The lived experience of acute mental health inpatient care: What’s recovery got to do with it?

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Certificate of Authorship

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Name: Bronwyn Hyde

Signature :

Date: 26 July 2017
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Publications


Ethics Approval

This study was approved by the Greater Western Human Research Ethics Committee - number HREC/12/GWAHS/88.

The Charles Sturt University Human Research Ethics Committee subsequently accepted the approval from the Greater Western HREC and granted its own approval - number 2013/042.
Abstract

Thesis Title: The lived experience of acute mental health inpatient care – what’s recovery got to do with it?

This study explores the lived experience of acute mental health inpatient care and uncovers meanings attached to the notion of recovery in this setting by consumers, workers and managers. A number of questions are considered including how acute mental health inpatient care impacts on a person’s recovery and what facilitates recovery. In particular, consideration is given to practice implications for the social work profession. By purposively selecting participants, twenty four individual semi-structured interviews were conducted across three key groups – consumers, workers and managers. Hermeneutic phenomenological methodology including the use of a reflective journal was employed to explore the phenomenon of acute mental health inpatient care.

Acknowledging the lived experience of workers and managers alongside that of consumers provides a new insight into mental health inpatient care and the meaning of recovery within this setting. Differences are noted between the key groups in how a period of inpatient care is experienced and in the understanding of recovery. These differences accord with current literature on recovery in mental health, however it is the similarities of experience shared by the three groups that are of particular note within this study. These similarities challenge the usual dichotomies found in mental health recovery literature especially clinical/personal, and expert by training/expert by experience. While these might be useful ways of describing different perspectives, they ignore the shared components of both the experience of inpatient care and the meaning of recovery. It is this shared space that provides a focus of practice change and reveals the potential for optimizing the recovery experience within an acute inpatient setting. This study reveals the presence and power of the intersection, the shared space occupied by the three key groups.
CHAPTER 1 - Introduction

1.1 Overview

The delivery of mental health care and the notion of recovery from mental illness or disorder have undergone significant challenges on a global level in recent decades brought about by the influence of a strong consumer movement. This movement developed in part as a response to the perceived inadequacies of the biomedical discourse that has dominated the delivery of mental health care. A questioning and critiquing of the meaning of recovery as it pertains to mental health underpins this call for change. Traditional interpretations of recovery are being challenged as consumer voices have been brought to the fore. The strength of this consumer movement is evident internationally with consumer lived experience firmly embedded and indeed driving official policies and guidelines governing mental health service delivery. However as the contemporary models of mental health care proposed by these policies and guidelines favour community-based services, the voices of those experiencing inpatient care have not been afforded an adequate share of research space despite acknowledgement that this level of care is an integral part of a comprehensive and responsive mental health service.

This study focuses on exploring the lived experience of an episode of acute mental health inpatient care from the perspectives of three groups – consumers, workers and managers. An understanding about the meaning of recovery is then extracted from this exploration and compared between the targeted groups. A two-part definition of recovery is used as the conceptual framework from which to view the explanations of recovery and hermeneutic phenomenological methodology enhanced by the use of a reflective journal, leads the analysis of the exploration of lived experience. Data from this research add to the understanding of the concept of recovery in mental health service delivery, specifically acute inpatient care, and its actualisation into practice.
1.2 Background Information: mental health care and the notion of recovery

Historically mental health care has been the subject of an “on-and-off” relationship between medical science and social science (Bloom 2005). This relationship wove a path between perceptions of mental illness as a social condition or perceptions that defined it as a biological disease. At times the phenomenon of mental illness is seen to be a result of an interplay between the two. The concept of recovery from a mental illness has therefore also fluctuated, favouring explanations that fitted with the dominant thinking of the time. According to Bloom (2005) neurobiological explanations for the causes of mental illness came to the fore in the middle of the twentieth century hand-in-hand with advances in psychopharmacological treatments. When this occurred the contributions of the social sciences to this subject waned despite the protestations of writers like Engel (1977) who strongly advocated for a biopsychosocial approach. In a medical model, scientific rigour could be applied to prove the efficacy or otherwise of treatments, fulfilling a need of psychiatry to align with other branches of medical science in the pursuit of evidence-based practice and professional legitimacy. Recovery became aligned with the treatment and abolition of symptoms – a defined and evident outcome. Those who did not achieve this level of recovery despite the best efforts of their professional treaters were doomed to accept that their condition was chronic with little or no hope of leading a fulfilling “normal” life. A chronicity paradigm had enveloped mental illness (Slade 2009a).

Those on the receiving end of these treatments however, were beginning to voice concerns. Their interpretations of recovery did not necessarily match those in whose hands the decisions about treatment lay (Deegan 1988). These consumers/survivors/service-users began to protest about the kind of sentence afforded them by the diagnosis of a major mental illness. They exposed treatments that, far from alleviating distress, often exacerbated it and were even considered inhumane and contrary to human rights. As the collective voice grew, so did an air of hope and positivity. Recovery began to be viewed as more than just a cure. It was seen as a process, a journey in which characteristics considered as symptoms could
be managed, incorporated into a personal identity and even celebrated. Evidence emerged, and was eventually shown to have been there all the time, of high rates of recovery from chronic mental illnesses (Slade 2009a; Ramon, Healy and Renouf 2007).

Not surprisingly there have been many years of debate and controversy about the meaning of recovery in mental illness stemming from these tensions between the positivist interpretations of clinical recovery embedded in the biomedical model and the fluid, individual, postmodernism of the consumer-driven notion of personal recovery. Many authors have called for an end to the dualism between these interpretations, instead suggesting a dialectical immersion into the ambiguity of the world between (Parker 2014; Bracken et al. 2012; Glover 2009; Slade 2009a). Arising from this is a two-part definition of recovery that honours both scientific traditions and lived experience. Recovery is seen as both an outcome - clinical recovery, and a process – personal recovery (Slade 2009 a&b).

Recovery is more than just an agreement about its definition or explanation, as important as this is in the translation to organisational and practice change. The recovery approach that has been enthusiastically embraced on a global basis as the preferred method of mental health service delivery requires a fundamental shift in the value base of providers and practitioners. To truly practice within a recovery paradigm one needs to be comfortable with a power shift (Slade, Amering and Oades 2008). This requires an equal acknowledgement of the expertise inherent in lived experience, a true understanding of collaborative partnerships, a desire to learn from the other and an understanding of and belief in empowerment and human rights. These elements are far removed from the requirements to practice within a positivist, expert-driven mindset familiar to the majority of health professionals and those responsible for the provision of mental health services. A challenge exists to actualise a marriage of the two positions to create responsive and effective mental health services.
1.3 Rationale for the study

The rationale for this study originated in the researcher’s experience as a social worker within an Australian rural inpatient mental health facility. Observations of worker practice within this setting indicated that the mandated principles of recovery-oriented practice were not generally being adhered to and curiosity was aroused as to why this was so. As principles of the recovery approach closely align with the principles of the social work profession it was challenging to be confronted with individual worker practice and organisational culture that appeared to be contrary to the mandated approach to service delivery and therefore to the researcher’s own principles of professional practice. A number of areas of inquiry began to take shape.

First, a question arose as to how consumers experience an episode of acute inpatient care in this setting as a recipient of the service provided. Was this experience as negative as observations appeared to indicate? Likewise, how do workers experience this very same inpatient context as care providers? The question also arose as to how the concept of recovery featured in this fusion of experiences. Do the perceptions of recovery held by consumers and workers in an acute inpatient setting align with each other or are workers and consumers working at cross purposes in the delivery and receipt of inpatient care in regard to their understandings of recovery from a mental health disorder or difficulty?

Secondly, the inpatient setting elicits questions regarding mental health’s move to recovery-oriented service delivery. It is asserted here that the acute inpatient setting is the most challenging of the mental health services in which to incorporate recovery principles of practice. The recovery approach requires a stance of client-centred care emphasizing self-determination and empowerment as well as the maintenance of hope, optimism and the identification of personal strengths. The inpatient setting is often a place in which people with mental health problems find themselves on an involuntary basis. Other more powerful authorities have temporarily removed their rights, albeit within the spirit of prevention of harm to
themselves or others. The medical and legal worlds combine in what could be viewed as a heavy-handed move of protection - one in which the elements of recovery-focused care struggle to be enacted. Even if care is being provided on a voluntary basis those requiring this intense level of support and intervention are often in a vulnerable state in which a degree of powerlessness and helplessness is inevitable. This begs the question of whether recovery-oriented practice is possible in an acute mental health inpatient facility. This line of inquiry raises the issue of the purpose of inpatient care and how a model of care for such a setting is developed. What is the experience of those responsible for the delivery of this care, that is, the managers? What are their perceptions of recovery and how does this influence their role?

A third reason for undertaking this research also became evident. The similarities between the principles underpinning the recovery movement in mental health and the principles and values of the social work profession are undeniable. Questions began to form about social work’s contribution to this move for mental health reform. What could social work as a profession learn from the lived experiences of inpatient care that would inform this contribution? What role could or should social work be playing to introduce practice change and service reform? What social work voice already existed and what further knowledge was required to clarify the profession’s role in this reform? The research was predicated on the belief that the social work contribution to reform should draw from a broad perspective of inpatient care as experienced by all stakeholders rather than focusing alone on the limited perspective of experience from its own ranks.

As noted previously the researcher held a social work position within the setting. The implications of undertaking this research from the position of a worker in the research site and more specifically as a social worker is further explained in Reflection #1 at the end of this chapter.
1.4 The research gaps

In accessing the literature on recovery in mental health there was little to indicate how consumers experienced an episode of acute inpatient care. This was evident in the appeal for further research that places consumer opinion at the forefront in keeping with a recovery orientation. Walsh & Boyle (2009) state “Indeed it would appear that there has been very little research carried out specifically on psychiatric acute hospital service with inpatients as participants” (p.31). Nordfjaern, Rundmo & Hole (2010) agree, stating “…more studies should be carried out in order to gain knowledge about how patients perceive their treatment as well as recovery” (p.46).

This call is repeated by Johansson, Skarsater & Danielson (2013) in their study of health worker experiences in locked acute mental health units in which they state that further research is essential from other perspectives such as the experiences of patients and their next of kin.

According to the Australian document, A National Framework for Recovery-Oriented Mental Health Services (2013), the inpatient setting holds an important place in the spectrum of mental health services. At the same time however, there is a clear and strong call for a shift away from hospital care to community-based services that is articulated in Australian State Government documents (NSW Mental Health Commission 2014; Queensland Government 2008; Government of Western Australia Mental Health Commission n.d.). This is a trend reflected across international policies as outlined in Ramon, Shera, Healy, Lachman & Renouf (2009) in their comparison of mental health policy and practice in Australia, Canada, England and Israel. It is not surprising then that research on mental health recovery tends to focus on community experiences in order to inform the development of more contemporary systems of care. Reflecting this move away from hospital care, many of the reviewed studies on the subject of recovery in mental health were located in community settings or involved respondents who were not currently in an inpatient facility, for example, Marshall, Oades & Crowe (2009), Kogstad, Ekeland & Hummelvoll (2011), Aston & Coffey (2012) and Jacob, Munro & Taylor (2015). Many studies that focus on inpatient care often do so from the perspective of the health
care workers. For example, Tsai & Salyers (2008) call for further research on staff attitudes to recovery in hospital settings and the implications for recovery-focused practice. Likewise Cleary, Horsfall, O’Hara-Aarons & Hunt (2013) canvassed mental health nurses’ views of recovery within an acute setting.

There are also few studies that provided perspectives from different players within an inpatient setting. One study on multiple stakeholders within an acute psychiatric setting is that of the Sainsbury Centre for Mental Health in the UK (2006). In this study on staff and managers, service users and their families participated in questionnaires and focus groups on aspects of inpatient care across four sites. Another study by Aston & Coffey (2012) also utilises focus groups to compare the understanding of the concept of recovery between nursing staff on an inpatient setting and service users. The service users, however, included those who had had previous or recent experience of inpatient mental health services and not those currently in an inpatient setting. An Australian study by McKenna, Furness, Dhital, Park & Connolly (2014) provides a description of service delivery in a secure inpatient mental health service that strives to be recovery-oriented. Staff, consumers and carers were interviewed providing an illustrative case study of a recovery-oriented care.

Social work-specific contributions to research in the field of recovery in mental health are surprisingly scarce given the shared principles and language of the social work profession and the mental health recovery movement (Hyde, Bowles & Pawar 2014; Ramon 2009). This gap is starting to be addressed with social work professional journals devoting special issues to the subject in recent years and authors like Tew (2013), Bland, Renouf & Tullgren (2015) and Walsh (2013) explicate the social work contribution to the area of mental health work. The research in this thesis adds to the call for a social work voice as a significant contributor to knowledge building and practice change in mental health.

Inpatient care is an integral part of mental health service delivery, therefore it is essential to investigate and understand ways in which the recovery experience can
be maximised for those in need of this form of care. The work of Wyder, Bland & Crompton (2013) and Wyder, Bland, Blythe, Matarasso & Crompton (2015) have recently contributed, not only to the social work perspective in mental health but also to the understanding of the context of acute inpatient care. The current study contributes to this understanding and addresses some of the gaps identified in the literature regarding the experience of acute inpatient care and its contribution to recovery from an episode of mental distress. This is done first and foremost through foregrounding the here-and-now accounts of those experiencing the phenomenon.

The research aims to:

- Explore the “in the moment” experience of acute mental health inpatient care from multiple perspectives within a similar timeframe;
- Compare meanings assigned to recovery by those experiencing acute mental health inpatient care;
- Explore the impact of acute mental health inpatient care on a person’s recovery;
- Review the social work profession’s contribution to the change to recovery-focused practice within mental health.

1.5 Thesis title and research questions

From these aims the title of the thesis emerged - *The lived experience of acute mental health inpatient care – What’s recovery got to do with it?* and key research questions evolved.

*Key research questions:*

1. How is an episode of acute mental health inpatient care experienced by consumers, workers and managers in the chosen facility?
2. Do consumers, workers and managers in this acute mental health inpatient setting share a common understanding of the meaning of recovery from mental illness?
These two questions shape the way in which the data is gathered and provide the focus “thread” of the study. Contained within these two key research questions is the potential for discovery of other perceptions of the phenomenon that hold valuable insights into how acute inpatient care is experienced and how it can be understood and enhanced. This is reflected in the following additional questions.

3. What are the challenges for an acute mental health inpatient facility in changing to recovery-focused practice?
4. What are the implications for social work practice?

1.6 A note about language

There is little if any agreement globally on the use of a term for those who have experienced mental illness and the subsequent services available to treat or assist. According to McLaughlin (2009), whatever term is used is imbued with connotations of hierarchy and power and describes a relationship rather than the person. In this thesis the term “consumer” is most often used to ensure congruency with its status as the preferred term in Australian mental health literature. At times however, this term is interchanged with others such as “patient”, “service user”, “expert-by-experience” or “client” especially when quoting from literature or from the interview transcripts. In the same way the terms used for those providing care can vary, especially when the worker and manager groups are referred to collectively. At these times terms such as “health professional”, “staff” or “caregiver” are used. In order to protect individual identity, pseudonyms are used throughout this thesis for all participants of the study.

