians to recognise other aspects of recovery, not just what's written out there, but what is it? **What is it to you the clinician? What is it to you? What are the things that you should be aware of and that you should recognise as being recovery?***

In her experience, Marama seems to find some meaning in raising awareness to advocate for service users when they may not be able to do so themselves. She voices how it is imperative to recognise recovery practice, and empower nurses to feel able to change, to address their learning needs and to support service users by practical recovery training in nurses' education. In addition, to be able to affect change, nurses

must be able to recognise when recovery-oriented practice (or non-recovery-oriented practice) is happening.

Marama further explains how she feels it is the responsibility of the nurse to help service users (at times when they are experiencing some inability to recognise their own strengths) and to support and enable them to then recognise some of their positives. This may effectively create a space for advocacy and promote recovery practice.

The history of mental health and nursing experience is that it provides nurses with reflections and memories of how mental health nursing practices have continuously changed and grown over the years. Here Matt reflects on his experience of how the nursing workforce used to look and his learning from his past experiences in practice:

> *Charge nurses and ward sisters looked after the ward, really looked after the ward, they were there, and they were the experienced person who governed everything you did. You also had the deputies who were also experienced nurses who were there on hand to help and support junior staff. **So, there was always someone to turn to say, 'am I doing this right'? Can I have some help and support?** I don't think we get that as much now you know.*

Matt reflects on how the structure within nursing cultures has changed over time and how the approach of the past may be now viewed in a more positive light. There is a sense of security and positive care for service users and staff alike, a nurturing space that he reflects upon fondly. For Matt, nursing teams were more organised and more focused, and provided a safer and more supportive environment for junior staff, which he feels is somewhat lacking in today's teams. One particular recollection that seems important for Matt is that there was always someone more experienced to seek support from when he was unsure, which subsequently provided a learning space for Matt to grow and improve his skills.

The need for teamwork, speaking out and reflection

In the following section, nurses reveal how important it is to work together as a team in such a way that traditional professional hierarchies are reduced and the nurses feel safe and confident enough to challenge deficient modes of care. Nurses also discuss how recovery-oriented practice is neither straightforward nor always black-and-white, and that it may require speaking out and challenging traditional ideas, for instance challenging boundary issues. However, it is also important for nurses to self-reflect on their own practice to ensure new ways of working are safe for all.

Anna brings forward the notion of how teams are making positive changes, both in an inter-professional and a service-user focused way. Anna does this by acknowledging

that team work involves being confident in the team and, if and when necessary, challenging others (within a traditional team hierarchy) by voicing concerns and adopting a more recovery-oriented focus.

> *It is not just the nurse, we are a very small drop in the ocean, in the whole picture, you know, **we're a very good working team in an environment on the ward** with the doctors, psychologists, the diversional therapists. You know **we've all got a part to play in that person's [recovery]**, not just nursing, we don't just come in and give the medications that the doctors have said. The doctors are brilliant because if we're not happy with a particular medication that they'd given them or they're actually not listening, **then you know we feel quite confident enough to sort of bring that to the table.***

Anna discusses how making a difference for service users has a positive effect on her. Anna explains that she feels positive and is managing her role in providing a recovery approach within her area of work. Anna also reflects on how such positive changes have led her to feeling included in the team. The part she plays, and the ways in which teams have changed and grown, demonstrate an exceptional team working philosophy with collaborative working, and are to be admired. A pivotal change that Anna describes is how team doctors listen to other professionals, and how this positive change has empowered her, creating a new level of confidence in her role as an advocate for service users in communicating or challenging decisions made by the medical team. Anna shows this by being active and playing a part in advocating for service users, and encouraging others towards implementing recovery-oriented care within the team.

Growing skills and being assertive as a nurse within teams can help shape positive attitudes towards recovery practices in nursing. The challenge of not being silent, of speaking out against suspect practices, and using reflection as learning space, creates a sense of empowerment for nurses and may prove one more step towards shaping positive team cultures and supporting service users by utilising their recovery-oriented practice, as Pat describes:

> *I was more timid a few years ago, now it is kind of like well I actually I disagree with what is happening here and (I often say) 'you go and have a little chill', something like that. I still find it difficult to find the words to confront someone like that in my team. In saying that, it depends on the team as to how comfortable you feel that you can say that. I am very much into asking questions and, I am open to any answers, whether I am right or wrong you know. I am into constructive criticism, so it's, who you're working with that you feel comfortable that you can go and say 'well actually I don't agree' or 'I feel like I've got a suggestion that I might be able to help with', or 'I have something else to say about this'. If you get a team that you know you can do that with,*

it's great, it's great, because I don't do things right all the time, no way,
but you learn from that.

Pat is reflecting here on how she has grown more confident over the past three years since she qualified. She reflects on how 'timid' she used to feel, and how the team challenged her to use her 'voice' either to support service users or to identify troubling issues that may have arisen whilst working on the acute mental health ward. She may find meaning in this, by being able to empathise more deeply with service users, who are often less able to find their voices, albeit to a greater extent due to power inequalities. She describes how she is often able to communicate in a gentle but assertive manner with the team. This comes into play when she feels uncomfortable with culture and ward issues. However, she acknowledges that this can still be difficult at times and it may prove easier when teams are more comfortable and open to communication. She seems to approach team tensions with a good degree of self-awareness, humility and respect, by acknowledging that "I don't do things right all the time, but you learn from that."

A further tension described in these nurses' stories is the need to build close relationships, while keeping themselves and service users safe. There is a tension between wanting to be-with service users in a human way, while having an awareness of when the closeness may get in the way of other important aspects of recovery. This is illustrated in Anna's story, as follows:

I got told off by a couple of colleagues one time saying, 'you are close to that patient' and I find that quite hilarious, you know. I've been accused a couple of time of being too close or involved, and I said 'define too close for me because I struggle with that because I'm just being a human being and I am being kind'. It's my nature and you know so far in my career I haven't been proven wrong or any differently by being that person. It is just first and foremost I'm X, I'm a registered nurse and I work in a psychiatric unit and these people are human beings, they're all individuals.

She was a coordinator actually, she said you are too emotionally involved with this person so you're not nursing them today, and I couldn't understand any rhyme or reason of why she would use those words, but because she is more experienced than myself I respected what she said, and I thought okay, I will pull back because sometimes you can get bit blinded and you can get sort of you know quite intensely concerned about your patients.

Anna experiences feeling slightly 'ostracised' by her colleagues. Anna is experiencing first-hand the challenges of managing the relational staff tensions and dynamics on the

ward. Furthermore, by being 'close or over-involved' (in the view of her colleagues), she is frowned upon and perhaps feels that her manager may be indicating that she should be more professional or 'boundaried' within her interpersonal and therapeutic relationships. Anna struggles with this concept of being too emotionally involved with service users; she feels that although one needs to be mindful about practice and boundaries, she is only displaying her 'humanness' and 'kindness'. Anna is attempting here to manage these tensions by pulling back from the situation, recognising that at times she may get over-involved due to her caring nature. In addition, perhaps Anna has identified here the challenges that nurses face around some of these professional boundary issues. She is questioning how it is possible to invest oneself into an authentic relationship by not Being-with the service user wholeheartedly, despite her colleagues' cries of opposition.

The stories in this section have shown that the nurses are reflective practitioners who think about the meaning of their professional experiences. However, nurses also recognise that recovery-orientated practice is not always clear and straightforward, and it brings challenges where nurses often feel the need to speak out and question traditional hierarchies whilst being cognisant of the multitude of complexities within teams. Therefore, it is interesting to examine more explicitly how that leads to change and growth for the nurses. Furthermore, there is a need to promote service user choice and for individuals to gain back some control within systems. These topics are discussed in the following section.

The need to promote service user control within rigid service systems

Heidegger wrote about the hermeneutic philosophy of 'Being-with' and the benefits of being alongside individuals and building relationships. Showing care and simply Being-with service users helps support service users' sense of belonging, empowerment and usefulness as members of the community. Within the following stories nurses' reveal their experiences of working with service users within often rigid service systems. Many of these nurses' show how they worked hard to give choice and reduce power inequalities. These stories reveal how (despite the challenges of the system) there is a positive shift occurring within today's ward environment, which supports both recovery-oriented practice and provides a sense of hope for individuals.

Carole describes how she sees these positive changes in practice:

> *I guess even the Mental Health Act is much more focused around the client and being less restrictive. I think we do our best to not put someone under the Mental Health Act unless we really have to. I think there is more discussion around what's best for the client rather than*

us dictating, so yeah there is more of a balance, and that's where I think like the District Inspector and things like that are good now too, where you can get an advocate for the person.

Carole continues reflecting on the need to allow some flexibility within the routine structure of the ward environment.

I guess the ward routine in terms of, you know, meals at certain times, bed at certain times. It's the structure and routine and stuff. I guess in some ways, you know it can be a positive or a barrier really. For some people when they're unwell they need that structure and routine. I think a lot of it is how you communicate it with the client and put it to them individually, really, so I think you know, I think it can be a positive in terms of the structure and the routine, but I also think we need to be flexible to and letting family stay later or stay the night.

Carole discusses how important it is to find the right balance between providing safety and structure whilst also creating a positive empowering and hopeful environment by utilising a flexible recovery approach. She explores some of the pertinent issues around ward routine and the structures which may be viewed as barriers, and has learnt to use a balanced approach whilst providing useful structures, as opposed to strict rules that oppress service users' choice and autonomy. She advocates the 'need to be flexible' and to communicate effectively, whilst providing individualistic recovery-focused care and promoting service users' choice in their care.