While the researcher has chosen to use the third person within the main body of the thesis, personal reflections are interspersed throughout to highlight the personal connection to this body of work and as part of the reflexive process of the chosen methodology. The first of these reflections outlines the researcher’s positionality in relation to the study and further explains the rationale. It is an introduction to the motivation behind the study as well as an explanation of the personal and professional connection to the subject matter.
1.7 Personal reflection 1

**Personal Reflection #1**

A gnawing feeling existed within me that eventually took shape. The sensation began when, as the Senior Mental Health Social Worker employed in a large mental health inpatient facility in rural New South Wales, I found myself working hard to present a different perspective of care and engagement with the people with whom I was working – one that wasn’t dependent on “treating” sick people or focused so intently on a collective risk aversion to the detriment of individuality. I didn’t choose mental health, I think it chose me. When I wanted to return to a social work position after spending five years in a teaching role, this position in mental health was the first to come up. I was the successful applicant and after two years I took on the position of the Senior Social Worker in charge of a small team of inpatient mental health social workers. Not only was it the first position I had taken in mental health but it was also the first position for me in an inpatient setting. Never have I remained in one field of work so long – I am now clocking up 15 years. Perhaps the reason I have remained so long is because I felt and still feel there is so much to be done to humanise this system of care. There is constant tension between preserving and respecting an individual’s personhood and rights while at the same time providing protection for them when there is very evident danger of risk of harm to themselves or those around them. The system of care errs on the side of risk reduction, often sacrificing the personhood of the individual. This was disquieting to me as a social worker and as a person. I often felt alone with this discomfort as I observed the system rolling on as it always had, certainly saving lives in many instances, but at the same time dehumanizing a number of lives in the process. It was evident that this system of care - a system driven by the need for urgency and action - had the capacity to steam roll over everyone in its way. There was a real danger of succumbing to certain ways of behaving and certain practices including language-use that dominated and smothered alternative views. Narrow explanations of cause and treatment could not account for everyone’s experience, however, in this reactive and time-driven environment, it appeared the experiences of all were moulded to suit the dominant framework with many an ill-fitting result.
It should be stated that I view this inpatient experience as an outsider, as a person who has never experienced the jarring, terrifying emotional disconnection from the world that an episode of mental ill health can be. My observations in this setting over the years impacted on me as a person and as a social worker. As a person I felt affronted on behalf of those whose lives were being affected and as a social worker I felt the need to “do” something. The alternative was to become moulded to the system myself which I’d already felt I had succumbed to in part. As a “non-lived experience” worker I could identify closely with my colleagues on the effects of the job demands. A danger was present of viewing mental illness as a thing to be treated, a separate entity from the person whose body it inhabits but fusing with that body such that the boundaries become invisible and the person becomes the illness.

I felt I inhabited an “in between” world. On the one hand I felt the injustices that were perpetrated on those requiring help and the effects on those around them – loss of decision-making, heavy-handed treatment in the pursuit of protection, the isolation and evident distress of family members. On the other hand I felt empathy for the staff often having to bear the brunt of both physical and verbal abuse that was difficult to not take personally and making decisions that were often time-pressured and contrary to the person’s wishes. While each consumer had his or her individual and unique lived experience, workers had a different kind of lived experience that was made up of hundreds if not thousands of individual experiences that they had collectively shared in a “second-hand” way. My “in between” position of empathy for all players led me to consider how this phenomenon of acute mental health inpatient care was being experienced by all those involved and what it meant for them. At the same time the principles of recovery were being written into all policies and guidelines mandating mental health service delivery. To me these principles represented a welcome endorsement of social work practice in this field of work but seeing it in print did not ensure its enactment and the system rolled on. As a researcher, my position in this “in between” world allowed certain privileges. Being a trusted colleague it was not difficult to recruit participants. This trust also
perhaps afforded the worker and manager participants a certain comfort and familiarity that affected their responses to the requests made of them in the interviews. At the time of the research I did not have a clinical role in the acute units and had not done so for approximately three years, providing me with some distance from an otherwise familiar experience. The position of trust with colleagues also eased the process of consumer recruitment as those working most consistently with consumers readily took on the role of advertising the research with those people currently admitted to the acute units. I hope my years of working with people experiencing discord in their mental health provided a similar level of comfort and ease for the consumers in relating their stories.

With my empathy being pulled in all directions I wanted to try to make sense of this acute inpatient experience. Did others share my concerns that inpatient care could in fact be experienced as harmful when it was supposed to be restorative and healing? Did others share my fear that being part of this system meant I was in collusion with practices that were contrary to my professional and personal principles? This desire and interest led to a gathering of stories (data) and a process of making some sense of them (analysis) in a way that could provide insight or new perspectives that would cause the steam roller to pause in its rumbling path for a moment and consider its impact.

1.8 Structure of the thesis and overview of chapters

Chapter 1 introduced the topic of recovery in mental health and the researcher’s motivation for choosing to undertake the study and its rationale. Gaps in current research were identified along with how this study addresses those gaps. The research aims and questions were presented.

Chapter 2 provides an overview of the approaches to mental health care over time and a discussion of the concept of lived experience. It examines the history behind
the growth of the current recovery movement and the way in which mental health care has changed. It also explores the contested views of mental health recovery.

**Chapter 3** investigates the national and international policy context of mental health care and outlines the challenges of moving from policy into practice. The chapter also presents the organisational context of inpatient care and how it sits with recovery-oriented practice.

**Chapter 4** compares social work’s professional principles and values alongside those of the recovery movement. Social work’s contribution to the move to recovery practice in mental health is outlined.

**Chapter 5** explains the methodology of the study including the location of the study, the position of practitioner-researcher and the research framework. A detailed outline of the research design is then presented explaining the stance of hermeneutic phenomenology.

**Chapter 6** provides the specifics of the methods used to undertake the study including sampling, recruitment, data gathering and data analysis.

**Chapters 7 and 8** present the initial interpretations for the first two research questions culminating in one main interpretation for each. The voices of the participants and the interpretations weave together through these chapters to ground the interpretations while ensuring the voices are placed at the fore.

**Chapter 9** takes the two main interpretations as set out in Chapters 7 and 8 and produces a major interpretation encompassing the whole study. Two types of lived experience are identified that are positioned with each other in three different ways.

**Chapter 10** discusses the main finding of the study based on the major interpretation. This involves the discovery and description of a “shared space” – an
overlap of clinical and personal lived experience that holds within it a number of practice implications.

**Chapter 11** further explores this “shared space” and details the practice implications. Commencing with a discussion of the notion of professional relationships, two important practice skills are identified and the role of social work is highlighted.

**Chapter 12** presents a list of recommendations for the organisational context and for social work education based on the findings of the study. The chapter concludes with an outline of the limitations of the study and suggestions for future research.

Chapter 1 has provided an introduction to the subject matter of this thesis and has outlined the researcher’s professional and personal position in relation to the study including rationale and motivation. The following three chapters provide a more detailed outline of issues within the field of mental health that form the context of the thesis topic. The first of these, Chapter 2, presents the concept of recovery in mental health as drawn from the literature.
CHAPTER 2 - The Concept of Recovery in Mental Health

2.1 Approaches to mental health care – from “bio” to “psychosocial”

The traditional approach to mental health care is informed by the tenets of the biomedical model. From this perspective psychiatric disorders originate from a brain dysfunction, the symptoms of which can be classified to determine diagnosis and appropriate treatment. A biomedical approach favours scientific rigour and is focused on deficit and disease. Engel (1977) takes issue with the application of this perspective in the field of mental health. At the time of writing he strongly opposed calls for psychiatry to adopt a medical model of disease and the calls to reject the “psychosociological underbrush” that was considered to be outside medicine’s responsibility (p.129). He describes the medical model as reductionist, accounting for disease simply as deviations from the norm of measurable biological variables and ascribing to a mind-body dualism. Engel questions whether the medical model of disease is adequate for the entire field of medicine let alone psychiatry. He argues for the validation of social and psychological factors in determining the onset, course and management of disease. Engel proposes instead, a biopsychosocial model that acknowledges the person’s account of their condition and the wider social circumstances to more fully understand the determinants of disease and to provide relevant treatment.

Bloom (2005) questions the displacement of the term “biopsychosocial” in recent years as he traces the history of the relationship between sociology and medicine. Bloom notes that the understanding of human disease as influenced by social activities and the cultural environment was written about in the late 19th century and was consolidated in medical education and research during the 1920s and after World War II. However towards the 1980s psychiatry turned towards a biopharmacological model that is reflected in Engel’s writings above. Bloom notes that psychiatry was and continues to be “self-conscious about its role” (p. 77) relying on the connection with biological sciences and technology to more clearly align with the discipline of medicine and to conform to evidence-based requirements. He
laments the loss of the partnership between the social sciences and psychiatry particularly as it affects the teaching and studying of human behaviour in medicine.

While Engel was writing in the 1970s more recent literature indicates that mental health services continue to reflect the reductionist approach of a biomedical model (Gandi & Wai 2010; Slade 2009a; Morley 2003). Parker (2014) describes a number of “models of madness” that impact on mental health practice. He discusses five different models including the medical model proclaiming that there are vast differences between approaches each with its own distinctive ontology and epistemology that impacts social policy, treatment and social justice. Parker names CBT (Cognitive Behaviour Therapy), systemic, psychoanalytic and medical as the mainstream or expert models of madness and then proceeds to add one more – the model of “madness itself” (p.32). His purpose in adding this last model is to examine how the expert models relate to it, pointing out that when consumers speak about their experiences they are heard from within the framework of the expert models. Parker comments on these different perspectives of madness saying that on the one hand madness is characterised as too rigid and too certain while on the other hand it is seen as disordered and unreasonable. He suggests that the struggle “to win” between the various models compromises social justice which can only be realised when the voices of those who experience the concept of madness are heard “in all their complexity and contradictoriness” (p.32).

Bracken et al (2012), in a movement labeled as “post psychiatry”, strongly challenge the epistemological underpinning of current psychiatry stating that the biomedical framework, or “technological paradigm”, on which psychiatry is based is inadequate and fails to account for the significant role played by other influences such as psychological, social and cultural. They assert that psychiatry is “in the midst of a crisis” and cannot continue to rely on the positivist assumptions of the technological paradigm that views mental illness through a lens of neuroscience where causality can be mapped and interventions administered to target symptoms. In this paradigm, contextual issues such as relationships, values and meaning making are of secondary importance. The authors argue that this order of priorities determines
what is considered as evidence-based practice in the field of psychiatry despite the existence of evidence indicating that technological responses to mental ill health “have a limited impact on the overall burden of serious mental illness” (p.432).

Bracken (2014) continues this argument when he states that for psychiatry to be truly evidence-based, the discipline needs to rethink its epistemological base from the reductionist epistemology of the natural sciences, to one of hermeneutics (p.241).

Slade (2009a) acknowledges this persistence of the biomedical model in mental health service delivery stating that most mental health services today continue to be geared towards meeting the goals of clinical recovery. These goals reflect the biomedical model and are primarily concerned with the elimination of symptoms and a restoration of function in order to attain a socially and culturally determined level of normality. He notes characteristics of a traditional approach that include professional accountability, scientific-based, decontextualised, illness-based and anti-disease - an approach in which the workers are the experts and the holders of power, where compliance and a return to “normal” are goals of the service (p.6).

Slade (2009b) provides a table outlining these differences between the traditional approach to mental health care (based on the biomedical model) and the approach of a recovery-oriented service. The two columns of this table appear almost oppositional to each other, one counteracting the other. This table is reproduced on the following page.
<table>
<thead>
<tr>
<th>Table 2.1 Comparison of Traditional and Recovery Approach</th>
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<tr>
<td><strong>Traditional approach</strong></td>
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<td>Return to normal</td>
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Slade (2009a) explores the origin of the biomedical model’s influence in the mental health field attributing this influence to Karl Jaspers, a German philosopher and psychiatrist prominent in the first half of the twentieth century. Jaspers promoted “careful listening” on the part of the clinician to establish a connection with the patient’s inner world. However, as Slade recounts, the careful listening was for the purpose of fitting the patient’s account into a predefined theoretical framework of psychopathology. Slade concludes that the biomedical model as it exists within mental health is a model of psychopathology. The listening merely elicits evidence for predetermined diagnostic entities, the existence of which is not questioned. Slade comments that this results in “an impoverished and decontextualised version of meaning” (p.10). Slade (2009a) questions the success of the biopsychosocial clinical model as a means of counteracting the dominance of the “bio” component. He refers to the persistence of diagnosis as a key indicator of the biomedical model that serves to relegate psychological and social factors as mere triggers of an underlying illness. The “psycho” and the “social” of the biopsychosocial are adjuncts only and not equal partners in this clinical model. They are seen to be valid only when they support the “bio”.

An integrated approach to mental health care has sought to overcome the differences of these approaches and to acknowledge the contribution that each approach can bring to good mental health care. Cloninger (2006) describes the emergence of integrated mental health care as a response to the failure of psychiatric drugs and manualised psychotherapy methods to improve the mental well being of general populations in Western societies. He questions the validity of the categorisation of mental health disorders believing this is inherently stigmatising and states that the focus of psychiatry has always been one of deficit rather than an understanding of what constitutes good mental health. Therefore a change of focus is required to one of universal interventions that ensure mental wellbeing. However, Geller (2015) draws attention to the challenges of creating an integrated approach from a system that is currently dis-integrated and fragmented.
2.2 The concept of lived experience

The traditional approach to mental health care implies that recovery from a mental illness or disorder is only possible through the reduction or elimination of clinical symptoms. Consumer narratives that document lived experience of a mental illness or disorder beg to differ. A recovery approach to mental health is one that is built on consumer lived experience that is individual and not easily measured within a framework of scientific rigour. It is the “model of madness itself” as described by Parker (2014). This delivers a considerable challenge to the traditional biomedical approach and has spawned a language of mental health recovery centred around hope, identity and meaning-making.

A biomedical approach positions expertise and knowledge with health practitioners while consumers are seen as passive recipients of treatment. A recovery approach challenges this notion stating that consumers are “experts-by-experience” (Slade 2009a&b) and should be acknowledged as equal partners in the management or treatment of a mental health condition. As noted previously Parker (2014) and Engel (1977) refer to the central importance of hearing consumer accounts of experiences to effectively manage a mental health difficulty and to ensure social justice. Patricia Deegan (1988), a mental health consumer and noted pioneer of the recovery movement stated simply that “those of us who have been disabled know that recovery is real because we have lived it” (p.55). She notes the paradox of the notion of mental health recovery believing it to be elusive and complex because it is so fundamental and defies description in scientific, psychiatric or psychological language.

The term “lived experience” now occupies a central place in official documents prescribing best practice mental health care. In the Australian Health Ministers' Advisory Council document, National Mental Health Recovery Framework: Guide for practitioners and providers (2013b), lived experience is described as “the heart of the framework” stating that the focus on lived experience “offers a new and
The inclusion of consumer lived experience and its role as the “heart” of policy and practice frameworks creates a shift in the epistemological foundation inherent in the traditional delivery of mental health services with significant implications for service design and clinical practice.

Lived experience is the basis on which a number of peer-led recovery programs have been developed. One such example is that of the Wellness Recovery Action Plan (WRAP) program developed in 1997 in the United States and led by Dr Mary Ellen Copeland. Slade (2009b) recommends this recovery program in Rethink’s recovery series in the United Kingdom, describing it as “the most widely used approach internationally” (p.17). The WRAP system is a self-monitoring tool that assists people to identify responses that will help them to relieve symptoms and enhance their wellness. It is an individualised plan of action developed by the person who will use it (Copeland 2002). Davidson (2005) identifies other user-led programs that have since emerged including The Manic Depression Fellowship Course, Rethink Self Management Course and the Expert Patient Program.

The link between social justice and lived experience as noted by Parker (2014) is further expatiated by Bell (2012) who introduced the notion of epistemic injustice from feminist philosophy to the social work context. The concept of epistemic injustice was coined by Fricker (2007) to describe the process of devaluation of a marginalised group’s knowledge by a more powerful group resulting in a partial knowledge base or “epistemic loss” (Fricker 2013). In the field of mental health, the biomedical model predominates and is preferred as a knowledge base in the
delivery of care. Bracken (2012) writing in Ireland about that country’s Mental Health Act, declares that the Act privileges the voice of psychiatrists. He states “The assumption is that no other group in society has such knowledge and therefore can be trusted to make decisions about people who are mentally deranged for one reason or another.” (p.55).