Policies and ward practices bring another type of tension and challenge for nurses. As has been noted earlier, Anna identifies that smoking policies are another significant point of tension on acute wards for service users, which causes conflict and impacts on service users' usual coping strategies. Here, however, she finds a way of managing this challenge by supporting the service user to manage his distress using alternative methods:

He was quite upset about being back on the ward and he said 'I just need to go outside for a cigarette'. I said 'you know that's not possible', and he said 'well I'm just going to smash my way out of here' and I thought ah, we've got the potential here for him to kick off, because he had in the past. So, I thought he is really into his fitness, so I said, 'I tell you what, let's go out to the courtyard. I need you to show me some of these, these moves that you've got, because you know I've been putting a few pounds on around my middle and I need to get rid of it'. Suddenly he forgot about the smoking and I mean it nearly killed me doing these exercises out in the courtyard, but for that moment it worked, you know he forgot about the smoking, in fact I nearly killed myself doing these crunches. All the time I was doing this, I'm thinking, you know, sometimes I go above and beyond myself as a nurse.

Anna opens up a new space by creating an opportunity to allow this individual to use his frustration towards ward rules in a more constructive way. Within this narrative Anna shows how she skilfully supports his recovery pathway in his moment of distress by investing herself in 'going the extra mile'. Here, Anna uses self-disclosure around her own difficulties in regard to her fitness issues. Thus, she opens a relational space, through a more collaborative dynamic, and enables the service user to feel that he can reciprocate by showing his knowledge and offering support back to Anna. He does this even though he is in a vulnerable space. It seems important for Anna to use her creative way of supporting him by thinking of exercise as a welcome distraction, and for the service user to be able take back some element of control in the situation. Nonetheless, she is feeling quite challenged and exhausts herself in her action. But, despite working within an often rigid and policy driven service, partnership and flexibility can work to foster and grow relationships as in this beautiful example from Anna.

It just gives me a great sense of achievement and contentment, yeah, that I'm doing my job correctly and I am making a difference, so that's all I want to do at the end of the day, is make somebody's life a little bit better…

Summary

Within the stories in this chapter, the nurses revealed how deficient modes of care can negatively impact the relational space of connection and continuity of care. The nurses' narratives in this chapter highlighted aspects of how historical cultures, power, and risk-averse practice remain present in practice. These, in turn, may create barriers that prevent nurses from working in a recovery-oriented manner, or may influence them against so doing. Similarly, external processes, such as the systems and processes in which nurses' work may have a detrimental effect on how nurses work towards supporting service users.

Nurses also spoke about how they continued to attempt to manage practice tensions in the workplace, often with trepidation and some bravery, through the use of advocacy, challenging institutional practices, and standing up for service users' rights. These nurses seemed to adapt well towards promoting choice within often rigid systems, and towards a more recovery-focused practice when it was called for. This occurred despite the lack of resources or support from the wider services. Despite the deficit modes of care they encountered, the nurses' spoke of processes they put in place to overcome them. They also spoke genuinely about pertinent examples of more recovery-oriented practices despite the challenges. Overall, the nurses' stories showed a certain parallel to the service users' experiences. They too want a sense of community, want their strengths and life experience to be recognised and supported, and want to learn new

ways of working towards recovery. They continue to give themselves tirelessly, as nurses, to working within a challenging system, whilst continuing to build close and meaningful relationships with service users. Nonetheless, these same nurses were also very cognisant of how to observe necessary boundaries within their practice so as to keep themselves and service users safe. Nurses (again like the service users) also showed how they want to feel empowered within their roles, and be allowed to have a voice within the system. Without nurses having the support to feel connected, valued, and empowered to speak out and use their strengths, it will be very difficult for them to do the same for service users and be recovery-focused.

Chapter 7: Discussion

Introduction

The preceding findings chapters revealed how nurses found meaning through connecting with service users in the process of recovery-oriented practice. The stories of practice revealed many hidden or taken-for-granted aspects of working in acute mental health care, including how systems and team practices can either support or create barriers to recovery. The phenomenological lens used in this research helped to uncover how the nurses' experiences shaped their attitudes, values, and behaviours as well as the meaning of recovery-oriented practice within the acute setting.

In this chapter, I reflect back to the original question that marked the starting point of this study, namely: 'What is the experience and meaning of recovery-oriented practice for nurses working in acute mental health services?' A summary of the key findings is provided in the first instance. Then the nurses' understandings of recovery-oriented practice are discussed in relation to the wider literature. Thirdly, the discussion considers the nurses' experience of supporting recovery through the creation of different spaces in which to open up a sense of safety, shared connection, and opportunities for healing. Following this, the barriers to recovery-oriented practice and the impact of deficient modes of care will be discussed. Finally, the implications of the findings will be outlined, and strengths and limitations of the study will be considered.

The Nurses' Experience and Meaning of Recovery-Oriented Practice

As discussed in Chapter 2, there are many definitions of, and ideas about, recovery-oriented practice, and some of the participants within this study had learnt these through their nursing training or listening to others' discussions. They may have also read the literature related to the need for hope, a strengths-based focus, and close relationships. However, in phenomenological terms, this is not necessarily their 'lived' experience of recovery-oriented practice. The nurses' accounts within this study indicated that they had varied understandings of recovery-oriented care, but overall the stories indicated that to these nurses it was just good nursing practice. Their routine and often taken for granted practices revolved around striving to help service-users to feel safe, build a shared commitment and collaboration, and assist service-users to make some sense of what was happening to them now and in the past. However, these elements of creating safe,

relational, and healing spaces were always competing vigorously with both the medical and custodial paradigms that exist within inpatient mental health services.

The medical and the custodial approaches have the power of the broader system and a traditional, hierarchical ward culture behind them. At times, these approaches led to coercive and deficient modes of care. It was evident that in order to provide recovery-oriented care, the nurses had to avoid slipping in to deficient modes and go beyond the norms and expectations of traditional ward culture. At times this required bending some of the 'rules' and boundaries, and advocating for different ways of practicing. Some of the norms that were challenged related to how much time it takes to get to know service users or support them through their distress, and how close to get to people, both emotionally and physically, whilst trying to figure out what each service user's priorities for treatment and ongoing care were.

Both the tensions and triumphs within the participants' experience contain the real 'meaning' or significance of recovery-oriented practice for these nurses. It required an approach where there was no particular formula; practice was often unstructured, intuitive, and sometimes uncertain and messy. However, the accounts also showed how 'care-full' the nurses were, and how they experienced and shared genuine love in their Being-with service users. Because recovery is different for each individual, recovery-oriented care could not be pre-determined and therefore required constant reflection and discussion. Intuitive practices and the flexing of boundaries needed to be made explicit and shared amongst a supportive team. By sharing their thinking, and introducing new ways of working openly with their team, the nurses pointed to the potential for changing attitudes and ingrained cultures to develop safer, more collaborative and healing spaces for service-users. The elements of this experience are captured in Figure 1 (p. 116), which shows the core aspects of recovery-oriented practice that underpin the creation of safe, shared, and healing spaces. At the heart of recovery-oriented practice lie some core elements identified by the nurses. Elements such as working collaboratively and instilling hope run through all aspects of recovery-oriented practice. The nurses also described different foci within their practice, summarised here as creating safe, shared, and healing spaces. The creation of these spaces was affected by the ward context, which created tensions and barriers to recovery-oriented care. These elements, combined, capture something of the experience and meaning of recovery-oriented care. These key aspects of the nurses' understanding and experiences of recovery-oriented practice will now be further discussed in relation to the wider literature.
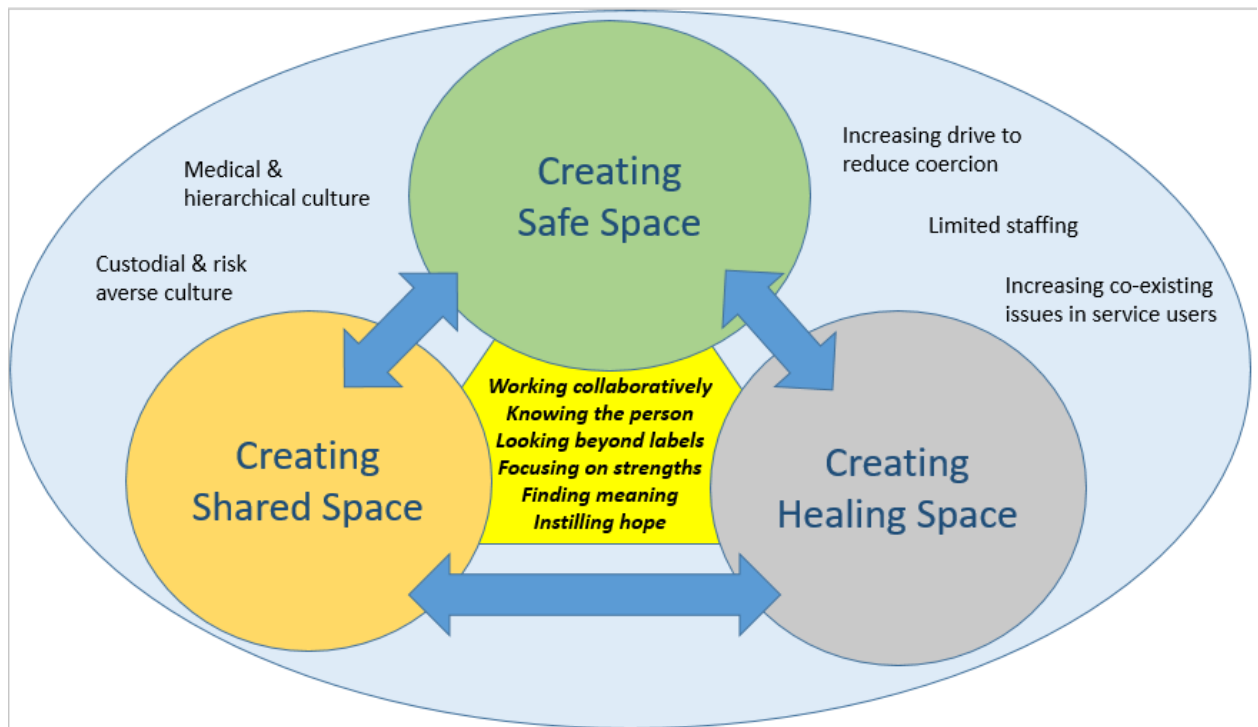
Figure 1: Elements of the nurses' experience of recovery-oriented practice

Nurses' Understanding of Recovery-Oriented Practice

Nurses' understandings of recovery and recovery-oriented practice are pivotal to the adoption of recovery-oriented care. This is particularly the case in acute mental health services, where nurses make up the majority of staff. Within this study it was found that, similar to service-users' experiences of recovery, each nurse experienced recovery-oriented practice in his or her own way. Published research (Cleary et al., 2013; Noiseux et al., 2009, 2010) supports this finding, indicating that nurses in acute mental health settings have a great diversity of understanding of what recovery-oriented practice means, varying from it being seen as holistic and connected, to the more traditional medical focus on treatment. For example, research from the United Kingdom (Aston et al., 2012) explored mental health nurses and service-users' views of recovery. The nurses had various understandings of recovery and had difficulty articulating what recovery meant to them; and therefore how principles of recovery could be applied in practice. Some of the nurses in Aston et al.'s (2012) study seemed to view recovery as something that is 'done' to service users, while others viewed it as an ongoing journey which needs a collaborative approach. This apparent lack of shared understanding was found to create difficulties when trying to achieve a fully integrated recovery-oriented mental health service. The implications of the lack of shared understanding will be discussed later in this chapter.

Despite the range of understandings and experiences within the present study, there were some common themes related to recovery-oriented practice. These themes revealed that by having hope and really knowing the person the nurses created strong and lasting relationships which supported recovery. As illustrated in Chapter 4, the key themes included; *working collaboratively*, *knowing the person, looking beyond the label, focusing on strengths*, *finding personal meaning* and *instilling hope*. These findings align with Boutillier et al.'s (2015) research, which explored factors that support personal recovery included providing choice and fostering hopeful and collaborative relationships. In order to explore these points in more depth, each of the themes is now considered in relation to the broader literature.

Collaborative engagement and knowing the person

In alignment with the literature related to recovery-oriented practice (Ministry of Health, 2008) the nurses' stories highlighted the value of having meaningful, collaborative relationships with service users. It was within the context of relationship and spending time 'Being-with' (Heidegger, 1927/1962) that the nurses were able to come to understand the person behind the distress and agitation. The nurses talked about the importance of really getting to 'know the person' and building engagement in 'genuine' relationships. This occurred through multiple encounters and in some cases over several admissions, with a strong emphasis on consistency, trust, and collaboration in a shared commitment.

One striking finding was the difference participants reported in their approach to engaging with Māori service users and, in particular, how Māori nurses work alongside service users. There was a high percentage of Māori service users in the unit and one nurse reported how she had learned to be able to recognise and value the role of immediate and extended family (whānau) when working with this population. This included allowing time to get to know and connect with both the service user and his/her whānau as the starting point for any care. In other words, for Māori, 'knowing the person' meant knowing the immediate and extended family, an insight that aligns with other research related to supporting Māori wellbeing (Wyder, 2017).

Engaging collaboratively with Māori service users required an investment of time, and involved nurses being open to sharing more of themselves. This was important in finding a way to connect and in creating a deeper, trusting relationship over time. This particular aspect of the findings reflects the findings of Wilson and Baker's (2012) study of Māori mental health nurses, which highlighted the importance of being available to connect with service-users through revealing more of themselves as human beings. This was believed to grow and enhance relationships, and support service users' recovery

pathway, but did involve dealing with tensions related to expectations and norms within mainstream health services (Wilson & Baker, 2012).

There is a growing interest in understanding recovery from a collectivist perspective (e.g., Tse & Ng, 2014) and the present findings provide insight into recovery-oriented care within a collectivist culture. Māori perspectives may challenge approaches to care that are overly focused on self-advocacy and independent decision-making at the expense of interdependence and kinship. It could be argued that mainstream services can learn from Māori ways of working. Prioritising relationship building, mutual sharing of oneself, and working with broader family to create a sense of belonging, are all aspects of care that would support recovery for most service users – not just Māori.

Looking beyond labels and focusing on strengths

The nurses recognised that using labels only divided people, heightened differences, and negatively impacted the service users' sense of being 'othered' in the ward. The participants spoke about how recovery-oriented care meant looking beyond labels or diagnoses to break down power structures and move away from medicalised ways of working. This involved shifting their focus from the service users' deficits towards a more positive inclusive strength-based viewpoint. In doing so, the nurses aimed to move the role of the service user from that of a passive onlooker in their treatment, into an active partner in their own recovery. The emphasis on a strength- based focus in implementing recovery-oriented care aligns with findings from a study of 1249 Irish mental health nurses (Cusack, Killoury, & Nugent, 2017). The study explored how the nurses worked in recovery-oriented ways and found that the integration of strength-based approaches and moving away from a medical model was critical in supporting resilience and recovery. Similarly, the results of an Australian study of 21 inpatient mental health nurses (Cleary et al., 2013) found that working alongside the person, focusing on the individual's strengths rather than the diagnosis was important. This meant leaving aside or ignoring the diagnosis when needed. As one of the nurses in the present study related, it was about seeing the 'whole person and looking at their entire journey', as opposed to just illness and symptomology.

Instilling hope and finding personal meaning

Hope has been highlighted in the literature as an essential factor in psychological and therapeutic change and an integral part of recovery (Cleary et al., 2013). Therefore, it is not surprising that having hope and finding personal meaning was a key theme in the nurses' accounts. The stories indicated that instilling hope involved creating a feeling of safety and walking alongside service users through their difficulties and tribulations. The act of holding hope for each service user's recovery was important, particularly at times

when the service users were struggling to hold it for themselves. Believing and having hope in each individual, enhanced the nurses' relationships with service users and, importantly, provided service users with a glimmer of hope or a 'light' at the end of the tunnel. Indeed, as one nurse related, having hope meant that things could get better, and this involved a shared commitment between the nurse and service user, focusing and working collaboratively in a trusting relationship. Instilling hope also involved supporting service users to be future-focused and using hopeful language.

These findings align with Snyder's research (2000) which found that hope was needed for a person to have belief in his or herself and reach goals, despite the challenges or obstacles that they may face. Similar viewpoints were highlighted in Cleary et al.'s (2013) study, which explored humanism and hope within an acute mental health setting. They noted that being future-oriented, allowed service users to explore difficult situations and gain different perspectives on their issues as well as have a clearer picture of outcomes and life goals. It was acknowledged that service users need hope to keep moving forward. This was also found in the present study, which highlighted the importance of nurses being a guide or navigator, to help individuals recognise the possibilities that exist. Ultimately, hope may fluctuate from time to time in service-user's lives; however, it was found that nurses have the ability to show hope and make a difference in helping service users to keep on achieving in their pursuit of personal recovery (Cleary et al., 2015).

The nurses also highlighted the importance of supporting service users to maintain a positive sense of self and personal meaning in their current situation, as well as in their broader life. This involved making sense of their experiences and one nurse suggested this required nurses to just 'be-with' and to 'stop, validate, listen' when service users shared their stories. The nurses' accounts demonstrated how, despite high levels of distress at the time of admission, positive outcomes can be achieved through the process of meaning making. One nurse within the study related that a 'true recovery approach', involved being able to see past the acute phase, to enable the service user to maintain hope and a positive sense of who they are as a person (Hamer, Clarke, Butler, Lampshire, & Kidd, 2014).

The preceding discussion of the nurses' understanding of recovery-oriented practice reiterated some common themes in their accounts and highlighted the alignment of these with other recovery related literature. The ways in which the nurses demonstrated these elements of recovery-oriented practice varied and were illustrated in different modes of practice that focused on creating safety, building shared commitment, and facilitating healing. The accounts that were captured in Chapter 5 showed how forms of therapeutic

space were created through embodied or intuitive care, where elements such as working collaboratively, instilling hope, and finding personal meaning were implicit in their practice.

The Centrality of Creating Therapeutic Space

Within the findings, three types of interrelated therapeutic space emerged from the nurses' stories, namely: safe space, shared space, and healing space. These interpersonal spaces were created to help service users feel safe and comfortable, allow the establishment of a shared commitment, and to make sense of current distress, loss, and traumatic experiences. The nurses revealed that they experienced different ways of Being-with, which shaped the service-users' lived space in different ways. Subsequently, the nurses found this had a meaningful impact on how they were able to support service users' recovery. The notions of lived space and embodied knowledge (van Manen, 1997) were evident in nurses' accounts. The notion of lived space helped to clarify *what* the nurses were creating in their recovery-oriented practice. The notion of embodied knowledge or intuition showed *how* the nurses created and worked within these spaces.

Creating safe space

Within the findings, the nurses reported that creating a safe space for service users was an essential element of recovery-oriented practice. Creating a safe space to manage crisis and distress was both challenging and, at times, emotional for nurses. Acute inpatient units are extremely busy and demanding places, so creating safe space in a timely manner was not an easy proposition. The notion of creating a safety for service users has been explored by Slade (2012) who advocated that a recovery-focused service should be geared towards preventing crisis, and then knowing how to respond well when crisis does occur. Slade outlined four principles in this work: 1) prevent unnecessary crisis, 2) reduce the loss of personal responsibility, 3) maintain hope during crisis, and 4) support identity during and after the crisis. Although similar in outcome to Slade's principles, the findings within the present study showed the different ways in which these principles were achieved in the creation of safe space.

The nurses felt that they were able to prevent crisis through their attunement to service users' distress and recognising potential vulnerability before a situation spiralled out of control. They did this by genuinely 'being-with' with the individual before and during his or her distress. This finding aligns with literature about service users' perspectives of what helps them when distressed (Anthony, 2004; Borg & Kristiansen 2004; Leamy et al., 2011). For example, one study (Kidd et al., 2014) found that support and acceptance

from nurses was instrumental in service-users' experience of safety within an acute setting.