In a discussion of epistemic injustice, Dotson (2011) uses the term “testimonial quieting”. Testimonial quieting occurs when a speaker from a marginalised group is not seen as a “knower” and the speaker’s testimony is subsequently dismissed by the dominant group (p.242). This constitutes epistemic injustice. The recovery movement maintains that the knowledge base underpinning mental health service delivery arises predominantly from the biomedical model and represents only part of the story as the knowledge generated from lived experience has been discounted or quieted. Genuine acknowledgement of lived experience is central to a recovery focus and necessary to redress epistemic loss. Dotson also talks of “testimonial smothering” in which marginalised groups engage in a process of editing in order for some of their communication to be heard by the dominant group especially if the content is seen as risky or challenging to what is acceptable. This results in a form of “co-erced silence” (Bell 2014). Within a medically dominated environment such as a mental health inpatient setting there is a risk that consumer voices of lived experience are silenced and marginalised.

Included in the previous definition of lived experience from the National Mental Health Recovery Framework (2013b) is recognition of the concept being applied to those other than persons actually experiencing the mental illness or disorder. The definition recognises the experience people have of “others’ mental health issues” and includes this as acknowledged lived experience. There is debate about this notion of lived experience as some authors have seen the inclusion of experience other than consumers, especially that of health professionals, as appropriating the concept of recovery away from its true and fundamental consumer focus (Byrne, Happell & Reid-Searl 2015).
2.3 History of the recovery concept in mental health

Recovery in mental health as described through people’s lived experience has an historical background originating in the survivor movement of the 1930s that leads some authors to question its “newness” (Ramon, Healy & Renouf 2007). Hopper (2007) refers to the work of Emil Kraepelin, a psychiatrist in the late 19th and early 20th Century, who pioneered psychopharmacological research in the field of psychiatry. Kraepelin’s terms “cure with defect” or “healing with scarring” referred to a return to a healthy state albeit with continuing eccentricity or moodiness in the context of reduced aspirations of functional ability in the world – an early version perhaps of the more recent notion of recovery. Glover (2009) notes that recovery as a concept in mental health has existed for decades with Onken, Craig, Ridgway & Cook (2007) declaring that mental health recovery has been evident in the consumer/survivor self help movement since the 1930s and in writings of consumer/survivors since the early 1980s. Ramon et al (2007) state that professional literature began to incorporate the concept of recovery in the early 1990s initially in the United States followed by New Zealand. The writings of Anthony (1993) and Deegan (1988 & 1995), both originating in the United States, initiated and maintained the current movement to incorporate recovery principles into mental health service delivery. Anthony (1993) states that the recovery movement emerged as an aftermath of deinstitutionalisation, or rather in response to the failures of this move. As services needed to focus on the consequences of the illness rather than the illness itself, they were forced to be more responsive to consumer needs and factors within the broader social and cultural context.

Deegan (1988) welcomed the incorporation of rehabilitation principles into mental health service delivery providing an alternative perspective away from the illness and chronicity models that positioned consumers as passive recipients of treatment often with no hope of attaining functional improvements. She saw the rehabilitation paradigm used in physical health as offering a new perspective in mental health care, one that nurtured recovery and a sense of hope, allowed for setbacks, offered mutual support and self help networks and was individually focused. Both Deegan
(1988) and Anthony (1993) called for mental health practitioners to utilise their own experiences of vulnerability, loss, catastrophic events and grief to better understand and empathise with those who have experienced a mental health problem. This would then abolish the polarity of normal and abnormal that according to Deegan (1988) sets up an oppressive environment for those struggling with recovery.

While both Deegan (1988) and Anthony (1993) utilised the rehabilitation model to explain the move to a recovery focus in mental health, more recent writings began to distinguish the recovery notion from a framework of rehabilitation. Crowe, Deane, Oades, Caputi & Morland (2006) assert that perspectives on recovery should no longer be limited to medical model definitions or models of rehabilitation. They believe this limits the concept of recovery to one of symptom management or amelioration (medical model) or improved functioning alone (rehabilitation model). They argue, instead for the incorporation of a dimension that includes psychological recovery processes.

The history of recovery in the Australian context is set out in Ramon et al (2007) and follows the documents of the National Mental Health Plans the first one of which was published in 1992 and the second in 1996. While the initial two National Mental Health Plans did not make explicit reference to recovery, Ramon et al (2007) state that the concept of recovery was implicit, evident in statements about inclusion of consumers in service development, early intervention, health promotion, prevention and rehabilitation. *The Third National Mental Health Plan* (Australian Health Ministers 2003) was the first to state a commitment to recovery as a guiding principle of national policy. Barker & Buchanan–Barker (2011a), whose work focuses on the situation in the United Kingdom, make reference to the *Standards of Practice for Australian Mental Health Nurses 2010* published by the Australian Congress of Mental Health Nurses (2010) that highlights recovery practice. The authors acknowledge this as “a highly-significant development” to incorporate the notion of recovery, distinguishing mental health nursing practice from psychiatric nursing (p.341). Despite this pioneering role that Australia has played in the development of
recovery-oriented practice, Ramon et al (2007) still question the depth of this commitment in public mental health services.

Writing in 2000 (reprinted in 2006), Jacobson & Curtis (2006) discuss the experience of the United States. They state that the adaptation of the concept of recovery to psychiatric disorders is relatively recent and originates from two sources – that of the grass-roots, self-help initiative of the survivor movement and that of psychiatric rehabilitation which they describe as a professional approach to mental health service delivery. The goals of the survivor movement are embedded in empowerment both on a systemic level involving a redistribution of power held by the state, and on an individual level with consumers taking responsibility for their own lives. On the other hand, psychiatric rehabilitation focuses on the development of community resources and an understanding that recovery is a product of the interaction between the individual and the environment. Recovery is therefore conceptualised in both political and personal terms as well as a way to regain functional ability. Jacobson & Curtis refer to concerns expressed by consumer advocates that in the hands of policy-makers recovery will become little more than “a fad, a passing fashion” (p.369) unable to take into account the fundamental change required in the relationship between consumers and the system and relegating consumers to a continued state of dependence on the system.

Almost a decade later Kemp (2010) writing about the United Kingdom experience, maintains that user or consumer involvement in mental health services is not a “passing fad” as it is embedded in wider social changes including the move towards more participative forms of governance that demand the establishment of collaborative partnerships. This represents devolution of power from the state but as Kemp points out, this does not equate to a loss of power. Instead, it requires a development of new forms of control. He outlines other areas of social change that reinforce this move including the availability of information afforded by the use of the internet, a 24-hour news culture and an increasing public distrust of those in power, particularly politicians but also professional workers. This has led to increased expectations about standards of care. Kemp refers to social movement
theory in which public concerns such as quality of life, equal rights and participation take precedence over the old politics that was more concerned with economic distribution problems.

Social movements such as feminism, gay rights, black power and environmentalism can be compared to the consumer-led changes in mental health. Kemp (2010) points to the anti-psychiatry movement of the 1960s initiated by psychiatrist R.D. Laing as significantly influencing and being significantly influenced by the expansion of user organisations that took place in the 1980s and 1990s. This critiquing of traditional psychiatric care offered an alternative discourse that aligned with consumers’ personal experiences. Like Ramon et al (2007), Kemp notes ongoing questions in relation to continuing the momentum of user involvement including the barriers to practical implementation, how to safeguard against tokenistic responses and how to reconcile user involvement with pressures to provide a safe mental health service.

2.4 Mental health recovery – definitions and debates

The recovery concept in mental health has arisen as a response to the narrow and constrictive notions inherent in the biomedical model, however there are a number of controversies surrounding the definition of the concept and its meaning. Recovery in mental health is a contested notion that continues to be debated on an international level. It is a concept that can be viewed from a number of different theoretical perspectives – is it a set of guiding principles, a social movement, a model? According to two authors who are attributed with pioneering the movement in the late 1980s and early 1990s the recovery approach is based on the simple tenets that people with a mental illness need more than symptom relief (Anthony 1993) and that people who have been diagnosed with a mental illness are first and foremost human beings (Deegan 1995).

Recovery from a mental illness or disorder is a profoundly individual experience and as a result the clarification of the meaning of recovery in mental health practice is one that is fraught with debate and discussion. The debates centre on the lack of
consensus for a definition with some authors instead describing it as a process for which agreed themes can be isolated and likening the concept more to a social movement or a framework supporting recovery principles (Glover 2009; Walker 2006). One study attempted to provide a consumer definition of recovery only to state that the attempt had been unsuccessful due to consumers not being comfortable with the word “recovery” (Tooth, Kalyanasundaram, Glover & Momenzadah 2003). This discomfort with the word “recovery” is also noted in a study by Aston & Coffey (2012) where some of the consumer participants found difficulty using “recovery” as associated with mental health. When asked to provide an alternative the consumer focus group struggled with one person stating “it’s not the word really...it’s getting there, getting it sorted”(p. 260).

Only a few authors venture to present their own definitions of recovery (Crowe, et al 2006; Andresen, Oades & Caputi 2003; Thornton & Lucas 2011) with many (Gandi & Wai 2010; Happell 2008a; Kogstad et al 2011; Meehan, King, Beavis & Robinson 2008; Ramon et al 2007; Ramon 2009; Ramon et al 2009; Glover 2009) instead referring to the pioneering historical definitions from Anthony (1993) and Deegan (1988) based on consumer lived experience. The most quoted definition either directly or as a variation, is that of Anthony (1993):

Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (p. 527)

Deegan (1988) distinguishes between “rehabilitation” and “recovery” stating that rehabilitation is about the services and technologies that assist people with disabilities to adjust to their world. Recovery on the other hand, refers to a person’s lived experience as he/she accepts and overcomes the challenge of disability. She uses the rehabilitation concept to refute the practice of isolating people with a psychiatric disability. Anthony (1993) sees the chronicity of mental illness as being caused as much by the symptomatology as by the consequences of the illness.
including stigma, discrimination, homelessness and poverty. He states that a rehabilitation model provides a more comprehensive understanding of the impact of severe mental illness as it deals not only with the illness but also with its consequences. In separating the symptoms from the consequences Anthony utilises the analogy of a person with a spinal chord injury stating that the person can recover even though the spinal chord cannot. Similarly, he states, “... a person with mental illness can recover even though the illness is not ‘cured’” (p.525).

Ramon et al (2007) assert that recovery has been “rediscovered” by service users in recent decades and is perceived to be both a process and an outcome. The meaning of recovery in mental health has moved away from a psychiatric focus that views chronicity as an inevitable impact of a major mental illness. The authors challenge the chronicity view of mental illness by referring to studies from the 19th century and through the 20th century that evidence high recovery rates from major mental illnesses. They question why the “chronicity paradigm” has had such a dominant place in the provision of mental health services (p.109) where poor outcomes have become a self-fulfilling prophecy. Reference is made to Anthony’s reshaping of the term “chronicity” – changing it from being seen as linked solely with clinical symptoms to being seen as the product of community stigma and disadvantage. The authors argue that viewing recovery instead as being concerned with self-efficacy, self esteem, optimism and control over the future has the potential to act as a catalyst for change in the delivery of mental health services on an international level.

Shera & Ramon (2013) state that definitions of recovery can be compared along a continuum of power. They refer to the variation of approaches to recovery evident when the policy documents of several countries are reviewed. At one end of the continuum the language of patient-centred care is merely added to a predominantly medical model. The other end of the continuum is imbued with the language of recovery as a unique and individual journey reflecting a consumer-driven perspective, while in between are notions of collaborative practice and community-capacity building.
Many authors have isolated key themes that are consistent across the multiple interpretations of recovery. Onken et al (2007) describe these concepts as hope, a sense of agency, self-determination, meaning and purpose, awareness and potential while in a similar vein, Slade (2009b) identifies self-identity, meaning-making, self-management and the development of valued social roles as the key tasks for personal recovery.

Some authors, predominantly those with a personal history of mental illness (Glover 2009; Deegan 1995 and 1988) prefer a focus on the processes that support recovery. Slade et al (2008) state that rational debate about recovery cannot take place in the absence of further clarity of its meaning believing that the “rhetorical consensus conceals a more complex reality” (p.128). This rhetorical consensus, according to Slade et al (2008) relates to the use of the term “recovery” in mental health policy on an international level that often lacks recognition of the sometimes incompatible meanings. Thus a two-part definition of recovery has emerged (Slade et al 2008; Walsh & Boyle 2009) to distinguish between clinical recovery described as an absence of symptoms and functional impairment (aligned with the biomedical model and which can be reasonably measured) and the definition of recovery as a personal narrative, or social recovery, which is uniquely individual and involves gaining new meaning and purpose in life even in the presence of ongoing symptoms. Slade (2009b) refers to “experts-by-training” and “experts-by-experience” to recognise the knowledge that each of the significant players, the consumers and health professionals, bring to the table in furthering the understanding of the concept of recovery.

Slade et al (2008) propose this two-part definition to provide conceptual clarity to the discussions of recovery in mental health. Separating clinical recovery from personal recovery allows appropriate research to proceed from both perspectives. Clinical recovery as the amelioration or removal of symptomatology remains invariant across individuals. The authors state that clinical recovery defined in this way and including other categories such as the ability to remain in work, living without support of carers and developing friendships across a sustained period of
time can be investigated through epidemiological prevalence studies. They refer to a WHO report on recovery from schizophrenia (Hopper, Harrison, Janca & Sartorius 2007) that evidences significant recovery rates from schizophrenia dispelling the pervasive notion that a diagnosis of schizophrenia is a life-long sentence of chronicity. The natural consequence of this clinical “illusion” is that a lack of hope and low expectations for the future are communicated to those on the receiving end of this diagnosis (Slade et al 2008).

The personal meaning of recovery provides challenges for evidence-based practice as it is not something that can be easily measured or scientifically scrutinised. Personal recovery referred to by Slade et al (2008) and Slade (2009b) reflects the individual experience of recovery and is subsequently subjective and fluid. Walsh & Boyle (2009) note that individual definitions of recovery pose problems for academics and professionals in developing recovery-focused services. In response to this, a number of authors call for the exploration of personal meanings of recovery to enrich the knowledge base of mental health practice and service delivery. Kogstad et al (2010) call for a challenge to the reductionist and symptom-oriented views of recovery through the epistemological acknowledgement of client lived experience. They put forward the case for more knowledge within the mental health field to be based on users’ experiences placing emphasis on the role of language in the social construction of mental illness. This is echoed strongly by Walker (2006) who argues from a philosophical perspective for an understanding of the social construction of mental illness stating that “the mental health profession somehow missed out on the evolution of the postmodern perspective” (p.71). Walker states that failing to acknowledge the role of language, or the “linguistic paradigm” has enormous implications for the implementation of a recovery focus in mental health. According to Walker, failing to understand that language creates reality may result in the creation of the best recovery program that continues unwittingly to linguistically cast people in a pathological and deficit based vocabulary limiting the chance of improving quality of life and even causing iatrogenic problems.
The philosophical approach to recovery is also taken up by Thornton & Lucas (2011) who strive to justify the application of the term “model” to the notion of recovery. Like Slade et al (2008), Thornton & Lucas believe that recovery as it has been touted in policy documents, is more akin to a practical orientation to care and a guide for the roles of clinicians, service users and carers rather than an explicit model of care. They state that to compete with the biomedical model, the recovery approach needs to have a normative dimension or a link to values. While physical health can be described in statistical terms, mental health cannot and therefore requires an end point that is essentially normative or evaluatively characterised. Recovery would therefore be aimed at a valued end point, defined by the person, such as a valued life connected to their identity. They proceed to put forward a definition of recovery that they believe is worthy of the title “model”:

Recovery – a move (from a position picked out by a normative sieve) to a normatively characterised end point – for example, a conception of a valued form of life. (p.26)

Glover (2009) disputes the move to devise models and theories to explain recovery stating that this is merely satisfying a need of systems. In fact she expresses concerns that the attempts to reduce recovery to a model or theory is against the spirit of recovery and risks destroying the uniqueness of the ways in which the concept can be actualised. While she calls for an “unpacking” of the term to avoid the risk of it being misused or misunderstood, she calls for emphasis to be placed on the underlying principles and values in order for services to better evaluate whether or not their service is supporting individuals in their recovery process.