This finding illustrates how important it is for nurses to have the ability to create a safe space through an intuitive or attuned awareness. This embodied knowledge has been described as 'savoir de familiarite' or the knowledge bred of familiarity (Merleau-Ponty, 1962). Through their accumulated experience of being with people in distress, the nurses were able to notice subtle changes in both the service users' embodiment as well as their own. This proved invaluable as the nurses observed changes in body language during times when service-users were just becoming distressed and required careful de-escalation to prevent further crisis. The findings also revealed that nurses who had worked together a lot, had an intuitive form of communication amongst each other in acute situations. In fact, it was such a powerful intuitive state, that one nurse likened it being *almost like a stage* where they know how and when to de-escalate. This had a positive effect and allowed the nurses and the service-user time and space to feel calm and safe.

The nurses also shared how they attempted to prevent unnecessary crisis and develop safe space through knowing the person. They highlighted the importance of building close relationships over time and having consistent, authentic connections with service users. This consistency and familiarity was reassuring and induced a sense of calm safety. This finding aligns with other research that found that the creation of safety was highly dependent on the nurse's ability to connect with, and know the service user well (Johansson et al., 2012).

Slade's (2012) second principle of reducing the loss of personal responsibility was illustrated in the current study where the nurses guided individuals in applying self-management and coping skills to help regain a sense of safety and control. Slade suggested that service users and nurses need to be equipped with the skills to identify early warning signs, whilst sensitively and collaboratively working on these early markers in a recovery-focused way. This involves being honest when communicating with service users, and knowing how to balance safety with autonomy (Johansson et al., 2013). It also requires highlighting the service users' rights without being overly vigilant and "creating more anxiety" (Slade, 2012, p. 184). Nurses need to acknowledge that certain feelings (such as hurt and anger) are normal, healthy reactions to events, and are part of life's rich tapestry (Johansson et al., 2012). It is important to highlight that these reactions and feelings are not always an indicator of relapse. If these feelings are expressed in the context of a safe space then learning related to self-regulation can occur, and the crisis can become an opportunity for personal growth (Randal et al., 2009)

In accordance with Slade's (2012) third principle, the nurses in this study showed how they kept on trying to maintain hope with service users in the midst of distress and crisis. They related to the service users that they believed things would get better, that together they would get through it; that there would be a sense of relief. In doing so, they were able to instil the belief that service users have the internal resources in which to manage themselves or their situation, whilst getting the necessary support. Importantly, through maintaining a safe space the nurses did not abandon service users when they had lost all hope. This was vital for the service users, as they had often been let down and felt worthless and stigmatised, and had this reinforced both in the public domain and the services with which they engaged. In addition, the nurses showed this in the current study by using positive language and framing often challenging situations in an optimistic manner. These findings align with Slade's (2012) fourth principle, which supports individuals' identity during and after crisis. Slade reported that hope could be built in the context of relationships, which are safe and where others can role model a hopeful focus on the future.

Creating shared space

Creating shared space through engagement in an ongoing relationship was another key element of recovery-oriented practice within the findings. Many of the nurses recognised how their relationships grew and improved when both they and the service user were committed to working together towards a common goal. Here, nurses met the challenge of shifting from the role of the empowered nurse (in control and with no problems) to the mindset of two individuals both struggling to work out how best to support the service user's recovery (Slade, 2012). To achieve this shared space nurses found it was vital to look beyond labels or diagnosis. The nurses found that rejecting labels or diagnoses reduced power imbalances, and provided a different framework for building the relationship other than the medical or custodial paradigms. This shift created a more connectable, humanistic way of working together, which created a sense of possibility and was more hope inducing.

The nurses revealed how humour played an important role as a conduit for opening up shared space and building commitment. Humour helped by breaking tensions, sometimes in the midst of crises, and by building trust. Sensitive moments could be de-escalated through the judicious use of humour at the right moment. Prior literature has found that the use of humour can be a fundamental component when connecting with service users. Struthers (1999) explored how community psychiatric nurses used humour and also found that the paradoxical nature of using humour in serious situations had an effect on altering service users' narrow perceptions, thus breaking tensions. The

research further highlighted the need for nurses to use humour respectfully and sensitively to avoid it being misconstrued or seen as demeaning by the service user (Struthers, 1999).

Within the nursing world, there is frequent discussion about the importance of having professional boundaries in place to safeguard the service user and the nurse. However, during this study, nurses described how letting go of 'traditional roles and ways of working' helped enable the opening up of relational space to move beyond distress and crisis. Traditionally, this goes against the norms of practice. It complicates decision making, and 'letting go' seems to create anxiety for many professionals for various reasons. It is, of course, important for nurses to be mindful and continue to maintain certain boundaries, which help to safeguard service users and themselves. However, the message that strict boundaries portray is one where the service user's role as being 'less than' or limited in power is reinforced (Slade, 2012). In discussing the findings of their qualitative study into practices that support recovery, Borg and Kristiansen (2004) argued against such strict boundaries. They indicated that being open to letting go of professional boundaries was important for breaking down power, conveying hope, sharing of oneself, being available to service users and openness to diversity (Borg & Kristiansen, 2004). However, the relaxing of boundaries needs careful introduction to a team, with an agreement of shared responsibility between service user and nurse, and amongst the team and service as well.

In the previous finding's chapters, both Māori and non-Māori nurses shared their stories about how significant it was to recognise ways of opening up relational space for Māori service users on the ward. They discussed how they felt that Māori nurses, in particular, have a unique ability to open shared space using different ways of connecting with individuals. Some of the stories that these nurses shared were about having a sense of hospitality, and building connections through welcoming processes and using soothing waiata (song). This was further enhanced through the use of Māori language with Māori service users. Furthermore, nurses talked about creating a whānau (family) environment and sense of belonging with and for service users. It was also highlighted that more time and space was given to developing relationships at a slower pace (Wyder et al., 2017) which allowed for greater depth in the connections made with both the service user and whānau.

Interestingly, nurses spoke about how they had no hesitation in using a hug or touch to convey care in the appropriate circumstances. In addition, using the word *love* and showing humanness over traditional nurse boundaries in their interactions with service users created a space for strengthening their relationships, and gave service users hope

for recovery. A study by McCarthy-Jones and Davidson (2013) revealed that platonic love (or philia as it was termed in that research) played a role in the therapeutic relationship between service users and therapists. This helped to forge a more 'friendship like' relationship and reduced distress associated with voice hearing for service users with psychosis. However, overall, there is surprisingly little mention of love being important to nursing practice within acute mental health settings.

Prior literature again supported the current findings, which reflected how nurses who are skilled at the therapeutic use of self were also shown to be highly skilled at knowing when and how to use language when they spoke to service users (Cleary et al., 2013). In addition, literature further supported these findings by recognising the value of knowing how to pace responses and how to use proximity to individuals, without rushing the service user due to time restraints (Cleary et al., 2018). Furthermore, the literature highlighted that using these person-centred approaches require both core and advanced nursing communication skills to create a trusting space. Overall, this creates a recovery-oriented environment that helps build a positive, committed, collaborative, and relational therapeutic environments for service users (Cleary et al., 2013, Dawson, Lawn, Simson, & Muir-Cochrane, 2016).

The commitment shown by nurses in creating shared relational space showed it was paramount that nurses were able to be flexible and balanced in their approach when working alongside service users. However, many service users have also experienced trauma and loss during their life experience and so, in this final part of the discussion on the centrality of creating therapeutic spaces, there is a need to consider how the nurses supported service users through creating healing spaces.

Creating healing space

The findings of this study indicated it was important for nurses to provide a healing space for service users to process and find meaning in their distress, loss, and trauma. The nurses identified that grief and trauma are shown in various guises, often through the service users' expression of distress and in certain behaviours. Feelings of loss and vulnerability translated into withdrawal and shutting down, but at times into anger and rage towards others. While some direction and safety processes were necessary to maintain a safe environment, the nurses indicated that rather than punishing distressed or aggressive behaviours, it was important to spend time with the service user, calmly validating his or her experiences. This allowed the space for trust and connection to slowly grow, a space where verbal and non-verbal dialogue between nurse and service user facilitated meaning making. In the meaning making, service users were able to make sense of their experiences, which was healing. Recognising that all individuals are

simply trying to get through their grief, loss, and trauma in their own way helped nurses to practice in a recovery-oriented manner.

Prior studies and literature support these findings. After many years of working as a psychiatrist, Kopacz (2014) argued that clinicians must have an absolute belief that service users have the power (with support) to reconnect to their own healing. It is about bringing one's heart and soul into Being-with and working alongside individuals to find hope and meaning in a space that sometimes may seem both meaningless and hopeless (Kopacz, 2014).

The nurses in the present study understood how important it was to instil hope in order to create healing spaces. Their accounts indicated that the experience of loss and trauma left service users with a sense of futility and failure. Such despair reduces purpose and meaning in life, and leaves a sense of emptiness with no positive future. It has been said that healing is the ability "to grow into one's skin and fill the gaps of emptiness within, to grow into oneself becoming whole" (Liggins, 2018, p. 4). Therefore, if nurses hold a positive and hopeful outlook, and are able to build on service-user's strengths and support them to make sense of and cope with their challenges, the possibility of recovery can be glimpsed (Walsh, 2006). Further research (Liggins, 2018) indicates that healing affords an opportunity for deeper connections and that every individual has his or her own way of healing. Healing can also reduce the differentness or 'othering' associated with mental illness that contributes to mental health stigma.

Overall, nurses created healing spaces through helping the service-users make sense of their past experiences, present situation, and future possibilities. This in turn supported a shift towards wholeness and coherence.

During this study I created a poem called '*Gently & Safely*'. The poem explores how I looked inwardly at myself to explain how nurses often create a safe gentle space, with no words needed. To just hold the person, and to allow a healing, safe and collaborative space that can quite often be very distressing and chaotic.

Holding you so gently,

Holding you safely, I won't abandon you, I am here…

Listening quietly, with heart not words,

I see a flicker of recognition in your weary tired eyes

And a small glow begins in those tired sad eyes,

A calming breath, a healing space, amidst the distress and tears that flow
so readily

A bruised heart begins its healing, and a safe space is found amongst the
chaos.