The challenge of bringing together the concepts of personal and clinical recovery are evident throughout the literature. Meehan et al (2008) look at key questions regarding the implementation of recovery practices in mental health care. They state that little attention has been focused on the impact of recovery-based practice on mental health services and maintain that the notion of recovery has not been clearly thought through. They call for “a stepping back from the rhetoric of recovery” to consider the implications for service providers and practitioners (p.177). Meehan et
al (2008) believe that the move to recovery-oriented care is as radical as the move from institutional to community care and state that the broader community must also be involved in the debate due to the potential for increased exposure of the community to mental illness and recovery. Borg & Kristiansen (2004) also outline the dilemmas faced by mental health practitioners in recovery-focused practice particularly the need to remain professionally competent through evidence-based practice while simultaneously meeting the requirement to adhere to a user-based perspective. Likewise Shera & Ramon (2013) outline a number of challenges in the implementation of recovery-oriented care noting prevalent skepticism of the ability of professionals and systems to adequately change attitudes and practices. Further risks of the recovery approach are articulated in Henderson, Curren, Walter, Toffoli & O’Kane (2011) who, like Meehan et al, raise concerns about “subjugation of the health professional to consumer demands” (p.57) resulting in the need for a reconstruction of the notion of “professional” and raising issues about the individualisation of the responsibility for health.

As noted previously the measuring of recovery for evidence-based practice raises another debate within this topic. A review of recovery measures undertaken in Australia through the National Mental Health Strategy by the Australian Mental Health Outcomes and Classification Network (Burgess, Pirkis, Coombs & Rosen 2010) distinguishes between measures required for individual recovery and those required to measure the recovery orientation of a service. Some of the criteria this document uses to evaluate the recovery instruments include the requirements that the measures have been scientifically scrutinised and can yield quantitative data. An article by Happell (2008b), on the other hand, in outlining a qualitative study that explored consumer perspectives on the effectiveness of services promoting recovery, criticises the use of routine outcome measures within mental health. The author states that current measures used do not evaluate aspects of service delivery considered crucial to consumers. She asserts that the lack of consultation with consumers about the implementation of these measures reveals a tokenistic approach to recovery principles. The relevance of clinical outcomes as a measure of individual recovery is also noted by Ramon et al (2007) who refer to the dilemma for
service users in maintaining a sense of ownership of the notion of recovery while at
the same time retaining credibility to influence policy by conforming to an evidence-
based framework. Credibility in the form of an evidence-based framework has been
taken up by Leamy, Bird, Le Boutillier, Williams & Slade (2011). In a move to create
an empirical base for research and practice and to provide conceptual clarity on the
notion of recovery, Leamy et al offer a conceptual framework for personal recovery.
This was developed using a method of systematic review and modified narrative
synthesis and includes 13 characteristics of the recovery journey, 5 recovery
processes and recovery stage descriptions.

2.5 Theoretical perspectives within the debates on recovery

Recovery as a concept has been discussed within a number of theoretical
frameworks evident in the literature. Different theoretical frameworks or lenses
provide varied perspectives and emphases in subsequent discussions about
recovery. For example, the focus may be directed towards the impact on the
workplace and professional roles, the challenge in translating recovery theory into
practice, the implications for resource provision, consequences for consumers or
identified barriers and areas of resistance in implementation.

Onken et al (2007) identify a number of theoretical perspectives of recovery
including the psychiatric disability perspective that has always viewed recovery in
terms of the alleviation or elimination of symptoms. This perspective sits in a
potentially oppositional stance to the perspective of lived experience from which
the current notion of recovery has emerged. Recovery from a deviance perspective
emphasises the stigma of mental illness and the structural barriers to achieving
wellness. This theoretical perspective leads to discussions about social inclusion to
counteract marginalisation and structural factors such as homelessness and poverty.
The authors refer to the value of narrative therapy as a means of supporting
individual recovery through the process of re-authoring and discuss change theory
involving the understanding of first and second order change. They utilise this
theory in their proposal that a person’s individual recovery is akin to first order
change while changes within the wider environment (societal or organisational) constitute second order change. They proceed to use an ecological framework to incorporate these various theoretical perspectives to view recovery as existing within an interrelationship between the environment and the individual. This notion of recovery is also present in the Rethink series (Slade 2009a; Ajayi et al 2009; Bowyer et al 2010) in their emphasis on contextual factors as a necessary ingredient in understanding the concept of recovery and reinforces Bloom’s (2005) call for a return to a biopsychosocial framework as first proposed by Engel (1977).

Slade et al (2008) note that a critical approach is embedded in the recovery movement as it challenges current power structures and work practices particularly as they have been defined by the biomedical model. According to the authors this approach has often triggered responses of “denial, ridicule and appropriation” from professional groups whose power is threatened (p.135). Henderson et al (2011) critique the impact on the profession of nursing of the move to relocate a mental health unit for older adults into a general hospital. They label the use of managerial techniques of the private sector within public sector health as neoliberalism. Within this theoretical framework a perspective of recovery is offered that is less positive than that derived from the notion of lived experience. The emphasis on consumer-led care is viewed as a threat to current professional identity and as possibly shifting responsibility for health outcomes onto the consumer while at the same time increasing professional accountability. This is a contradiction that may not have been highlighted if the lens of neoliberalism had not been employed by these authors.

Gandi & Wai (2010) use a theoretical framework based on cognitive and behavioural theories to promote a program that allows for more collaborative partnerships between consumers and workers within a mental health hospital based service in Nigeria. The overall framework is one of humanism emphasizing the centrality of human values and the importance of the individual as unique (Ife 1997). This approach is also evident in the work of Kogstad et al (2011) who see the humanistic approach of recovery as being under threat by the evidence-based movement. The

Systems theory is used by Horsfall, Cleary & Hunt (2010a) in describing the role of teams within a hospital setting and attachment theory is used by Holmes (2002) in his description of mental health services as a “secure base” for individuals in their recovery journey. Postmodernism is used by Walker (2006) in his criticism of mental health’s failure to acknowledge the power of language, particularly the language used by the dominant discourse in mental health care – that of the biomedical model.

Starnino (2009), writing from a social work perspective, recognises the many theoretical approaches inherent in discussions about mental health recovery. He parallels this with social work’s tradition of drawing on diverse theoretical orientations and suggests a model proposed by Ken Wilber who he describes as an “integral theorist” (p.821). Starnino suggests grouping the multiple theoretical orientations of recovery – including those of depth psychology, strengths perspective, neuroscience, behaviouralism, systems theory, social construction and empowerment theories – into the four quadrants of Individual/Objective, Collective/Interobjective, Collective/Intersubjective and Individual/Subjective. In this way he is proposing that each of these orientations are different ways of looking at the same thing rather than seeing them as competing viewpoints. Glover (2009) proposes a similar synthesis of theoretical perspectives in her suggestion that evidence based knowledge and lived experience knowledge need to combine in a responsive way to support individual recovery and not be distracted by the apparent competition between them.

Onken et al (2007), as noted previously, utilise an ecological framework in an attempt to create a multidimensional analysis to assist in the creation of a definition. They note that definitions have emerged from a number of perspectives including philosophy, grounded theory based on lived experience and operational definitions for the purpose of shaping practice and research. An ecological framework, they
Recovery is multidimensional, fluid, nonsequential, complex, and permeates the life context of the individual, with some elements linked primarily to the individual and others that are more deeply infused with the role of the community to provide resources and opportunities to individuals as they embark on a recovered journey.

Within all the contested discussions of recovery some common threads emerge once the detailed minutiae are disentangled. It seems that mental illness has always posed a problem to those searching for simple definitions and clarity of meaning. Similarly the notion of recovery from a mental illness has defied the challenge of unified agreement. However, within these differences lie great opportunities to expand understanding and contribute to the development of effective mental health services that are more responsive to and shaped by consumer experience. Indeed, despite the controversies and differences inherent in the discussions of recovery, government policy-makers internationally have embraced the concept, developing official documents that call for the embedding of recovery principles into all aspects of mental health service delivery. Chapter Three now looks at mental health service delivery through a discussion of the policy and organisational context of mental health care.
CHAPTER 3 - Policy and Organisational Context of Mental Health Care

3.1 Policy context

Despite the contested views about the notion of recovery in mental health, principles of the recovery approach have become embedded internationally in mental health policy and guidelines. It is reasonable to consider then, how it is that such a contested notion has come to be universally adopted as a key driver of policy on a global basis. As noted previously this change in approach to mental health care can in large part be attributed to the consumer movement of the early 1990s. The prevailing view of mental illness as being a long-term chronic condition was challenged by the reported experiences of recovery of those who had received a psychiatric diagnosis and who had been subject to the treatment regimes of the time. This lived experience coupled with evidence that clinical recovery from mental illness had been reported for centuries, led to a radical reconsideration of the notion of mental illness and its associated treatment. Ramon et al (2007) outline the factors that led to this new understanding of recovery culminating in its adoption into policy on an international level. These factors included; the acceptance of evidence that new medications did not result in higher levels of recovery; de-institutionalisation leading to the development of more community-based rehabilitation focused services; the valuing of expert-by-experience knowledge; the social model of disability recognizing the existence of strengths and weaknesses in all of us that we learn to live with; and, following on from the disability model, the acceptance of the strengths model fostering social inclusion (p.110). While there is universal adoption of the recovery approach, there is an acknowledgement of the degree of change required to embed the concept into practice and to develop new systems of care. Some authors, for example Hopper (2007), question the extent of transformative change that can be achieved when ideals of a social movement are confronted by the realities of institutional bureaucracy.

3.1.1 Australian policy context

In the Australian context the National Mental Health Plans are referred to as key documents by Rickwood (n.d.), Ramon et al (2007), Meehan et al (2008) and Ramon
et al (2009) in the transformation to recovery-oriented mental health services. These documents aim to provide a vision for mental health service delivery across Australia and are used to identify essential actions to guide reform. This series of documents began with the release of the National Mental Health Policy in 1992 (Australian Health Ministers 1992), a joint statement by the Health Ministers of the Commonwealth, States and Territories of Australia to overcome the variance in mental health policy and service delivery on a national level. As noted by Ramon et al (2009) up until this time mental health policy in Australia was almost exclusively the domain of the individual State Governments. The National Mental Health Policy of 1992 proposed that mental health services should be integrated into the mainstream health system to improve the quality of services, increase access and help reduce stigma. It also called for better linkages between mental health services and other health and community services such as housing, accommodation support, social support, community and domiciliary care and employment and training opportunities. The stated underlying principles of this document include, among other things, the recognition that mental health is the product of biological, psychological and social factors and that the quality and effectiveness of mental health services rely on consumer participation in decision-making about the development of services and individual treatment. The word “recovery” is not present in this first national document although there are many references to what would now be described as recovery language – inclusion of consumers in the decision-making process about services and treatment and the understanding of mental health beyond just clinical symptoms to include social context. The term “lived experience” that becomes such a central concept to future national publications is also absent in this early document.

Plan 2003-2008, was the first one to explicitly identify recovery as one of the guiding principles of national policy and to include a definition that is based on the oft-quoted definition of Anthony (1993). However, the term “lived experience” does not enter the vernacular of these landmark mental health documents until the Fourth National Mental Health Plan 2009-2014 (Australian Health Ministers 2009). In this document the first priority area is identified as “Social Inclusion and Recovery”. The document reinforces the definition of recovery from the previous Plans and in addition includes two other examples of definitions. The first definition is from Patricia Deegan:

Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again...The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability, the aspiration is to live, work and love in a community in which one makes a significant contribution (p.26)

The second definition originates from the New Zealand Mental Health Advocacy Coalition...”a philosophy and approach to services focusing on hope, self determination, active citizenship and a holistic range of services.” (p. 26).

The Fourth National Mental Health Plan 2009-2014 clearly articulates recovery as something more than the absence of symptoms and includes such factors as hope, empowerment, choice, responsibility and citizenship. It acknowledges that a recovery focus in Australia has been adopted more readily by the non-government sector and calls for the attitudes and expectations underpinning the recovery focus to be taken up by clinical staff within the public and private sectors (p.24). One of the National Actions identified in the Plan calls for mental health services to adopt a recovery-oriented culture underpinned by appropriate values and service models, however, these values are not specified. Interestingly, a later document of the National Mental Health Strategy entitled Review of Recovery Measures (2010) is critical of the indicators for the first priority area “Social Inclusion and Recovery”
believing they do not gauge the performance of mental health services in offering recovery-oriented care (p.7).

Other nationally produced documents include the *National Standards for Mental Health Services* first introduced in 1996 with the most recent document published in 2010 (Australian Government 2010). The purpose of this document is to “assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services” (p.2). While only one of the key principles of this document directly refers to recovery – “Services are delivered with the aim of facilitating sustained recovery” – many of the other principles contain recovery concepts such as consumer involvement in all decisions regarding treatment and care; mental health treatment, care and support to be tailored to the specific needs of the individual consumer; and reference to promoting an optimal quality of life for people with mental health problems and/or illness (pp 3-4). While the word ‘recovery’ is only included once in the statement of principles, two of the Standards in this document explicitly address recovery. Standard 6 states:

> Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery (p.14).

This is followed by eighteen criteria by which this standard can be evaluated.

Standard 10 concerns Delivery of Care and has a subsection entitled 10.1 “Supporting Recovery”. This Standard states:

> The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery. (p. 21)

There are ten criteria for 10.1 (Supporting Recovery) outlining the expectations for Mental Health Services. This document also contains a section on “Principles of recovery-oriented mental health practice” (p.42) that clearly sets out six principles of
practice - uniqueness of the individual, real choices, attitudes and rights, dignity and respect, partnership and communication and evaluating recovery.

A more recent document, National Practice Standards for the Mental Health Workforce 2013 (Australian Government 2013), outlines values, attitudes, knowledge and skills required for members of five professions working within the mental health sector. The five professions include nursing, occupational therapy, psychiatry, psychology and social work. The document works alongside the National Standards for Mental Health Services (2010) and together they provide a set of foundational standards for mental health services in Australia. Eleven of these workforce standards directly reflect the ten National Standards for Mental Health Services with two others designed to address specific professional practices – Standard 11: Communication and information management and Standard 13: Ethical practice and professional development responsibilities. The practice standards are designed to be used in conjunction with the discipline-specific standards and competencies of each of the professions.

Two significant documents recently published in Australia have attempted to bring together the range of recovery-oriented approaches across both state and national arenas. The National Framework for Recovery-Oriented Mental Health Services – Policy and Theory (Australian Health Ministers’ Advisory Council 2013a) and The National Framework for Recovery-Oriented Mental Health Services – Guide for practitioners and providers (2013b), are designed to specify “a national understanding and approach to recovery-oriented mental health practice and service delivery” across Australia (p.8). The purpose is to assist practitioners to align their practice with recovery principles, review the current skill mix of the mental health workforce encouraging a greater role for peer practitioners and to “influence the design and development of innovative service models and systems of care” (p.9). In the Forewords of both documents it is noted that the next step on from the publication and distribution of these documents is to “make the framework live” by embedding the principles into everyday practice and service delivery (iii). Lived experience as a concept takes centre stage in these documents; described at various
times as being “at the heart of everything we do” (p.iii), “the heart of recovery-oriented culture” (p.2) and “the heart of the framework” (p.7).

These national documents have informed and guided numerous State documents that continue to be produced, reviewed and updated. Examples include *Queensland Plan for Mental Health 2007-2017* (Queensland Health 2008); *Victorian Department Health Framework for recovery-oriented practice 2011* (State of Victoria Department of Health 2011); *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (NSW Mental Health Commission 2014); *South Australia’s Mental Health and Wellbeing Policy 2010-2015* (Government of South Australia 2010); *Western Australia’s Mental Health 2020: Making it personal and everybody’s business* (Government of Western Australia Mental Health Commission n.d.); and Tasmania’s *Mental Health Services Strategic Plan 2006-2011* (Tasmanian Department of Health and Human Services 2006). The Territories have also developed local documents including *Mental Health Services Plan 2009-2014* (ACT Health 2009) and the *Northern Territory Mental Health Service Strategic Plan 2015-2021* (Northern Territory Government 2015). All documents refer to the National Mental Health Plans and all have recovery-oriented principles and language embedded in them.

3.1.2 International policy context

An international comparison of mental health policy is addressed in a selection of articles with interesting differences emerging in emphasis within recovery practice and implementation between countries. A consistent theme, however, is the international consensus for the change to recovery-focused mental health service delivery.

Ramon et al (2009) provide a comprehensive multi-country comparison of policy and practice across four countries, Australia, Canada, England and Israel. These countries were chosen for their similarity in terms of the prevalence of mental health disorders, socio-economic status, health and mental health infrastructure and their involvement in mental health reform (p.108). While Australia has included recovery concepts in planning and policy-making since the early 1990s, as noted previously,
the need for major reform to the Canadian mental health system was articulated in the 2006 report of a Government commission set up to investigate the state of mental health in Canada. The report entitled Out of the Shadows at Last included 118 recommendations with recovery as a central concept. In terms of implementation the recommendations endorsed a shifting of resources from the institutional sector to community-based services.

Ramon et al (2009) state that social inclusion is the unique English contribution to mental health care that complements the current notion of recovery and constitutes the focus of the National Framework for Mental Health developed in 1999. It is noted by these authors that recovery in its current meaning appears for the first time in a UK policy document in 2001 entitled The journey to recovery: The government’s vision for mental health care. However, guidelines published in 2002 in the UK by the National Institute of Clinical Excellence on outcomes related to recovery from schizophrenia were written from the perspective of clinicians without reference to any definitions by consumers or any acknowledgement of the importance of concepts such as hope or personal control. At the time of writing the authors stated that “... a clear policy and implementation process for England is not yet present ...” (p.118) and call for a move away from the deficit model towards one based on strengths and personal control.

In Israel as well there has been a move from psychiatric hospitalisation to community-based rehabilitation services that has been legislated since 2001. The key changes both inside and outside of Israel that led to this move are identified as de-institutionalisation, a shift from the medical model to the social model, the consumer movement, new legislation and the emergence of the concept of recovery in psychiatric rehabilitation. However, the authors identify many barriers to the implementation of the proposed reforms that have only been partially accomplished. These barriers include, among others, the continuing stigma of mental illness with its accompanying fear and lack of belief that a person diagnosed with a mental illness can experience improvement and recovery; the pervasiveness of the paternalistic and pathology-oriented medical model; and the continuing
disruption caused by ongoing wars resulting in a strong military influence favouring an institutional orientation.

Ramon (2009) adds to this overview of international perspectives of recovery by including the United States, New Zealand, Italy, European post-Communist countries, Africa, Asia and Latin America. She notes the role of lived experience in the policies and service delivery of countries like Australia, UK, Canada, New Zealand and the United States; changes that she states indicate the shift in the recognition of user experience to sit alongside professional knowledge. Despite this aspect of change, Ramon also comments on the continuing dependency in the same countries on the use of psychiatric medication as the preferred intervention mode and a continuing dependency on the medical model. In European post-Communist countries, Ramon reports some moves towards de-institutionalisation and consumer participation but notes that these are happening alongside the use of poor quality institutions and a lack of political interest in mental health. Similarly, while the mental health services of developing low-income countries in Asia, Africa or Latin America are following in the direction of de-institutionalisation, they also continue to be dominated by medically oriented institutions and governments who remain disinterested in mental health reform.

Barker & Buchanan-Barker (2011b) refer to the influence on the notion of recovery in the Unites States, of the American Declaration of Independence that emphasises self-determination. In comparison, they state, the concept of recovery in New Zealand favours social support and pro-cultural factors, being strongly influenced by respect for cross-cultural dialogue. Slade et al (2008) assert that the understanding of recovery in Australia is heavily influenced by the literature from the United States, Canada and New Zealand, with little reference to European contributions. In their comparison of the policies and practices in recovery in Australia and German-speaking Europe, Slade et al comment on the Western individualised notion of recovery and question its relevance to indigenous populations. They also note that some non-English speaking countries do not have an equivalent term and have adopted the English word “recovery” rather than attempting to translate it. Barker &
Buchanan-Barker (2011b) believe that major differences regarding the understanding of recovery still exist on an international basis despite the attention received over the past twenty years.

### 3.1.3 The challenges of policy to practice

Despite government endorsement of the recovery paradigm in the mental health field on a global level, the realities of service provision and practice appear to indicate that official commitment to and articulation of an ideology does not automatically result in the transformation of a health care system. Ramon et al (2009) hold hopes for the move to a recovery-oriented approach, believing it contains the potential for transformative change in mental health service delivery. However, they also note the realities of existing systems internationally that continue to adhere to the dominant medical hegemony and a regime of medication as the primary intervention. Writing in 2007, Ramon et al noted that there was still much to be done before mental health systems “emerge from the ‘chronicity paradigm” (p.119), needing to actualise changes in attitudes and practices in order to truly reflect a consumer focused, recovery-based orientation. Likewise, Davidson, Brophy & Campbell (2016) note the skepticism with which some service-users view the translation of policy into practice stating that little guidance has been provided about what these mandated frameworks mean in practice. A lack of guidance about the implementation of “positive-sounding policy” is a key message also of Shera & Ramon (2013) in their review of policies and policy implementation in England and Canada. They cite examples of practice across the UK and Canada identifying outstanding issues that are yet to be addressed including more emphasis on the social determinants of mental health, more attention on primary health care, the need for educational institutions to modify training for key health professionals and increased opportunities for exposure to recovery-oriented practice.

The embedding of recovery principles into public mental health service delivery to create transformative change entails an unavoidable encounter with bureaucracy. The enormity of such a task is discussed by Hopper (2007) who states that institutional reform “inevitably involves a reckoning, a sorting out of competing
versions of allegedly shared assumptions, and their selective translation into practice and policy” (p.868). He notes that the “institutional imprint” of the recovery movement remains weak despite the high hopes it brought of transformative change. He describes the disappointments and frustrations of converting “flaccid doctrine into useful guidelines and tools for public mental health” (p.868) when they “go up against the demands of mass production” (p. 872). Hopper points out that the exercise of renaming old practices with the nomenclature of recovery could be seen as a strategy to avoid fundamental questioning of current power structures, a point noted previously by Shera & Ramon (2013).

Tilly & Cowan (2011) note the apparent tokenistic acceptance of recovery values and principles among some mental health providers leading to a call for the medical model to be more assertively challenged. An exclusive commitment to the medical model is viewed as a barrier to the successful implementation or inclusion of a recovery-oriented approach to mental health. A focus on the lessening of psychiatric symptoms alone results in a reductionist view of the individual that ultimately impedes the potential for recovery. However, they also refer to emerging calls for the medical model to be seen as an essential component of recovery rather than in opposition and inconsistent with recovery principles. These authors assert that for implementation to successfully proceed, discussion is required about the tensions that exist between the medical model and a social model of recovery.

Both Tilley and Cowan (2011) in their discussion of recovery in mental health policy in Scotland, and Hopper (2007) writing in the United States, draw on the work of Jacobson (2004) who in her examination of recovery policy development in Wisconsin identified three stages – recovery-as-ideology, recovery-as-policy and recovery-as-politics. Australia is certainly in the phase of recovery-as-policy as indicated by the number of formal government documents. It is less clear however, the extent to which Australia has progressed to the phase of recovery-as-politics which Tilly & Cowan describe as the implementation of policy in practice, service development and associated funding (p.97). In a similar vein and writing at an earlier time in 2000 in the United States, Jacobson & Curtis (2006) state that questions
raised by the introduction of a recovery focus begin with problems of how to study and measure recovery but end in problems of politics and values, reflecting society’s attitudes to assisting people with a psychiatric disability.

3.2 The organisational context – inpatient care

Healy (2005) and Payne (2005) note the impact of the organisational context of the workplace on practice and Gardner (2006) states that the organisation as much as the worker is constantly interacting with and being influenced by the broader context in which it exists. The organisational context in which this research was undertaken is that of the acute inpatient unit. This context is strongly impacted by the dominant biomedical discourse that is now under challenge by the introduction of recovery-oriented practice. Borg & Kristiansen (2004) caution against viewing recovery practice within a “contextual vacuum” and refer to influential contextual factors such as what is meant by “being professional”, the environmental conditions, economic structures and the arenas where consumers and practitioners meet (p.504). This theme is strongly supported in Bowyer et al (2010) in a call for research to investigate the links and interrelationships between factors such as the social, cultural, therapeutic and psychiatric contexts in which individual recovery is to take place. Moving from the broader context of national and international mental health policy, the following section focuses on the specific organisational context in which the research took place – the mental health inpatient unit, beginning with a discussion of the role of inpatient care.

3.2.1 The role of inpatient care

The role of inpatient care is under scrutiny as the concept of de-institutionalisation and a move to community-based services is seen as the preferred mode of mental health service delivery. In Australia the NSW Mental Health Commission’s (2014) Living Well document notes that the historical underspending on community services has in part been due to the hospital system remaining “such a powerful centre of gravity”, taking funds from other areas of care (p.5). The report views hospital care as one part of a good mental health system to be utilised only when specialist inpatient care and support is indicated and not because of the absence of more effective community services. The report calls for hospital care to be seen as
the last resort and not the “front door for mental health services” (p.56). Likewise the Australian *Fourth National Mental Health Plan* (2008) notes that while there has been a move from bed-based mental health care to a community-based system, there is recognition of the vital necessity of access to inpatient care during the acute phase of some illnesses. The lessening of reliance on inpatient care is a theme throughout many of the Australian policy documents but none call for the total elimination of this mode of care, instead appealing for reforms to the way in which it is delivered.

In a discussion about the nature of care in modern inpatient psychiatric facilities, Casher (2013) outlines the principles and goals determining inpatient care. These include: review and integration of psychiatric/psychological/medical data for the purpose of diagnosis and treatment; continuity of care and co-ordination with outpatient treatment; the provision of a multidisciplinary team approach; and inclusion of the person’s support system. He then goes on to describe the inpatient environment as providing refuge, asylum and respite; care and nurturing; safety, stability and containment; and activity and engagement (p. 182). Casher integrates the notions of D.W. Winnicott, a noted pediatrician in the first half of the twentieth century, who coined the terms “holding environment” and “good-enough mother”. Casher applies these notions to the psychiatric inpatient environment stating that they:

... add clarity and nuance to the notion of a hospital patient as a person in crisis, temporarily residing in a highly structured therapeutic environment and embedded in a matrix of therapeutic relationships with unit staff, including his or her psychiatrist, the assigned nurse, the social worker working with the patient and family, and other inpatient staff. (p.182)

The notion of “holding environment” refers to an infant’s total dependency on the environment for the satisfaction of basic needs. Likewise, according to Casher, an acutely unwell person on admission to an inpatient unit is in a position of heightened dependency on the unit staff, referring to the role of an inpatient unit as providing respite, refuge, safety and care. Holding is part of a process that ultimately leads to
an integrated sense of self and an ability to relate to others. Casher again relates this to the experience of inpatient admission, stating that an acutely unwell person may use the hospital’s holding environment to provide respite before a gradual re-entry to the outside world. This concept is similar to the notion of “secure base” found in attachment theory. Casher calls for an awareness of this notion to form part of discharge planning to ensure at least some of the hospital’s holding functions are replicated in the formal and informal care systems of the receiving community.

While Casher (2013) questions whether or not the likening of Winnicott’s concept of “good-enough mother” to “good-enough hospital unit” is somewhat fanciful, he nonetheless points out a number of similarities. Good-enough mother is a term that relates to a mother’s (not necessarily the biological mother’s) ability to actively adapt to the infant’s needs as they change in line with the infant’s ability to tolerate frustration and his/her ability to account for failure of adaptation. Similarly, Casher notes that inpatient care can be viewed as a temporary substitute caregiver that meets the patient’s changing needs as he/she moves from acute illness to a more reality-focused understanding of the illness and need to deal with the issues of life.

Casher (2013) uses Winnicott’s notions to emphasise to staff working in an inpatient environment the importance of being aware of the complexities of the relationships between themselves and persons admitted to the units. He states that “patients do not exist in a vacuum” (p.187) and uses Winnicott’s concepts to emphasise the significance of understanding the interaction between a person’s experience as an inpatient in a mental health unit and their mental health well-being. Understanding this will ensure that treatment goals, discharge plans, adaptation to the inpatient environment and the responsiveness of the environment to the person’s needs are taken into account to maximise the therapeutic values of an inpatient experience.

3.2.2 The legal context of inpatient care
The phenomenon of inpatient care is overlaid by the forces of a legal context that cannot be ignored in a discussion of its role within mental health services. It is this factor that often creates a conundrum for health workers in this setting who are
committed to working within a recovery framework. In Australia, as in many other countries, legislation exists to enforce admission and treatment on those who are deemed to be experiencing symptoms of a mental illness, are at risk of harm to themselves or others and for whom containment in a place of least restriction (in some cases hospitalisation) is considered the only option to restore their well-being. In many places, including Australia, the enforcement of treatment actions can extend beyond the imposed custodial care into post-discharge treatment. The granting of Community Treatment Orders places conditions on the person being discharged to comply with a prescribed medication regime overseen by community mental health staff. This has resulted in the creation of the term “imposed recovery” (Young 2011). Those detained against their will or who are the subject of enforced medication treatments through the legal process are faced with limited choices and opportunities for self-determination, as well as experiencing an affront to their autonomy. Significant decisions like length of stay for an admission are out of the individual’s hands and can result in a sense of powerlessness and helplessness. This in turn impacts on the maintenance of hope and optimism, key factors in a recovery approach.

McKenna et al (2014) articulate the conundrum in their article outlining a case study example of recovery-in-action in a secure mental health service in Australia. The authors note the challenges associated with adhering to practice informed by a recovery framework within an atmosphere of enforced containment. They refer to the service adopting a recovery mindset, developing a “self-professed” recovery-oriented model of service which includes the belief in the service’s ability to support “consumers to live well in the presence and/or absence of their mental illness, with the goal of a ‘good life’ once discharged” (p.64). This research was undertaken with consumers, staff and carers and revealed the importance of engagement with consumers from the point of admission in order to develop trust and a culture of hope. While choice was recognised as being limited in this setting in which individuals are involuntarily contained, flexibility was seen to be vital within these limitations. Consumer choices were acknowledged regarding such things as the type and dose of medications and preferred group activities, while staff focused on the strengths of
each individual with whom they were working. Involuntary care by its nature can be described as antithetical to recovery-focused practice. However, according to these authors, with a common vision informed by the principles of recovery there are ways in which clinical care, even within this restrictive setting, can reflect recovery principles. On a similar note Ramon (2011) describes the establishment of recovery-oriented practice in an acute admission ward as “a bold way in which to implement recovery practice” due to the high level of control and the focus on risk avoidance. Despite this, Ramon notes that within this environment it is likely that consumers and their carers are receptive to positive interest and attention and therefore more open and ready for change (p.42).