It was important for nurses to know how to create this space in the context of numerous challenges and barriers present within the health system. The findings highlighted how nurses minimise their role in creating space for recovery-oriented practice; they often said 'it's just what we do'. This taken-for-grantedness that nurses experience working in mental health was significant in that being or creating space to work in a recovery-oriented way was not consciously or deliberately thought about during the nurses' daily interactions with service users. The concept of daily routine, supporting daily living, and the practicalities of dealing with admission and discharges at times overtook the consciousness of how these nurses actually practiced recovery-oriented care on the ward. These findings are further supported by Patricia Benner's (1994) research in which she discussed how nurses will relate stories and experiences of care in ways which they have not consciously thought about. A skilled nurse tends not to be aware of how they create a space or use their skills or taken-for-granted practices that they carry out daily. Yet it takes knowledge and self-reflection and often requires this taken-for-granted practical know-how and understanding to support others in their recovery.

Barriers to Recovery-Oriented Practice and Deficient Modes of Care

Within the findings chapters, nurses talked about collaboration and self-reflection as an important part of their practice, for both themselves and the service user. Nurses found themselves questioning whether they actually worked collaboratively, or if they were actually doing 'to' or 'for' service-users, for reasons such as time limitations. Cleary et

al.'s (2017) systematic narrative review supported this finding by noting similarly that acute nurses were left with insufficient time to deliver collaborative, person-centred care with service-users. In addition, nurses revealed how they experienced significant struggles trying to create a safe and healing space when either observing or being part of a team where coercive practices towards service users were evident. They also identified and talked frankly about how internal team and external system barriers affected them as nurses, and hindered them in being able to create the space for a positive recovery environment in which to work with service users.

The findings showed significant service barriers that challenged nurses being able to work well with service users in recovery-oriented practice. The nurses told stories about their experiences of fatigue and frustration caused by the emphasis on mental health services eliminating seclusion practices, the increasing challenges of changes to service-user presentations, larger caseloads and having to manage delayed discharges. Overall, they spoke of the stress associated with trying to meet demanding expectations, seemingly without being resourced adequately. These findings have a familiar ring to them. Literature on these types of complexities within mental health nursing has revealed that under-resourcing is a familiar theme within mental health service delivery. The Australian Medical Association's (AMA, 2018) report aligned with the current findings and highlighted how mental health services are grossly underfunded when compared to physical health services. The under-resourcing of mental health services often restricts the most vulnerable from overcoming health challenges. This includes poor access to acute beds, and delayed discharges, which prove to be key barriers to service user recovery pathways.

Further published research has highlighted how the lack of resources, lack of bed availability, and early discharges without planning do not support service-users' recovery (Happell et al., 2009; Ministry of Health, 2018). Within the current study the nurses spoke about how they found themselves continuously trying to cope with additional tasks whilst attempting to lower seclusion rates. Furthermore, these nurses commented on how the additional pressures to meet government directives (reducing and ultimately achieving a zero-seclusion status) had not been supported by additional resources needed (such extra staffing) to implement and succeed with this vision. This led to frustration and closed down the space for nurses to spend time with service users. Indeed, the findings showed that part of the nursing role and organisational focus involved the continued expectation for nurses to apply force, restraint, and use seclusion for service users against their will. The challenges for nurses regarding balancing the risk versus service-users' therapeutic and recovery-focused needs have been highlighted and acknowledged as problematic for nurses and for service users. However, Maden (2007)

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argued in his research that nurses and other health professionals need to be mindful and somewhat cautious around risk management, and not to be too zealous regarding the rights of the service user to refuse treatment, as he argued that this can create more of a risk for others to be protected on the ward. Ultimately, however, there is overwhelming evidence shown that nurses and other professionals being overly custodial towards service users creates barriers to recovery. Building trusting relationships with service users is supported by the array of literature on reducing risk (Maden, 2007; Manual & Crowe, 2014).

The second element of the findings highlighted these challenges as deficient modes of care (Heidegger, 1927/1962). The nurses identified how service systems created significant barriers for them to be able to create space for working in recovery-oriented ways with service users. Effectively these findings show that there are continuing tensions around legal and procedural expectations. These tensions showed that intimidation and coercion towards service users (whilst under the Mental Health Act) unfortunately is still ongoing in practice. Nurses relayed stories about how they personally dealt with coercive practice on the ward and about the ways in which they attempted to manage these issues. Some spoke about how they eventually 'found their voice' to challenge such practice and actively showed this by speaking out against coercion.

The nurses had to navigate the power dynamics at play between themselves and medical colleagues when they voiced their concerns regarding service users being subjected to coercive practices, when they advocated for a service user, or challenged the psychiatrist's opinion on treatment modalities. This involved having to learn new ways of communicating, being aware and reflective of the team power dynamics, and even changing how they talked, by using a more academic style of language with medical staff, just to be listened to. They sought the right words to seek respect and validation in these interactions. They also seemed to want to find a way out of being stuck in a traditional stereotype of the nursing role, or to 'do as you're told' and 'know your place' as is found within the traditional power structures and hierarchy on acute wards.

Nurses found that, despite the system barriers, they constantly endeavoured to create choice for service users whilst working within somewhat inflexible and rigid systems. Nurses created a space to manage these tensions by being creative, using their skills to keep service users away from unnecessary tensions caused by inflexible rules or rigid-thinking nurses. No matter how hard the rules were, some nurses went 'the extra mile', showing their own vulnerabilities when engaging with service users, in order to give back some choice and empowerment to service users.

These findings are supported by phenomenological literature. Indeed, Heidegger (1927/1962), when discussing the notions of care and solicitude, suggested that it is important that individuals are open to their own vulnerability, in order to be able to hear the call to care for others. Should nurses try to hold all the power, or become hardened in their hearts, they shut themselves off from their human vulnerabilities and, in doing so, may find it difficult to hear the call to care.

Building Recovery-Oriented Services: Shifting the Culture and Team Practices

One of the significant findings in this study was that by creating space for Being-with service users in a recovery-oriented manner, a cultural shift was emerging and changes in focus at a team level was occurring. This varied from making relational space during assessment, by shifting the focus and priority on risk, to just 'Being-with' by building a more positive environment and focusing on the relationship rather than clinical processes, such as needing to complete a full mental health assessment. This change in practice showed that if nurses begin with a gentle humane approach with service users, they are building solid foundations for an ongoing relationship with the individual. Further, they are more likely to create a space that enables service users to gain trust and for nurses to get to know the person better in the process and build the relationship. This would, of course, enable the nurse to eventually gain what he or she wanted initially to know within the assessment in the long term.

Many of the nurses in the current study spoke about how they built recovery and changes in their practice by using a more collaborative and empowering approach, providing choice and autonomy whilst working alongside service users. It was found that involving the service users and their whānau created a positive change, a space for belonging, and this affected nurses by enabling them to be more reflective and inclusive in their practice. Creating a hopeful, collaborative, and inclusive space means opening up a space that moves away from using power and autocratic styles of nursing, and supporting service users and their whānau and enabling self-management strategies by sharing and connecting through collaboration and providing education. It was found that by nurses encouraging service users to look at their own self-management enabled service users to feel a sense of purpose, autonomy, and control in their own lives and helped them in their recovery pathway.

The literature supports these findings. Reid et al. (2018) found that nurses played a pivotal role as collaborators, assisting service users to reframe their challenges into

strengths and find ways together to achieve their goals. However, although the service user participants in this Australian study identified nurses as their allies, they were very astute at being able to tell when nurses were not being genuine in their interactions, and this significantly affected the collaborative relationship and their recovery. It was suggested that, due to the perceived busyness of nurses' roles, many interactions were short and focused on giving information or treatment. One recommendation from Reid et al. suggested that, to increase meaningful connections, setting time aside is paramount. However, applying this in practice can prove problematic. Within the associated literature, it has been shown that, in reality, nurses working in acute mental health services frequently find it difficult to apply the recovery concepts of collaboration and autonomy into their practice (Cutliffe & Happell, 2009; McKenna et al., 2014; Reid et al., 2018).

Another finding in the present study suggested that nurses are recognising and supporting recovery practice simply by creating a positive change through talking more about 'recovery' per se. However, one participant questioned whether nurses knew how to recognise recovery, and whether they are able to see the service-users' perspective and support individuals who are often acutely unwell. This is where the service users would possibly need nurses to support them to improve their knowledge and, importantly, be able to 'hold' service-users' hope for them and recognise their strengths at a time when they are unable to do so themselves. If nurses are able to do this, the space for growth and promotion of recovery-oriented practice will flourish.

Research supports these findings. It reiterates that unwellness and the recovery pathway is indeed a personal experience, and has meaning to each individual. Being able to see and relate to the service-user's viewpoint can shift a nurse's perspective, which in turn can lead to better empathy and further open the relational space. As the nurse's outlook on these phenomena changes, it provides a catalyst for positive (recovery-oriented) behaviour changes. Therefore, as nurses incorporate their experiences and interpretation into their world, their clinical role is enhanced (Landgren & Hallstrom, 2011).

Another significant finding of this study showed the fundamental importance of good teamwork, and of using assertiveness as a nurse to ensure that traditional hierarchal cultures in acute wards are reduced. This creates, once more, a safe space for nurses to challenge decisions within their workplace cultures and improve recovery practices within the unit. This helps shape better team cultures, and enables a change in thinking by nurses and a change in workplace cultures; thus, promoting more recovery-focused services. Further important findings here included nurses seeing value in breaking down

barriers with service users, and in starting to push boundaries where appropriate. This means being passionately involved, and being comfortable enough with showing their own vulnerability at times. Doing so provides a space for change when working alongside service users. Vulnerability is to be recognised as a positive, not a negative change in practice (which it is traditionally assumed to be within the nursing world) as it creates more authentic relational spaces in which to work. It shows how 'care-full' and recovery-oriented nurses can be, and how they can become more hopeful in their shared humanness with service users.

Implications for Research

In New Zealand, mental health nurses have struggled to be heard or create a space or a 'voice' to raise the concept of recovery within inpatient units. Furthermore, this aspect of practice has not been well researched in relation to the unique bi-cultural context of Aotearoa New Zealand. By revealing their stories of both positive and negative aspects of practice within this study, the nurses have provided useful insights into what recovery-oriented practice means to them, and have shared their personal experiences of using recovery-oriented skills in practice. However, there is still an urgent need to better understand and integrate Māori perspectives into guidelines for recovery-oriented practice. Further research into culturally relevant responses within acute mental health services could add depth to the insights gleaned in this study. The involvement of Māori researchers would add a safer context for relevant experiences and ideas to be shared and explored. Future research could also build on the insights from this study to explore how to translate some of the notions related to creating different types of spaces into training and practice. The inclusion of action research and co-design methods, where nurses and service users plan how best to work together towards recovery-oriented practices would be a useful way to progress this work.

Implications for Practice

This study took place in an acute inpatient mental health setting; therefore, the findings have significance for nurses working in similar settings. They have implications for how nurses learn to manage new ways of working alongside service users, and for integrating recovery-oriented practice within the reality and challenges of clinical practice.

The importance of building safe and healing relationships with service users was highlighted in the findings. In addition, the findings indicated how worthwhile it is for nurses to let go, to a certain extent, of the traditional boundaries that may create barriers

to building recovery, and work more creatively within a nursing capacity on the ward. This 'letting go' of traditional and often coercive cultures is not only restricted to working alongside service users, but also with colleagues. The opportunity to move away from coercive and traditional ways of working brings with it an opening up of space to connect with each other, speak out, and heal team cultures when they are not working well. This has implications for nurses to formally and openly discuss, and progress how to create therapeutic space effectively in recovery-oriented practice. It also affords an opportunity for training on these matters to be threaded through mental health services. However, it must be noted that, within the working environment of busy acute ward settings, a shift in thinking, including attitudinal change, may be required of nurses and the entire health care team in order to realise this vision.

For recovery-oriented care to take a more effective place within acute units the co-development of plans and strategies between nurses, service users and peer workers is required. This will necessitate perhaps a different kind of nursing practice altogether. Indeed, if nursing is to fully embrace and shift towards a paradigm with recovery-oriented practice at its 'heart', then it raises questions such as should nurses administer medication where service users are against having them, or continue to use restraint or coercive practices? These questions need considerable reflection, which may require those leading mental health services to think about the current dominance of traditional psychiatry, which may contradict the values of mental health nurses and their profession (Barker & Buchanan-Baker, 2011).

Māori nurses are under-represented in mental health services, despite the evidence that Māori access services to a significant degree. The Ministry of Health (2012) reported and evidenced that Māori made up 12% of the total New Zealand adult population (20-64 years) in 2013. The study, however, also showed a significant disparity between the proportions of the clinical workforce identifying as Māori making up only 13%. Despite the challenges of under resourcing, the current study showed how Māori nurses' contributions to recovery-oriented practice have been positive, and their ways of deeply threading connection and love within their work was indeed inspiring. Supporting Māori nurses to feel able to continue the way they practice must be allowed, and not dismissed due to western notions regarding professional boundaries. Furthermore, more Māori should be encouraged to enter nurse training, to increase recruitment and retention, and services to recognise the need to grow and develop a full Māori workforce (Ministry of Health, 2018). The space of safety and cultural support that these nurses provide for those who use the services the most should be considered paramount. This ensures that Māori service users are given choice, and are more likely to feel they are accepted, that they belong, and are safe within mental health acute units throughout New Zealand.

Importantly, if nurses are to be supported to practice in a recovery-focused and person-centred way, then the environment in which they work needs to welcome difference and be 'morally habitable' (Wyder et al., 2017). Enabling systems are paramount to facilitate those morally robust work practices, which allow mental health nurses to feel able to champion recovery principles, and deliver truly recovery-focused practice without experiencing burnout and exhaustion.

The findings also highlight areas for improvement. The participants discussed the practical realities and system barriers to recovery-oriented practice at length. If nurses are to support individuals by providing recovery-oriented practice, the resources necessary to achieve this goal must be provided. There is a need for increased staffing levels to support the ever-increasing and changing presentation of people being admitted. It would be highly recommended that more nurses are made available for spending time 'on the floor' Being-with and creating therapeutic space alongside distressed service users.

Implications for Education

The nurses in this study recognised the difference between good and bad recovery practices. They could tell me their stories about their experiences of how they tried to create better recovery-oriented practice. However, at times, nurses struggled to identify aspects of how best to embed recovery within practice. A suggestion for furthering education opportunities identified a need for more education for nurses around what recovery is, and how to recognise and apply it within acute areas of mental health practice.

Surprisingly, it also transpired that only a minority of the nurses' who agreed to take part in this study had any formal recovery training. To date this service and organisation still has no formal recovery training available for staff to access. This situation could be rectified by ensuring that nurses have the opportunity to attend formal, structured training that is specifically focused on recovery-oriented practice. Indeed, the possibility of a post-graduate education programme for nurses in recovery-oriented practice could be an opportunity for nurses to enhance their knowledge, share their experiences of what works and what does not work for them and for service users. Encouraging open dialogue between nurses in this type of situation would enable role modelling to novice nurses and colleagues, and create a formal space in which to strategise effectively on how to manage working in a recovery-oriented manner even when challenging situations occur on the ward.

My Own Reflections

As I approach the end of this study, I have been able to reflect on the insights and understandings that have been revealed. I feel humbled by the passion that acute inpatient nurses have shown throughout this study. I also feel privileged to be part of the sharing of the nurses' time, voices, and genuine honesty as expressed in their stories. These nurses showed how important they felt recovery-oriented practice is, and showed the true essence of who they are in their outstanding tenacity and passion for working so hard to work in recovery ways, often when presented with very difficult spaces and cultures in which to work. Within our conversations, it struck me how our understandings were parallel, how we shared a commonality as nurses 'being-in' this world together. This has left me feeling both hopeful for nursing, and for service-user recovery. It was also inspiring to witness how nurses value the sharing of their stories, which resonated through our shared experiences of being a nurse. The passion that led me to begin this study is the same passion that I have witnessed in these dedicated nurses' stories at the end.

Strengths and Limitations of the Study

One of the strengths of this study is in the nurses' insights into the experience and meaning of recovery-oriented practices within an acute mental health service. The stories and use of a phenomenological lens provide a rich exploration of their experiences. Some may view the limited number of nurses involved in the study as a limitation, which might compromise the generalisability of the findings. However, the number of participants is in keeping with other phenomenological studies, where the focus is on the depth and richness of data, and on the ability to transfer insights rather than achieve statistical generalisability. Furthermore, it may be argued that using one single acute mental health unit may not effectively translate to other different inpatient settings across New Zealand. The counter argument to this is that the description and exploration of contextual factors affecting the participants practice within the inpatient unit should allow comparison of the context and dynamics within other services. It should also be recognised that the interpretation of the narratives will have been affected by my own pre-suppositions, or how I have experienced recovery-oriented practice within my own work as a nurse. Nonetheless, the insights and stories that these nurses shared open up a space for readers to be able to experience thought-provoking reflections. Readers will need to determine the extent to which they can relate to the findings and transfer the experiences and insights into their own context.

Conclusion

Recovery-oriented practice has been extensively discussed over the past few decades. However, this study indicates there remains much ambiguity around the subject and how to apply recovery in practice. This study demonstrates that nurses working in acute mental health services face challenges and tensions, inclusive of trying to make the space to offer recovery-focused care, whilst balancing the contextual structures and systems in which they work on a daily basis.

Despite the fact that none of the 10 nurses had been able to access any formal training about recovery, or recovery-oriented practice, the majority of the nurses recognised the importance of creating a safe space, being hopeful and positive, being mindful of language and pace, and recognising service users as unique and central to their own recovery. Nurses also found that by speaking up against coercive and labelling practices and continuing to keep talking about recovery, upheld recovery principles in the workplace. Similarly, challenging aspects of the health system and processes was found to be essential in being able to progress recovery-oriented ways of working. As such, this study highlights how fundamental recovery-focused care is in supporting service users to achieve their own pathways to recovery and a fulfilling life beyond the inpatient unit.

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Appendices

Appendix A: Participant Information Sheet

Participant Information Sheet

AUT
U N I V E R S I T Y
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

13th March, 2015

Project Title

> The experiences and meaning of recovery-orientated practice for nurses working in acute mental health services: A hermeneutic phenomenological study.

An Invitation

Dear colleague,

My name is Berni Solomon and I am currently studying towards gaining a Doctor of Health Science qualification at Auckland University of Technology. I would like to thank you for expressing a willingness to participate in this study, which explores the experience and meaning of working in a recovery-orientated manner with clients who experience mental health issues. Participation is entirely voluntary and participants are free to withdraw at any point prior to the completion of data collection without any predjudice with regard to any other transactions with the researcher now or in the future.

What is the purpose of this research?

The purpose of this research is to gain insights into how registered nurses experience and make sense of their working relationships with clients and how they implement recovery-oriented practice.

This is significant in that it involves nurses who work in what is considered one of the most challenging areas of psychiatry, that is, acute mental health inpatient units. There is little research around the 'lived experience' of nurses that work in these settings, and it will prove useful to explore the true meaning of each participants experience in relation to supporting their clients' recovery journeys. This exploration of the meaning of practice experiences will add to an understanding of the relationships that form between staff and clients how it impacts clients' outcomes. This may prove helpful in informing future service provisions and generate knowledge to inform best practice. It will enable mental health nurses to consider the relationship between personal attitudes regarding recovery concepts and the quality of therapeutic relationships developed with clients experiencing mental illness. This will provide much needed understanding that can guide the development of recovery-orientated practice within inpatient settings and in turn benefit both professionals and clients. The findings will be presented through a completed doctoral thesis, a one page accessible summary, conference paper presentations and academic journal articles.

How was I identified and why am I being invited to participate in this research?

Participation in this study is voluntary and you are invited to share your practice experiences if you meet the criteria of a) being a NZ registered nurse, b) currently working in acute inpatient mental health services c) working directly with clients in delivery of services d) having at least one year of practice experience post registration e) conversant in the English language.