3.2.3 The experience of inpatient care
Historically descriptions of the inpatient environment found in the literature are cloaked in exceptionally negative terms. Quirk & Lelliott (2002) referred to research at the time of writing as painting a picture of life on psychiatric wards that is “unremittingly bleak” (p.344). In a related article Quirk, Lelliott & Seale (2004) report on studies from the seventies to the nineties that described inpatient wards as anxiety-inducing environments where patients were exposed to risks such as loss of personhood, medical disempowerment and violence from other patients. Deegan (1999) refers to the “myriad of micro-aggressions” that she observed on a daily basis within a hospital ward. She was referring not to the risk of violence from other patients, but the practices of mental health staff including take-downs, restraint, seclusion and the forced use of medications. Holmes (2002), writing in the United Kingdom put forward the case for more extensive use of psychotherapy in acute psychiatric wards in order to counter what he saw as the risk of the wards being not so much un-therapeutic as anti-therapeutic, where custodial rather than therapeutic values took precedence. This environment, he asserts, has as much a negative impact on the patients as it does on the staff. These sentiments are echoed by Slade (2009a). He refers to numerous studies that confirm hospitalisation as a negative experience, although the safety net function of hospitalisation is recognised. According to Slade the challenge is to make the hospitalisation safety net “springy rather than saggy” (p.183).
More recently, Bartholomew & Kensler (2010) comment on state psychiatric hospitals in the United States as continuing to use methodologies that predate evidence-based practice and recovery principles, including an emphasis on custodial measures and the use of medication – characteristics of a biomedical model. They note that a significant barrier to the introduction of the recovery model within inpatient settings is the existence of a “pervasive culture of custodial care and control” (p.123). This is supported by Tsai & Salyers (2008) also writing in the United States who describe hospitals as using methods that predate the recovery movement including coercive measures to manage disruptive behaviours and symptom focused treatments. Nolting (2010) states that there is still a role for state hospitals in the United States to provide care for those whom the community is unable to care for. He refers, however, to the contradictions inherent in the wording of state policies that put patients at the centre of mental health care when this is clearly not the primary concern of the bureaucracies that run the hospital system.

In a report by the Sainsbury Centre for Mental Health (2006) in the UK, acute inpatient units are noted as being places of last resort when all else fails. The report vividly describes the inpatient environment:

> We admit people at their most distressed into an environment that would be hard for anyone to cope with: a poor environment with many other distressed people, sharing a dormitory with strangers, mixed wards, being watched, liberty removed, loss of autonomy, no information and boredom. There is a vicious circle: because acute inpatient care is not valued as a positive intervention it leads to low expectations of its outcomes, and because it is often a negative experience for service users it is not highly valued. (p.84)

The report identifies previous research on the experience of inpatient care in the late 1990s and early 2000s in which service users had described inpatient care as “unsafe, inhumane and un-therapeutic” (p.9). The authors call for greater clarity about the role and function of inpatient care, stating that there continues to be an expectation on this form of care to fulfill the role of harm prevention and risk
management on behalf of society as a whole rather than on the individual’s recovery. The report highlights the apparent incompatibility of recovery-focused ideals and the reality of inpatient care with its focus on compliance and control.

One study that does explore the voices of consumers who have experienced mental health inpatient care is by Stenhouse (2011) in Scotland. He reports that patients were encouraged to ask for help and held high expectations of receiving help during their inpatient stay through talking to nurses. Their experience however, was that the responsibility of asking for help was incumbent on them, as nurses were too busy to talk. Instead, patients turned to each other for help. While this was reported as being generally helpful, some found this added to their emotional burden. The author concludes that while a strong nurse-patient relationship is pivotal to a positive inpatient stay, the findings of this study indicated a dissonance between the patients’ expectations and their actual experience of receiving help.

Somewhat countering the overwhelming negative descriptions of inpatient care, a qualitative study by Walsh & Boyle (2009) from Northern Ireland explored consumer experiences of mental health inpatient services and revealed the existence of positive perceptions of hospital. Consumers described the inpatient setting as a safe place where fellowship can be found to combat isolation, activities enjoyed and where some staff have good qualities (p.36). However, other themes revealed by this study were consistent with the negative perceptions of the preceding studies including boredom on the units, poor communication with staff, lack of information and a valuing of hospital routines over patient needs. Positive perceptions of hospital experiences are often referred to as an aside or as a false-positive. As an example, the UK report from the Rethink Series by Ajayi et al (2009) recounts consumer experiences of hospitalisation as “a necessary evil” or “an immensely sobering experience” (p.21).

Nolting (2010) along with Quirk et al (2004) refer to the emphasis on risk within hospital settings that diverts the focus of care from a recovery approach. Quirk et al (2004) describe this as the trend to re-articulate mental health work into the
language of risk. Nolting (2010) believes the management of risk has meant accountability has come to mean more about keeping allegations of neglect and misconduct out of the media rather than focusing on patient improvement.

Further inpatient experiences of consumers are related in a book edited by Weinstein (2010). These stories mirror the negative descriptions of the preceding accounts. Words and phrases utilised by consumers in these descriptions include “terrified”, “humiliated”, “no-one listened to me” (p.106), with one person stating that the fear experienced during an admission to an inpatient unit was more related to the prospect of coercive treatment by staff than to the prospect of being assaulted by another patient. This aligns with the previously noted comments from Patricia Deegan (1999) about the “myriad of micro-aggressions” she witnessed in an inpatient setting.

3.2.4 Inpatient care and recovery-oriented practice

The issue raised by the literature on this aspect of the research topic is the questioning of the ability of mental health inpatient services to provide care that is aligned with recovery principles. This is an issue taken up by a number of authors. The study conducted in the United States by Tsai & Salyers (2008) surveyed hospital and community mental health staff to gauge their levels of personal optimism, consumer optimism and the recovery orientation of the agency. The results indicated that staff at state hospitals scored significantly lower on all three levels. The authors note the difficulties that hospital staff have in accepting ideas of recovery compared to community staff who are more exposed to consumers living independently and experiencing success. They state that little is known about the extent of recovery orientation in a hospital setting but draw attention to the importance of fostering a recovery perspective in an acute phase of a mental illness. The authors highlight the importance of a recovery orientation in any mental health organisation but emphasise that the hospital environment has a wider gap to address in order to adopt a recovery mindset. Smith & Bartholomew (2006) believe that hospital staff lack exposure to recovery principles and so remain naïve about the potential of patients. They see the hierarchical administration structures of a
hospital setting and the normal/abnormal dichotomy promoted in hospital practices as being inconsistent with recovery principles. While describing the care provided within a hospital setting as being medicalised and in a one-way direction with little or no input from the patient, the authors do acknowledge the central role that medical care has within this setting. The authors describe the hospital model and the recovery model as needing to blend together requiring the hospital to relinquish the social control focus to one of client-centred empowerment. They assert, however, that few staff within a hospital setting are trained in this kind of practice that changes the client role from one of patient to person. The authors note that while many psychiatric institutions use the rhetoric of recovery in mission statements and policies, their practices are still firmly grounded in a focus of custody and control.

Longo, Marsh-Williams & Tate (2002) echo the previous authors in saying that inpatient services have not been able to sustain a focus on rehabilitation and recovery. They state that progress within a hospital setting is rated according to how well the patient conforms to hospital rules and medication compliance. According to Longo et al (2002) the changes required by inpatient settings to comply with a recovery approach constitute a “cultural transformation” (p.207) and they acknowledge the barriers to this transformation in the form of staff fears. These fears include anxieties about relinquishing control, fears that patients will be unable to tolerate increased participation in decision-making and fears of chaos and increased aggression within the ward environment.

In a similar vein, Andresen et al (2003) and Swarbrick & Brice (2006) state that the hospital context is not conducive to progressive ideas or consumer friendly policies. They assert that the medical model often augments illness rather than promoting recovery by ensuring a focus on deficit and incapacity rather than individual strengths and goals. In the Swarbrick & Brice study consumers reported that they were not exposed to any recovery resources during their hospital stay. The authors believe that recovery needs to start at the hospital level reporting on the challenges of implementing a consumer-led project within state hospitals in New Jersey in the United States. Caldwell, Gill, Fitzgerald, Sclafani & Grandison (2006) agree with
Longo et al (2002) that the change from custodial care to recovery-focused practice for hospitals requires a “multidimensional organisational process” and call for staff to receive appropriate training to obtain the skills and knowledge necessary to ensure collaborative partnerships with individuals on their recovery journey (p.112).

More recently Wyder et al (2015) reported on the experience of twenty five involuntary inpatients in an Australian acute inpatient setting. They note that the context of acute mental health inpatient care can be seen as oppositional to recovery approaches revealing competing perspectives and tensions such as the notion of dignity of risk versus risk aversion and autonomy versus involuntary treatment. Structural barriers such as short admission, scarcity of resources and increasing administrative duties are also unfavourable to the development of therapeutic relationships. They conclude however, that a balance can be struck between these apparent competing perspectives by the use of empathic engagement and a focus on treatment decisions that enhance capacity.

The literature search initially revealed few consumer-oriented studies of mental health inpatient experience within Australia. Horsfall, Cleary & Hunt (2010b) describe inpatient services from the perspective of admissions data and the skills required by nursing staff to meet the needs while Cleary et al (2013) report on nurses’ perspectives of recovery-oriented practice. Happell (2008 a&b) provides a consumer perspective of the routine outcome measures used in mental health services but does not present a picture of inpatient experience. Glover (2009) talks about services that reinforce an “illness saturated identity” for consumers but does not specifically single out the hospital environment. Roberts, Crompton, Milligan & Groves (2009) looked at one aspect of hospital care - the use of seclusion in an acute mental health facility - and noted that while consumers perceive the practice of seclusion as non-therapeutic, staff perceptions viewed the practice as appropriate and potentially therapeutic. Tooth et al (2003) highlight the existence of other differences in the perceptions of health professionals and those of consumers in regards to an understanding of the notion of recovery. The authors call for a greater focus on consumer stories to validate personal experience of mental illness, in this
case schizophrenia, as the way to progress individual recovery. This call is starting to be heeded now with the work of Wyder et al (2015) and Wyder et al (2013) contributing an understanding of the experience of inpatient care from a consumer perspective.

It is clear from the literature regarding the context of inpatient care that there are many challenges to be faced to ensure the successful implementation of recovery principles into existing inpatient mental health care delivery. It appears that consumers generally experience inpatient care as negative. The notions of recovery are minimal or absent despite the critical role that an acute inpatient admission has in the spectrum of mental health care and despite the rhetoric of guiding policy documents in promoting recovery principles as the driving force in the delivery of this service. Social work is a key discipline within the multi-disciplinary team that makes up the professional component of this service and it is a profession that shares the values and principles of the recovery movement. The role of social work within this setting is now discussed in the following section.
CHAPTER 4 - Social Work and Recovery-Oriented Practice in Mental Health

4.1 Social work principles and values and the recovery movement

The profession of social work is based on internationally agreed principles. The following definition was approved in July 2014 by the International Federation of Social Workers (IFSW) and International Association of Schools of Social Work (IASSW) at the General Assembly.

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. (“Global Definition of Social Work,” 2016.)

This definition is based on the overarching principles of social work including the inherent worth and dignity of human beings, doing no harm, respect for diversity and upholding human rights and justice. In a similar vein, the principles of social work that are outlined in the Australian Association of Social Workers (AASW) Code of Ethics (2010) include acceptance of the uniqueness of individuals, belief in collaboration and individual choice, valuing diversity and difference and engagement in participative and empowering processes to enable clients. For social workers the parallels between their professional values and principles and those of the recovery movement are undeniable, creating a feeling of familiarity and comfort with the language of mental health recovery. The similarities are striking when placed in a Table that directly compares the language underpinning the values and principles of both the social work profession and of the recovery approach to mental health care – see Table 4.1 (Hyde, Bowles and Pawar 2014, p. 11).
Table 4.1 Social Work and Recovery

<table>
<thead>
<tr>
<th>Social Work</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self determination</td>
<td>Self determination</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Empowerment</td>
</tr>
<tr>
<td>Acceptance and uniqueness of individuals</td>
<td>Personal meaning, expert by experience</td>
</tr>
<tr>
<td>Collaboration &amp; participation</td>
<td>Collaborative relationships</td>
</tr>
<tr>
<td>Identifying and developing strengths</td>
<td>Strengths</td>
</tr>
<tr>
<td>Respect for inherent dignity, worth and autonomy of every person</td>
<td>capacity to live a full and meaningful life of their choosing</td>
</tr>
<tr>
<td>Respects the human rights of individuals and groups</td>
<td>Upholding of human rights</td>
</tr>
<tr>
<td>Fosters personal/social responsibility</td>
<td>Focusing on strengths and personal responsibility</td>
</tr>
<tr>
<td>Hope giving</td>
<td>Hope and optimism</td>
</tr>
<tr>
<td>Reflective awareness as part of professional integrity</td>
<td>Staff to engage in reflective practice</td>
</tr>
</tbody>
</table>


Slade’s (2009) table included previously on page 29 clearly showed the differences between the traditional approach to mental health care and the recovery approach. Due to the alignment between social work and recovery principles as shown above in Table 4.1, the differences between social work and the traditional approach to mental health practice are similarly exposed. This indicates that social work practice in mental health is at risk of being viewed as at odds with exponents of the traditional approach.
The Practice Standards for Mental Health Social Workers published by the Australian Association of Social Workers (AASW) in 2014 outlines five of eight components of social work practice relevant to mental health. This document was developed in conjunction with the AASW Code of Ethics (2010) and the general AASW Practice Standards (2013). The mental health specific document calls on social workers to adhere to recovery principles, to engage in a biopsychosocial approach and to understand the impact of illness on a person’s sense of self. Recognising the role of the biomedical approach, Standard 4 covers knowledge for effective practice including the requirement to possess knowledge of mental health psychopathology incorporating psychiatric classification of illness.

Given the close interweaving of social work and recovery values and the position of social workers as part of the multi-disciplinary professional team within the inpatient setting, a presumption may be made that a move to recovery-oriented practice could be facilitated with some ease. As noted throughout the literature, however, this move is fraught with challenges.

4.2 The invisibility of social work in the mental health field

One of the observations made while initially conducting a literature review for this research was that few documents that were sourced via searches using the terms “recovery” and “mental health” yielded articles authored by social workers. Despite the close alignment between social work principles and those of the recovery movement, it appears that social work has not been at the forefront of the change to recovery-oriented mental health practice as evidenced by the limited social work contributions at the time to both the social work specific literature and the wider mental health literature. The introduction of a recovery approach in the field of mental health holds great potential for the role of social work. It legitimises a language and value base familiar to the profession that previously had been marginalised and subsumed within the dominant language of the biomedical discourse. This is the language of strengths, rights, personal meaning, collaboration and empowerment.
The invisibility of the social work profession within the debates about recovery-oriented practice in mental health was brought to the fore by a comment in Slade et al (2008) in which ten principles of recovery-focused practice were identified through a consensus based approach in the United States:

Self direction
Individualised and person-centred
Empowerment
Holistic
Nonlinear
Strengths-based
Peer support
Respect
Responsibility
Hope

The following statement was then made:

It will be challenging for mental health services to develop these characteristics, many of which are not central to the professional training of any mental health group (p. 131) (emphasis by author)

This is remarkable for a mental health social worker to read whose clinical training was embedded with “these characteristics”. Indeed, the introduction to mental health of the notion of strengths-based practice, one of the ten principles of recovery as noted above, has been attributed to social work (Ramon 2009). Elements of strengths-based practice include belief in the person, a focus on their hopes and visions, affirmation of the person’s narrative as well as an account of the assets, resources and capacities of the person (Saleebey 2000). According to Xie (2013) the strengths-based approach aligns well with mental health recovery principles as it focuses on the person’s abilities rather than their shortcomings, symptoms or difficulties (p. 6).
Ramon (2009) writing in the *British Journal of Social Work*, acknowledges that while social workers have been responsible for some of the changes in mental health practice, such as the introduction of a strengths approach and the inclusion of service-users in policy-making, the invisibility of social workers in the move to recovery-focused practice in mental health is noted. She states:

While recovery should have been a natural domain for social workers, given its psycho-social and self-determination emphasis, relatively few UK social workers are in the forefront of recovery work. (p. 1620)

Ramon adds that social work’s reluctance to engage in research is a weakness of the profession as a whole, but one that has resulted in its lack of influence specifically in the mental health field. Ramon et al (2009) reiterate this concern and add that social work perceives itself as being less powerful than other professions in the field of mental health. They call for further research to explore the obstacles and opportunities for social workers to engage in the formulation of recovery policy. Interestingly these authors in describing the UK experience, comment that mental health social workers assume they practice within a recovery focus of knowledge and skills due to the stated similarities between recovery principles and social work principles. In reality, however, they need to move away from pathologising and patronising approaches inherent in their work. The authors believe it is the role of social work education to address the specific skills required to work from a recovery approach.