This version was last edited on 8 November 2013

What will happen in this research?

The research will involve the participants' participation in a face to face interview with the researcher for approximately one hour and a half, with a possible follow –up interview (of approximately half an hour) should any clarification be needed. The participants' practice stories will play a large part in the research as experiences and meanings that are shared will form the study data. A digital recording device will be used to record each interview, which will be transcribed professionally. Participants will have an opportunity to check their transcribed interview for accuracy. The data will then be analysed and themes identified.

What are the discomforts and risks?

There may be a minimal level of discomfort due to the depth of inquiry about the participants' feelings towards their specialist area of work.

How will these discomforts and risks be alleviated?

Should a participant experience any concerns, the researcher will support the participant, and have the resources available to refer to EAP counselling should this be necessary. The participant will have no costs to pay for this service.

What are the benefits?

This study will provide much needed insight and understanding of each participant's 'lived experience'. It offers nurses an opportunity to discuss their thoughts and feeling about their work, including barriers and facilitators to supporting clients in their recovery. It will provide the service and the wider mental health sector with insights about barriers or facilitators that may inform the implementation of positive nursing practices.

There is the potential benefit for mental health inpatient and community service developments regarding knowledge advancement when working with clients, raising standards in nursing recovery-orientated practice and potentially improving the experience and outcomes for clients. There is the added potential to raise each participant's contribution regarding research active practice that may enhance career opportunities.

The potential benefits for the researcher include: gaining and developing a deeper understanding of the demands and pressures experienced by front line staff in acute settings and a greater ability to support clinical staff as they seek to use recovery-focused approaches, gaining a Doctorate qualification, increasing networking potential and personal career advancement opportunities.

How will my privacy be protected?

Interviews will be held in a room away from the direct inpatient setting, to support participant privacy. The researcher will keep all raw data in a secure place and change identifying features in the published findings. The final report will use pseudonyms to protect participant identity. The researcher will take all measures to preserve confidentiality, however given the limited numbers of potential participants in this area and the potential for participants to talk about their involvement with each other, total confidentiality cannot be guaranteed. The researcher will use the data collected solely for its purpose within this research project.

What are the costs of participating in this research?

There is no financial cost, but participants will need to allow one and a half hours for the face to face interview, with a possible follow up interview of no more than half an hour.

What opportunity do I have to consider this invitation?

Once the researcher has fully discussed the study with potential participants, they will have a period of one week to decide if they would like to participate in the study.

How do I agree to participate in this research?

An information sheet and consent form will be offered and if the participant agrees to take part in the research they will sign and date the consent form accordingly.

Will I receive feedback on the results of this research?

A one page summary of the written research findings will be disseminated to each participant. In addition the researcher will give verbal feedback, with an offer to discuss further if needed.

This version was last edited on 8 November 2013

Appendix A: Participant Information Sheet

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Daniel Sutton, Faculty of Health and Environmental Sciences, dsutton@aut.ac.nz 921 9999

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Bernadette Solomon, Clinical Nurse Educator, Lakes District Health Board. Rotorua

bernisolomon@lakesdhb.govt.nz

(07) 349 7971

Project Supervisor Contact Details:

Dr Daniel Sutton, Faculty of Health and Environmental Sciences, dsutton@aut.ac.nz 09 921 9999 x 7732

Approved by the Auckland University of Technology Ethics Committee on 13th March, 2015 *was granted*, AUTEC Reference number 15/66

This version was last edited on 8 November 2013

Appendix B: Consent Form

Consent Form

Project title: **The experiences and meaning of recovery-orientated practice for nurses working in acute mental health services: A hermeneutic phenomenological study.**

Project Supervisor: Dr Daniel Sutton

Researcher: Bernadette Solomon

 Please read the following conditions of consent and tick the appropriate circles

○   I have read and understood the information provided about this research project in the Information Sheet dated 13/03.2015

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a copy of the report from the research (please tick one): Yes○   No○

Participant's signature: ....…

Participant's name: ....………

Participant's Contact Details (if appropriate):

………
....
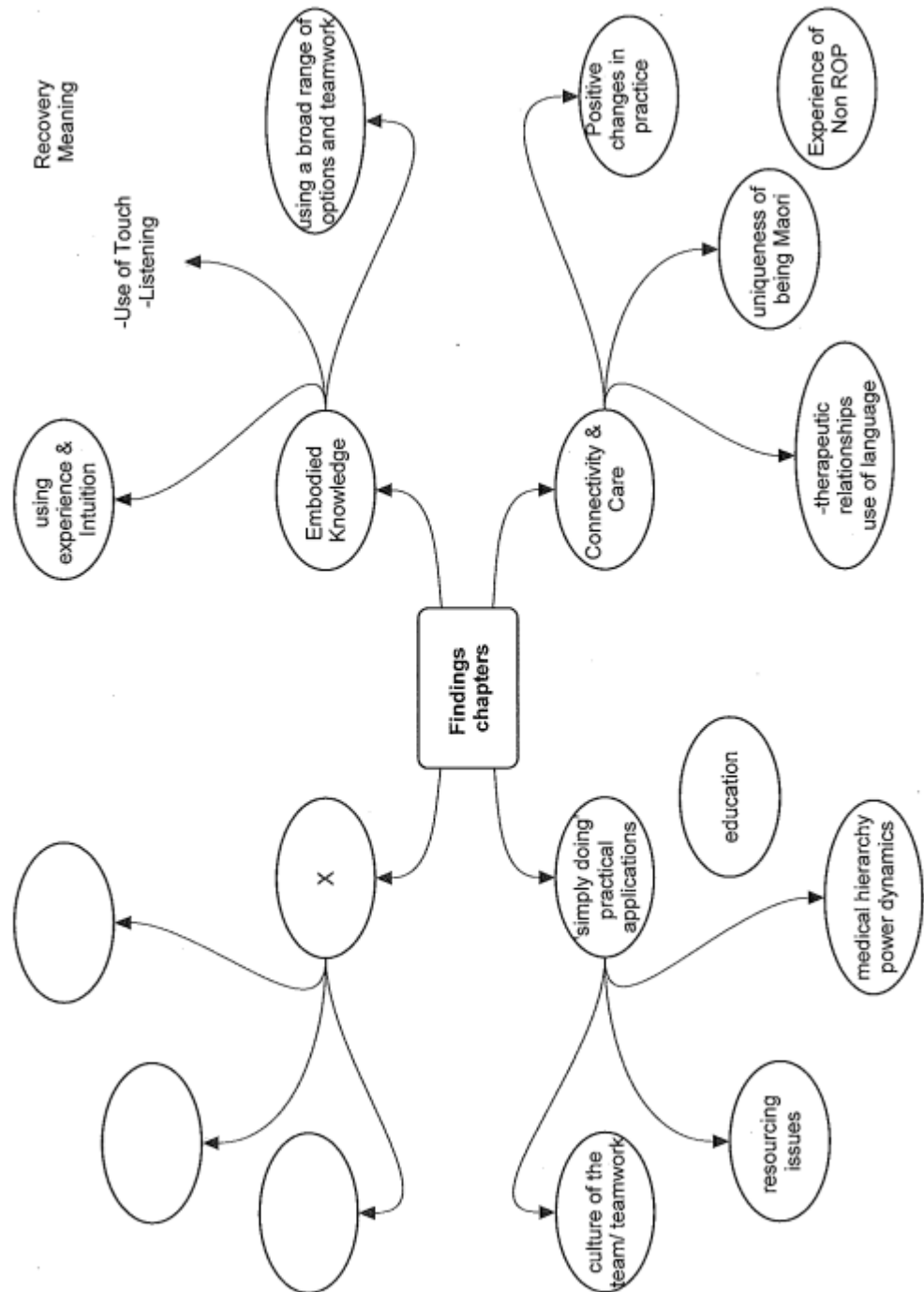…………………………………………………………………..

Date:

***Approved by the Auckland University of Technology Ethics Committee on** 13th **March, 2015** **AUTEC Reference number** 15/66*

Note: The Participant should retain a copy of this form.

Appendix C: Mind Map

Recovery
Meaning

using a broad range of
options and teamwork

Positive
changes in
practice

Experience of
Non ROP

-Use of Touch
-Listening

uniqueness of
being Maori

using
experience &
Intuition

Embodied
Knowledge

Connectivity &
Care

-therapeutic
relationships
use of language

**Findings
chapters**

X

simply doing
practical
applications

education

medical hierarchy
power dynamics

culture of the
team/ teamwork

resourcing
issues

Appendix D: AUTEC Approval

AUT UNIVERSITY | **AUTEC SECRETARIAT**

19 March 2015

Daniel Sutton
Faculty of Health and Environmental Sciences

Dear Daniel

Re Ethics Application: 15/66 The experiences and meaning of recovery-orientated practice for nurses working in acute mental health services: A hermeneutic phenomenological study.

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) subcommittee.

Your ethics application has been approved for three years until 19 March 2018.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 19 March 2018;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 19 March 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Bernadette Solomon berni.solomon@lakesdhb.govt.nz

Auckland University of Technology Ethics Committee
WA505F Level 5 WA Building City Campus
Private Bag 92006 Auckland 1142   Ph: +64-9-921-9999 ext 8316 email ethics@aut.ac.nz

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Appendix E: Research Poster

Appendix F: Data Analysis Table – Listening

Participant	Key notion/experience	(possible) meaning/significance in relation to supporting recovery	Hermeneutics/ Philosophical ideas:
Participant 3	Reflecting on the importance of being present, using listening to connect and build trust and support safety.	• Here the participant nurse finds the essence in her connection with the individual (service-user), by being reflective and skilful in her interpersonal and communication / language. • Listening is an important part for her connectivity with the individual; it's a 'thread' of non-verbal relationship building, which engages her in the nurse role (as a psychiatric trained nurse). It holds (possible) significance to her internal understanding a **pride** in herself and the part that she plays in walking alongside the individual service user in their recovery journey. • By listening intently, she is 'holding' the client in a **respectful** manner (why should you trust me?). She is creating a safe space, which will hopefully allow the client to **feel trust, support**, **non-judgment** and a sense of **comfort and hope**.	**van Manen** (1997). The concept of 'ontological silence' the silence of Being or Life itself. Here the nurse meets the realisation (after a meaningful interaction with the service- user) of a moment of greatness and of a fulfilling insight. "Being in the presence of truth" (p. 114, in Researching lived experience). **van Manen** (1997) Lived other (relationality) is the lived relation we maintain with others in the interpersonal space that we share with them (p. 104). **Heidegger** (1927/1962). The concept of Dasein (Being-with, in-the-world). Being and Time.

		• **Breaking down power issues**	
Participant 4	Acknowledging that power is used in relationships. Recognising that on reflection that it's important to recognise the SU as the 'expert' in ROP	• Here the participant is using **self-awareness** to recognise her part in being powerful over the service user. She becomes aware that her relationship with the SU is at jeopardy due to her 'pushing' him in a direction which she feels (at that time) would be the safest and best option. • She reflects that she needs to **listen**, and acknowledges that she needs to allow the SU time and a space to verbalise his own method of **healing**. She finds meaning in this by connecting and effectively empathising 'being in his shoes'. By listening she is **supporting respect, trust, autonomy and providing validation.** • She has found personal meaning that it's not necessary to be the 'expert' at all times. That her concept of recovery has 'shifted' positively due to this deep learning experience. • Breaking down **power inequalities**.	**Heidegger (1971)** On the way to language (p, 94) 'the being of language, the language of being'. **van Manen** (1997). The concept of 'ontological silence' the silence of Being or Life itself. Here the nurse meets the realisation (after a meaningful interaction with the service- user) of a moment of greatness and of a fulfilling insight. "Being in the presence of truth" (p. 114, in Researching lived experience). **van Manen** (1997) Lived other (relationality) is the lived relation we maintain with others in the interpersonal space that we share with them (p. 104).

| Participant 6 | Using self-disclosure and self-awareness / listening as a tool for engagement. | • The language and listening skills that are in this narrative may hold significance for the nurse participant by her self-awareness of the role that she plays in supporting the SU's recovery journey. This may support a sense of pride and reward in her role as a psychiatric nurse, and reinforce and motivate her to continue working in an acute ward setting. This positivity will encourage service users to feel a sense of hope and comfort in this type of culture.
• The participant talks about her own mental health difficulties, and how this connects her in a deeper way to each service user. She feels a deep understanding (whilst recognising that each person is individual in their journey) due to her own experiences. She emanates a sense of hope and inspiration for each service user. (Look at me; I was there just like you. It can happen to anyone, mental health issues do not discriminate). | **van Manen** (1997). The concept of 'ontological silence' the silence of Being or Life itself. Here the nurse meets the realisation (after a meaningful interaction with the service- user).
 of a moment of greatness and of a fulfilling insight. "Being in the presence of truth" (p. 114, in Researching lived experience).

Heidegger (1927/1962) 'Being-with' In Being and Time.

Self – Disclosure literature. |

		• By self-disclosing she is also breaking down power inequalities. Sharing her journey not only helps service users to have hope and feel that they are not being judged negatively, but also may have impact on (some) negative staff attitudes towards mental health within the service.	
Participant 7	Awareness of 'timing' listening, space and environment to support service user's journey.	• This narrative emphasises the concept of offering **'choice'** for the service user. This supports service user's journeys re: supporting their autonomy, building their sense of **value** and **self-worth** and respect, and **addressing power inequalities**. • Gives the meaning of **hope** (for the nurse and the SU) that there is hope for improving practice (as in using the nurse's skills and experience). Also highlights "being-in" and "Being-with" SU's in positive interpersonal / recovery relationships. • Listening is a communication skill that holds the thread of connectivity with each individual service user. This	**van Manen** (1997). The concept of 'ontological silence' the silence of Being or Life itself. Here the nurse meets the realisation (after a meaningful interaction with the service- user). of a moment of greatness and of a fulfilling insight. "Being in the presence of truth". (page 114, in Researching lived experience. **Heidegger** (1927/1962) 'Being-with' In Being and Time. **Heidegger** (1982) On the way to language.

		engages the nurse in a deep relationship of trust and may be significant for the nurse in her sense of value and usefulness (in this privileged role as a mental health nurse and support person) as an important person who supports SU's sense of gaining **personal meaning and self-determination in their recovery.**	

Appendix G: Data Analysis Table – Uniqueness of Being-with in culture (Māori nurses connecting)

Participant	Key notion/experience	(possible) meaning/ significance in relation to supporting recovery	Hermeneutics/ Philosophical ideas
Participant 6	1. This is a reflection about how the nurse finds connection and meaning through her cultural connectivity. How using Te Reo creates security and comfort. The use of Te Reo that connects both the nurse and service user to each other in a special sacred place. Language that both of them share that allows the nurse to experience a knowledge or insight into how the SU may connect and develop rapport on a deeper level. The participant is relating that she finds meaning in her interpersonal relationship by a common thread of culture and background. She is experiencing a strong connect by using her language in such a way that shows her deep connection towards the SU in the relationship in that moment.	• Supporting identity, and empowering. The participant is being responsive re: language. • The participant also expresses here how she strives to connect fully with the SU's. However, one must have the connection and ability to be able to 'know people' she experiences a sense of safety and pride when she is able to use her own skills as a nurse (connector) in supporting the person throughout the shift: reducing power imbalances, building therapeutic relationships. • Gives hope (for the nurse and SU). May have significance for improving and having an impact of practice. • Role modelling. Her communication style and use of Te Reo may encourage other nurses to reflect and improve their practice or use of appropriate Te Reo to support Maori service users. Helps SU's to feel less vulnerable, a sense of security and belonging.	• An example of Lived other, (Relationality) van manen (1997). It describes here how the participant has developed a conversational relation in an interpersonal space that she shares with them. The social sense of purpose in life, the communal (with the SU and the ward). • The participant's cultural connection is an important aspect of this narrative; as the participant (nurse) is engaged with the SU in a dialogue with the 'things of her world' which allows her to see things in a way which we could not possibly share (van der Berg, 1953, p, 5). • Lived time (temporality) this is when the participant wants to 'know a person' they ask the SU about their personal life history (including reading clinical notes) – to ask where they are, and their hopes for

	2. The thing about **"LOVE".** This narrative reflects on the use of the word "love" and how in this scenario it has a positive impact for both the service user and the nurse.		the future. van Manen (1997) stated that 'the temporal dimensions of past, present and future constitute the horizons of a person's temporal landscape'. • Lived relation to the other (van Manen, 1997). This gives the sense that this relation is highly personal and charged with interpersonal significance. The symbolic 'child' (SU) experiences a sense of support and **security** which allows the SU to move forward towards independence (recovery). • **Dreyfus. H. L.** (1996).Being and Power: Heidegger and Foucault. • **Giles, D, Smythe, E., & Spence, D.** (2012) Exploring relationships in education: A phenomenology inquiry. *Australian Journal of Adult Learning,52*(2). • **Heidegger**, M. (1927/1962) Being-with. Being and Time.
Participant 8	(connecting through culture, spirituality and song) The participant is connecting with the service user through a shared	• Supporting identity, 'holding' the persons sense of identity and security.	• The participants cultural connection is an important element of this narrative, the nurse is engaged with the

	'thread' of cultural connection. The participant is able to build on the therapeutic relationship through the common link of Maori language which includes in particular the Waita (song in Te Reo)	• Connection. Using respectful recovery language (Te Reo) Supporting the client by empowering. Showing responsiveness to language. • Reducing power imbalances. Building trust in the relationship. Language and song. • Gives hope (for the nurse and SU). May have significance for improving and having an impact of practice.	service user in a dialogue with the 'things of her world' this allows her (in a Maori world view) to see things in a way we (non-Maori) could not possible share. (**van de Berg,** 1953, p. 5) • **Lived relation to the .other (van Manen, 1997).** Give the sense that this relationship is highly personal and charged with interpersonal significance. The service user experiences and sense of security which allows the SU to continue towards recovery • **Heidegger (1927/1962)** the concept of Dasein existential (being with) Being and Time. • Lived body (van Manen, 1997) A sense of identity and belonging.

Appendix H: Findings Map

Discussion Chapter

Chapter 4

Recovery Meanings:

A nursing perspective

1. Collaborative engagement
2. Knowing the person (Maori and pace/crisis)
3. Looking beyond labels
4. Strength based focus
5. Finding personal meaning (unique, find their own pace)
6. Hope – not abandoning

Chapter 6: The space to work in ROP within health systems

1. Deficient modes of care: identifying the impact of non-ROP (power/coercion/ internal/external influences)
2. Service system barriers to ROP (notion: Thrownness)

Sub-theme A: Increasing demands and lack of resources (pressure/gov/ Zero S initiatives: but not enough resources)

NEW: synthetic substances – pressure on beds (no extra resources given)

ID: blocking beds. Casual staff raised caseloads. Monetary gain more important focus over care.

Sub-theme B: Tensions of legal & procedural expectations: MHA coercion MEDS, nurse has to change to match academia approach 'Do as you're told'

3. **Building Recovery :**

Steps that need to be taken to facilitate ROP.

Sub-theme A: Shifting focus from clinical assessment to managing risk (by using power and coercion) to providing positive experiences.

Sub-theme B: The need to recognize and support ROP (more ROP talk now/ need training etc.....

Sub-theme C: The need for teamwork 'speaking out and reflection (challenging ideas, being assertive – helps shape attitudes.

Sub-theme D: The need to promote SU choice & control within rigid systems

MHA now more focused towards SU's and less restrictive. Structure is also good! Be flexible within the policies and rules "go the extra mile"

Chapter 5

Finding safe/relational space

1. **Creating safe space to manage distress and crisis**

Sub theme: creating safe space for Maori

2. **Opening shared commitment**

ST's: Humour & Play

Maori ways of opening up relational space

Providing healing space for processing meaning, loss & trauma