The use of pathologising and patronising approaches by social workers as noted by Ramon could be viewed as an example of “silencing” (Dotson 2011). Dotson proposes that silencing is a form of epistemic violence and exists in two forms – testimonial quieting and testimonial smothering as noted previously. Testimonial smothering occurs when marginalised groups edit their communication in order for it to be heard and accepted by the dominant group, especially if the content is seen to be challenging prevailing opinions. Within a medically dominated environment
such as the inpatient setting, there is a risk that both consumer voices and social work opinion are silenced and marginalised. Perhaps feeling less powerful in the mental health field results in a situation where social workers are vulnerable to engaging in testimonial smothering in order to gain legitimacy and to be heard. This is demonstrated in a study in the United States by Probst (2012) investigating the relationship between psychiatry and social work. She states that despite being the largest group of mental health professionals in the USA, social workers occupy a subordinate role to psychiatry. As the clientele are required to have a psychiatric diagnosis in order to access treatment, mental health social workers are compelled to utilise psychiatric language to frame client problems and goals. This creates a dilemma for social workers “who may have to balance dissonant values reflecting the medical world view of psychiatry and the more contextualised and humanistic view of their ‘home’ profession” (p. 368).

4.3 Impact of the biomedical model on social work practice

Healy (2005) commences her analysis of social work with a discussion of the dominant discourses impacting on social work practice. She distinguishes three dominant discourses embedded within health and welfare institutions in Australia each impacting on the way in which these institutions constitute client need, social service provision and the social work role within them. These discourses are named as biomedical, neo-classical economics and law. Modernist notions of rationality, objectivity, logical analysis, measurable outcomes and scientific truth are embedded in the three dominant discourses in varying degrees. According to Healy, the biomedical discourse is one of the most powerful influences on the context of social work practice. She particularly names hospitals, rehabilitation services and mental health services as contexts most shaped by the biomedical discourse.

Morley (2003) in her critical analysis of social work practice in mental health, condemns social work’s alignment to medical constructions of psychiatric illness. She notes only a minority of social work literature explicitly acknowledges the limitations of the biomedical model of mental illness and instead demonstrates a
valuing and unquestioning acceptance of the modernist assumptions inherent in the biomedical model (p. 67). She calls for a deconstruction of the biomedical model as part of a critical social work approach and alerts social workers to the “blame-the-individual” notions inherent in a biomedical perspective of mental illness as a deficit of a person’s brain. This serves to de-politicise social causes and perpetuate both social control and social inequities resulting in stigma and discrimination.

Thompson (2002) also notes the significantly disempowering effect engendered by the medical model as a major feature of social work practice in mental health. He outlines three problematic implications of this:
- Power is invested in the medical profession that doesn’t necessarily have the skills to deal with complex psychological problems or understand the sociopolitical context in which they occur
- Treatments or remedies are presumed to lie with the expert health professionals thus undermining self-determination and authenticity
- The focus on biological determinants of illness fails to account for the social and cultural factors thereby increasing the risk of perpetuating existing patterns of discrimination (pp. 290-291).

The alignment between the values and principles underlying social work as a profession and those of the recovery movement in mental health are strikingly similar and should lay the ground for active contribution on the part of social workers to the transformation of mental health services through both research and action. Sadly this does not appear to be so with accounts of social work practice capitulating to the dominant biomedical discourse (Morley 2003; Probst 2012).

Ramon et al (2009) refer to the potential that exists for social work to act as a catalyst for much needed change in mental health service delivery across four countries – UK, Australia, Canada and Israel. This role for social work was also recognised earlier in Canada by Shera (1996) who noted the profession’s potential at that time to provide leadership in the field of mental health rehabilitation. Starnino (2009), writing in an American context, also notes the similarity between the goals
and values inherent in the recovery model and those of social work as does Loumpa (2012) who notes “the common ground” between social work and the recovery paradigm. Starnino promotes the need for clarity about recovery as a concept and states that social work is in an ideal position to take “a lead role in embracing an integral understanding of the mental health recovery concept” (p. 838).

The notions of lived experience and the centrality of relationships are central themes in Bland, Renouf & Tullgren’s (2015) book “Social Work Practice in Mental Health” where the similarity between the recovery approach and social work principles is noted along with the potential for social work to inform broader mental health practice. The authors caution against being caught up in the perception that a critical approach in mental health social work is a binary opposite to a clinical approach, resulting in social workers having to choose between being relevant or being critical. They believe the challenge for mental health social workers is to be both relevant and critical (p. 13). The literature emerging in the last decade indicates that social work is beginning to voice a stance and take a more active role in effecting change in mental health practice.

**4.4 Recent social work contributions to discussions of recovery in mental health**

Recently there has been a growing recognition of social work’s role in the move to recovery-oriented practice in mental health service delivery. At least three international social work journals have dedicated a special issue to the subject in 2014 and 2015. These include *Australian Social Work, Asia Pacific Journal of Social Work and Development* and the *British Journal of Social Work* indicating a move towards the showcasing of social work research and critiques of the recovery movement. These issues reveal articles written by social workers on aspects of recovery such as social work’s role in mental health, family needs, involuntary treatment and the recovery approach, alternatives to traditional medication treatments and social work’s contribution to a recovery focus through the use of strengths-based practice in mental health.
The international move to recovery-oriented approaches in mental health service delivery emphasises social factors rather than medical interventions as the main determinants of recovery – a perfect opportunity for social work to take the stage in aspects of recovery-oriented practice. Tew (2013) notes that this focus on social factors in mental health care is yet to be reflected in social work practice, that he states is still dominated by biomedical perspectives. He believes that social work buys into traditional mental health practice that views the person as a passive recipient of care and emphasises reactive approaches such as risk management. Tew proposes a “paradigm shift” for mental health social work to focus on social and other forms of capital, thus building a theoretical framework around recovery that is based on social science rather than illness models and medical interventions (p.362). His notion of “recovery capital” provides a conceptual foundation from which to develop new ways of assessment and understanding of mental health difficulties. While he speaks of the need for a “paradigm shift” in social work practice to reflect recovery capital, one is left wondering what happened to the foundational principles of social work that have always positioned the person in his/her social context. Perhaps Tew is calling for a return to a paradigm that is true to foundational social work principles and which in turn reflects recovery principles.

Wyder & Bland (2014) compare the recovery journey of family members with that of the person with lived experience, noting similarities and differences. They state that working with families is a key area of practice for mental health social workers and suggest that recovery theory offers new ways of identifying families’ needs beyond that of a potential support role for the consumer. They separate out five dimensions of recovery for family members that are relevant to social work practice. These include the importance of maintaining hope, overcoming secondary trauma, the journey from carer to family, self-determination and the relational basis for recovery (p. 189-190). Once again inherent in this article is a call for social work to return to what is a traditional focus of practice – working with families – but with an understanding of a family perspective of the recovery journey.
A book published in the United States, *The Recovery Philosophy and Direct Social Work Practice* (Walsh 2013), is devoted to the link between social work practice and the recovery philosophy. The book examines ways in which the social work profession “can operationalise its value base” in working with persons diagnosed as having a mental illness (p. 3). Walsh proposes a professional practice model for social workers describing the book as a practical guide.

Chapter three of Walsh’s book examines the alignment between social work practice and the recovery philosophy. Walsh’s discussion in this chapter highlights such issues as strengths-based practice. He sees this practice stance as assisting to counter the deficit-focused approach perpetuated by medically oriented services and those systems in which people with a mental illness become involved, such as managed care and insurance companies’ medically based reimbursement criteria. According to Walsh, a strengths perspective forms part of a risk and protective framework for social work practice. Social workers can recognise and validate strengths with consumers as protective factors to mitigate risks, a balance that will assist the consumer to function adaptively.

Walsh (2013) also calls for recognition of the importance of cultural factors in the understanding of the causes and consequences of mental illness. He promotes the significance of an empowerment orientation for social workers to combat the stigma, isolation and alienation experienced by many people living with a mental illness. Finally, Walsh includes the notion of spirituality as critical to understanding the recovery process. He sees spirituality as a search for meaning-in-life whether that is viewed in a religious context or in the context of uniquely individual searches for personal meaning (p. 53).

Walsh (2013) goes on to propose a social work model of recovery practice which he states is similar to clinical case management but with the added emphasis on partnering with consumers to attend to their needs in a holistic way. He draws on a biopsychosocial approach within a stress-vulnerability model that focuses attention on the quality of the relationship between consumer and social worker. Walsh
concludes his book by calling to social workers to be active in the policy-making arena to ensure that recovery principles become a permanent part of good practice.

An ongoing challenge, according to Walsh, is the continuing assumption within the public mental health system that mental illness is primarily an organic, biological disease – a position that is enhanced by the high esteem in which medical sciences are held in the Western world.

Littrell (2014), a social worker writing in the United States, comments on the emerging evidence indicating the potentially negative impact of current pharmacological interventions on long-term outcomes for people diagnosed with schizophrenia. She discusses the issue of the dilemmas this raises for social workers who have a role in providing psycho-educational services. She questions how these negative aspects of medication should be conveyed to consumers and questions the narrow treatment options available for consumers due to the reluctance of doctors to change their prescribing habits. Littrell also raises the issue of the involvement of high profile pharmaceutical companies for whom large profits are made from the sale of antipsychotic drugs and who provide funding for much of the clinical research in mental health. She makes the point that under such arrangements it is unlikely that research on alternative treatments will be made available, concluding with a call for social workers to advocate for better treatments for their clients.

Further dilemmas for community mental health social workers are raised in an article by Courtney & Moulding (2014) reporting on their research conducted in Australia. They set out to ascertain how mental health social workers incorporate a recovery focus into their work with involuntary clients in risk management-oriented services. The study interviewed social workers who worked with involuntary clients in the community. These clients were subject to Community Treatment Orders (CTO) whereby individuals are required by law to adhere to a medication treatment regime. Courtney & Moulding note that the granting of such orders is in accordance with the process of de-institutionalisation that allows for involuntary treatment outside the custodial environment of a hospital setting – a less restrictive environment. However, the issue of risk management has led to an increase in the
number of these orders and concerns have been raised that treatment compliance and public protection is taking precedence over therapeutic interventions. The authors state that involuntary treatment and recovery-focused practice are viewed as oppositional with confounding implications for social workers. They seek to explore how social workers deal with this quandary.

As noted in a study previously referred to (McKenna et al 2014) in the discussion on the context of inpatient care, Courtney & Moulding (2014) found that despite expressing feelings of discomfort with involuntary care, social workers demonstrated the ability to practice in ways that were consistent with both recovery principles and social work values. They described, among other things, the use of empathic language acknowledging clients’ lived experience, of developing partnerships with the clients to enhance decision-making, building positive relationships and ameliorating resistance from colleagues towards recovery approaches. The authors conclude that it is the deficit assumptions and paternalistic attitudes towards clients that impede recovery more than the imposition of a CTO. They state that social workers play an important role in advancing a recovery approach in mental health service delivery.

An initial literature review begun in 2011 as part of this study, revealed few contributions by social workers on the subject of recovery-oriented practice in mental health. This was despite the obvious alignment between the values and principles of the social work profession and those of the recovery movement. In recent years however, social work contributions to the literature have increased. International social work journals have devoted special issues to the subject of mental health recovery and specific models of social work mental health practice are being proposed. Robust discussions are emerging about the dilemmas created for social workers adhering to a recovery focus while working within a mental health system in which coercive methods of treatment are imposed on consumers either during an episode of inpatient care or post discharge through enforced treatment regimes. Ways of understanding and working with families, a traditional focus of social work intervention, are being reviewed and enhanced through an application of
recovery principles while the use of strengths-based interventions and fundamental engagement skills are finding new meaning in the development of worker-consumer relationships. Mental health social workers, emboldened by the legitimacy and credibility afforded them by the official global stance on mental health service delivery are recognizing the potential value of their contributions in actualising this service transformation. This is the spirit in which this study has been undertaken.

The following chapters provide the details of the research undertaken, commencing with Chapter 5 that explains the framework of the methodology.
CHAPTER 5 - Methodology

5.1 Locating the study

The study was conducted on a single site in regional New South Wales, Australia. The facility has a long history of providing public health care and treatment for people with a mental illness since it opened in the early part of the 20th century. The facility has provided, and continues to provide, a mental health inpatient service to a large area of the State of New South Wales.

The hospital incorporates approximately 156 mental health beds and provides an inpatient service for a number of specialist areas. The focus of this study is on the adult acute mental health inpatient units within the facility. The total adult inpatient acute service includes an 8-bed Mental Health Intensive Care Unit (MHICU) and two units providing graded, step down care, each with 16 beds. Recruitment for this study took place in the step down unit from which people usually prepare for discharge. The choice of unit was based on the consideration that those preparing for discharge were likely to be more emotionally settled than at an earlier stage of their admission, thus in a stronger position to make a choice regarding participation and to reflect on their experiences with less chance of harm to their wellbeing.

5.2 The position of practitioner-researcher

The choice of facility was determined by the researcher’s position within the setting as the Senior Social Worker noted previously in Reflection #1, placing the researcher in the role of “practitioner-researcher”. Drake & Heath (2010) outline both advantages and disadvantages of this research position. The advantages include insider knowledge of the setting and easier access to people for the purposes of seeking permissions and the gathering of data, as well as enhanced rapport and communication. These advantages are balanced with the possible negatives that include managing the workplace politics and the impact on collegial relationships. Of most importance is the need to acknowledge that neutrality on the part of the researcher is unattainable. Instead, the stance of the researcher and his/her
embeddedness as an active participant in the research process from the position as an insider is made explicit. This calls for a reflexive approach and requires an integration of both the professional and research identities of the researcher. Drake & Heath use the term “inhabiting the hyphen” to describe the balancing of issues and dilemmas required by one who straddles the identities of both positions inherent in being a practitioner-researcher.

Finlay (2011) calls for researcher subjectivity and intersubjectivity to be prized and embraced in the research process through the use of reflexivity which she describes as researcher self-awareness. The reflexive component of this study was undertaken through the use of a reflective journal and through regular reflective sessions with the researcher’s supervisors. As well, the written reflections included throughout this dissertation explicate the subjectivity and the intersubjectivity of the research experience and locate the researcher’s role in the co-production of the findings. The position of practitioner-researcher was an important factor in the choice of methodology for this study.

5.3 The Research framework

The research framework for this study is presented using an approach suggested by Crotty (1998) and represented in the following figure:

Diagram 5.1  Adapted from Crotty (1998, p. 4)
Crotty presents this structure of the research process to incorporate four essential elements that inform and support each other like a “scaffold”, enabling a justification of the methodologies and methods used. Each of these components will now be discussed to explain the framework for this study.

5.4 Epistemology and ontology – constructionist and critical realist

Epistemology is concerned with the theory of knowledge and questions what and how we know things (Finlay & Ballinger 2006). The epistemology of constructionism rejects the idea of knowledge as produced by the discovery of objective truths that are waiting to be revealed through scientific method. Instead it holds that all knowledge and therefore all meaningful reality comes into existence through human interaction with the world – “there is no meaning without a mind” - and is therefore not “discovered” but “constructed” (Crotty 1998 pp. 8-9). The aim of research within this paradigm is to understand experience, not to reveal an objective truth (Petre & Rugg 2012). This study is concerned with lived experience and the making of meaning. It is based on a premise that knowledge production is generated through the exploration of an experience of a particular phenomenon rather than the discovery of an objective truth.

It is important here to make a distinction between constructivism and constructionism. According to Crotty (1998) constructivism emphasises the uniqueness of meaning constructed by each individual mind, whereas constructionism brings into play the collective generation of meaning recognizing the impact of culture on the way people together view the world. This study focuses on the collective generation of meaning as it seeks to understand and explore an experience shared by a number of individuals taking account of the social and cultural context.

Ontology is the study of being and concerns the structure of reality (Crotty 1998). As epistemology has different positions dealing with the production of knowledge, so there are different ontological positions encompassing the understanding of the
world and reality. While Crotty (1998) does not name ontology within his schema he acknowledges its importance and states that if it was included in his framework it would sit alongside epistemology. He asserts that epistemological issues and ontological issues emerge together, believing that questions of ontology should be dealt with as they arise and therefore do not need to be named on his schema. It is recognised here, however, that a discussion of research methodology is not complete without the inclusion of ontology. It has therefore been placed in the adapted version of Crotty’s framework (Figure 5.1).

According to Finlay & Ballinger (2006) different ontological positions lie along a realist-relativist continuum. They state that the realist position views the world as made up of structures and objects that have cause-effect relationships with each other. There are essential structures within a phenomenon that make it real and that can be identified and described. A relativist position on the other hand holds that multiple interpretations can be applied to phenomena and that all experience is relative and constructed through language. Finlay & Ballinger claim that many qualitative researchers take a middle ground of critical realist. This is where meanings remain fluid but there is acceptance of the reality or existence of a particular phenomenon. The position of critical realist is the position taken within this research – seeking to capture the experience of an episode of inpatient care while exploring the multiple meanings attached to it. This stance also aligns with the epistemology of constructionism acknowledging the creation of multiple meanings.

5.5 Theoretical perspective – interpretivism

Crotty (1998) describes the theoretical perspective as “the philosophical stance” embedded in a methodology (p. 66). In keeping with the epistemological position of constructionism and the ontological position of critical-realists, this study takes the theoretical perspective of interpretivism. Within this perspective it is argued that researcher objectivity is considered unattainable as the researcher is an intrinsic part of the world being studied. The interpretations of the world that result therefore, are culturally derived and historically situated (Crotty 1998). The situatedness of the researcher is made explicit, recognizing that the knowledge gained has been
developed and constructed from the interaction between researcher and participants. This requires critical self-awareness on the part of the researcher through ongoing reflexivity in order to understand the social background, assumptions, positioning and behaviours of the researcher that impact on the research process (Finlay & Ballinger 2006). The critical self-awareness required for research conducted from an interpretivist paradigm is consistent with the requirements of a social work practitioner as noted previously in the profession’s principles. It also fits with the position of researcher-practitioner in which the embeddedness of the researcher in the world being researched, is made explicit.

There are a number of other influences that are at play that have led the researcher towards this stated position. As a practitioner first and foremost, the influence of the researcher’s professional background must be acknowledged. Social work is a profession that values human rights and advocates for change to social systems that perpetuate injustices. Professional integrity encourages social workers to practice reflective self-awareness through a process of critical reflection about “their personal beliefs and history, values, views, prejudices and preferences and to refrain from imposing these on clients” (AASW Code of Conduct 2010 p. 17). Therefore the notions of reflexivity and intersubjectivity valued within an interpretivist paradigm, hold a natural attraction. As noted previously the recovery movement and the profession of social work share a similar value base; one that recognises lived experience and thus, multiple realities of a phenomenon. The melding of social work professional values with those of the contemporary guiding values on mental health care espoused by the recovery movement, helps to further explain the theoretical base from which the research project has been constructed.

The identification of the epistemology, ontology and theoretical perspective underpinning this study gives context to the chosen methodology and methods that will now be outlined. It makes clear the assumptions about knowledge production and the nature of being/reality that informed these choices.
5.6 Methodology

5.6.1 Qualitative research

As noted throughout this dissertation the recovery movement in mental health is driven by lived experience and consumer narratives. It was therefore important that the choice of methodology for this study should honour the principles inherent in the recovery movement such as meaning-making, empowerment and the recognition of the uniqueness of each individual’s experience. Personal recovery in mental health is a subjective human experience. The human experience is complex, ambiguous and unique to each individual and therefore cannot be easily reduced to generalised explanations with claims of proof. Qualitative methodology was therefore chosen in preference to quantitative methodology.

Bryman (2012) notes that one of the features of qualitative methodology is the examination of the social world through the interpretation of the experiences of its participants. Likewise, Alston & Bowles (2003) identify qualitative research as the preferred methodology for exploring the meanings that people ascribe to their experiences. The literature supports this choice of methodology in research about the move to recovery practice in mental health. Marshall et al (2009) call for further research in the area of consumer perceptions of mental health recovery, noting that qualitative methodologies were likely to be of particular importance when exploring processes that can inform service delivery improvements. Kogstad et al (2011) utilised a qualitative, explorative and descriptive design in their study stating that this was the methodology most suited to providing access to lived experience. Like Marshall et al (2009), they state that a qualitative design is the most valuable means of understanding how mental health services work and how they can be improved.

Quirk et al (2004) selected only qualitative studies in their review of life on psychiatric wards stating that the benefit of qualitative research lies in its presentation of understandings from a patient perspective and the consequent impact on service improvement. Walsh & Boyle (2009) also note the value of the involvement of vulnerable groups, including those with mental health problems, in
qualitative research projects. This involvement is seen as potentially therapeutic and empowering and thus in keeping with the principles of the recovery movement. They question how services can be genuinely responsive to consumer needs if those needs have not been sought from the consumers themselves.

Anthony (1993) believes that an understanding of recovery through research is paramount and states that “Qualitative research would seem particularly important in this regard” (p. 533). In a later article Anthony, Rogers & Farkas (2003) state that for recovery based services to be informed by research, the concept of evidence-based practice must be broadened to include such research designs as quasi–experimental, exploratory analysis and qualitative research. They note that much of the research on evidence-based practice in mental health published up until that time was “conceived without an understanding of the recovery vision” (p. 101).

Nordfjaern et al (2010) note that qualitative studies on the topic of recovery are less likely to produce positivity bias than quantitative studies that limit response options. They claim this is a valid argument for more qualitative studies regarding perceptions of treatment and recovery, concepts they maintain that are unable to be understood through the consideration of specific interventions alone or sets of behavioural outcomes.

The role of the researcher in qualitative research designs differs to the researcher role in quantitative methodology. Objectivity and neutrality are characteristics of the researcher’s stance in quantitative methodology allowing for the collection of hard data for further analysis. Qualitative research, on the other hand, celebrates the human-ness of the interaction between researcher and participants, explicitly recognizing a co-construction of data that is approached tentatively and demands a reflexive exploration of the dynamics of the relationships between the researcher, the participant and the social world (Finlay 2011). This understanding and integral role of relationship in qualitative research matched the researcher’s stance as a practitioner in which an understanding and use of the relationship is a therapeutic tool. Genuineness is a characteristic of the therapeutic relationship and presupposes an understanding and acceptance of relationship as a two-way interaction.
Embracing and making this relationship explicit rather than falsely claiming objectivity sits more comfortably with the practitioner-researcher along with other characteristics of a therapeutic relationship including honesty and openness.

Hermeneutic phenomenology is the chosen qualitative methodology for this study. The rationale for this choice is addressed in the following sections, the first of which outlines phenomenological research and its fit with the nature of the study undertaken. This is followed by an explanation of hermeneutic phenomenology.

5.6.2 Phenomenological research

Vagle (2014) begins his book on phenomenology with a discussion of what is meant by a phenomenon. He states “phenomena are the ways in which we find ourselves being in relation to the world through our day-to-day living” (p. 20). Phenomena are not constructed or designed in the human mind separate from the world. Instead, when experiencing the world, human beings “find themselves in” the experience (p. 21). The concept of lived experience is not only at the heart of the recovery movement in the mental health field but is also the crux of phenomenology. A phenomenon can only be understood through the way in which it is experienced. The plea from the consumer movement to acknowledge lived experience is inherently connected to the plea from phenomenology to value the human experience of phenomena as a way of understanding the world.

Finlay (2011) explains phenomenology from the point of view of her work as a psychotherapist. She puts forward six components that she believes need to be present to signify a phenomenological project. These are as follows:

1. A focus on lived experience and meanings – a phenomenon may be an event, an object, a situation, a process. The aim is to describe how this phenomenon is known to us through our everyday experience of it. Emphasis is on the phenomenon itself and not on the individual participant’s accounts alone with a further challenge to “intuit implicit meanings” inherent in the experience (p. 16).

2. Use of rigorous, rich, resonant description – rather than eschewing complexity and ambiguity, phenomenology seeks to embrace and capture the richness that such
complexity exposes. This opens up otherwise hidden aspects of the phenomenon revealing the potential for new understandings.

3. Concern with existential issues – these existential issues are matters concerned with our experience of existence or our human condition. These are sometimes referred to as lifeworlds.

4. The entwining of body, self and world – phenomenology does not adhere to a mind-body dualism instead seeing the mind, the body and the world as intertwined. Finlay states that Western scientific thinking is embedded with the idea of ‘self’ as being a separation of mind from body. She calls for researchers to discard this polarised notion of self and the polarity of self and world, instead seeing self as part of the world and the world as part of self. As Finlay notes, those of us in the healthcare world are cognisant of the complex interaction between physical and mental health and between health and social conditions.

5. The application of the “Phenomenological Attitude” – here Finlay refers to the process of “bracketing” a concept that will be discussed in more detail in the subsequent section. Bracketing is a process whereby our pre-assumptions or habitual ways of seeing the world are put aside to see the phenomenon in new and open ways. This is not a way of claiming objectivity, rather new ways of seeing the world are arrived at through reflexivity or researcher self-awareness which require that the researcher is actively engaged with and cognisant of subjectivity and intersubjectivity. “It is seen as inevitable that researchers bring their subjective selves into the research along with preconceptions which both blinker and enable insight” (p. 23).

6. A potentially transformative relational approach – not only is research seen as relational, that is, an activity that requires an explication of the relationship between researcher and research participants, but in doing so the activity itself can be transformative. This is true, Finlay asserts, both for the researcher and for the participant. Recounting an experience can open up new ways of understanding for the person doing the recounting. It can also evoke emotions and new understandings in the person listening to the account, in this case the researcher “as we are touched and reminded of our human interconnections” (p. 25).
One of the rationales for this study lies in the bridging between theory and practice – what can we learn and contribute to the knowledge base about mental health care that will positively inform practice especially in an inpatient setting? According to Finlay (2011) qualitative phenomenological research provides this bridge “across the chasm between practice and research” (p. 3). The aim of the recovery movement in mental health is a transformation of the way in which mental health services are delivered. One of the ways in which this transformation is to be achieved is through a shared understanding and recognition of the lived experience of phenomena associated with mental illness. In this study the lived experience of both consumers and staff is acknowledged as a means of providing a more complete understanding of the phenomenon. As noted by Perkins (2007):

> Only by bridging the gulf between ‘them’ and ‘us’ – by understanding what services are like for those on the receiving end and appreciating the dilemmas and frustrations of those who provide them – can we ever improve the experience and effectiveness of in-patient care. (Foreword p. xxiv)

### 5.6.3 Philosophical underpinnings of phenomenology

A brief historical account of phenomenology helps to trace its development and eventual application to this research project demonstrating its relevance to the study and strengthening the rationale behind its choice. Dahlberg, Dahlberg and Nystrom (2008) refer to Edmund Husserl, an Austrian-German philosopher who wrote in the early twentieth century and who is credited as the founder of modern phenomenology. According to Dahlberg et al (2008) Husserl saw the rise of scientific study of the natural world as leading to the de-humanisation of society through its stance of separating the researcher from the research object in an attempt to claim objectivity. He argued that the integral connection between humans and the natural world could not be severed as the positivism of scientific method was espousing. He warned that any attempt to separate science from the everyday world would not result in any benefits for the world as anticipated. Instead this separation would lead to an estrangement and loss of importance for ordinary people who lived in the everyday world. Husserl proposed a radical shift in scientific thinking from the
positivist position. He asserted instead that the everyday human world as reified in phenomenology should form the basis of science, the guiding foundation for all scientific thinking. Within this position the scientist’s relationship with research projects is made explicit and the human factor is reinstated. Husserl’s aim in creating this new approach to science was to “bring forth the full richness of our lived world” (Finlay 2011 p. 44).

The notion of “intentionality” as it became used by Husserl was inspired by one of his teachers, Franz Brentano in 1889 developing an understanding of consciousness as ways we are attached to the world (Van Manen 2014). Husserl saw consciousness as intentional that is, consciousness is consciousness of something with an emphasis on the relationship between the act of consciousness and the object of consciousness. Intentionality is the first of many terms coined by Husserl and should not be confused with the English meaning of “intention” as a plan, a purpose or deliberateness. Instead it is used to explain the way in which we, as human beings, are meaningfully connected to the world (Vagle 2014). Vagle notes that students in the Western world find intentionality a much more difficult concept to grasp than students from Eastern countries. He believes this is due to the Western emphasis on individual ego that is, a belief that consciousness resides in humans and not in the interconnectedness between humans and the world. Again the Western scientific dualism of mind and body impedes an easy understanding of this component of phenomenology.

Another of Husserl’s contributions is the term “reduction”. Reduction requires a process of “bracketing” which refers to a special attitude required of phenomenologists that involves the putting aside of previous assumptions and theoretical knowledge in order to approach a phenomenon in an open and sensitive way – a method of reduction that allows for an analysis of data from a fresh perspective. This reduction provides the researcher with a perspective of the phenomenon in its “essence”, another term attributed to Husserl. When the term “reduction” is first encountered it appears to mirror concepts more aligned with a quantitative, positivist approach to research. According to Finlay (2011) the process
of bracketing has been wrongly and simplistically interpreted as encouraging an objective stance. Writing from the perspective of a therapist, Finlay compares this reductive process using bracketing to the therapeutic stance of temporarily seeing the world from the client’s point of view, standing in their shoes, while putting aside any personal preoccupations or misgivings. Rather than seeing it as an action to achieve objectivity, bracketing requires that pre-understandings and knowledge be placed temporarily aside. This allows the researcher to reduce distractions and expand the likelihood of experiencing the phenomenon as free from preconceptions as possible, opening oneself to the possibility of new understandings.

Dahlberg et al (2008) also outline difficulties with the term “reduction” saying that it was “too loaded with philosophical implications” (p. 129). Instead, the authors propose the term “bridling” in place of “bracketing”, using parallels with the equine world in which bridling is seen as a method of communication or embodied dialogue between two entities – the horse and the rider. They state that bridling allows for all the meanings of bracketing as putting aside pre-understandings in the form of personal beliefs and theories, but also allows for the holding of emerging understandings. By bridling the event of understanding, the researcher is not jumping too quickly or too carelessly, not “making definite what is indefinite”. Instead the researcher is described as “a hunter of meanings”, deliberately and slowly lying in wait for the phenomenon to show itself (p. 130).

Another advantage of seeing the process of reduction as “bridling” is that bridling creates a focus on the future through the holding of emerging understandings, rather than emphasizing the past as bracketing requires. That is, bracketing is directed backwards, requiring that past assumptions and knowledge be held back, not allowing it to affect the here and now. Bridling, on the other hand, focuses ahead with a more positive tone, aiming “to direct the energy into the open and respectful attitude that allows the phenomenon to present itself” (p. 130). Vagle (2014) supports Dahlberg’s reinvention of the process of reduction with the creation of the term “bridling”, stating that while it could be dismissed as a simple name change, it is in fact a significant departure from bracketing in both a methodological
and philosophical sense. According to Vagle the process of bridling means being patient and attentive while exploring the relationship between the researcher and the subject in the intersubjective relationship. As such, Vagle notes that the process of bridling is a reflexive act.

The development of the term “bridling” has also brought forth discussions on the issues of validity and reliability within phenomenological methodology. Van Manen (2014) asserts that validity as a concept utilising tests and measures is not compatible with phenomenological methodology. He states, “A common problem for phenomenological researchers is to be challenged in defending their research in terms of references that do not belong to the methodology of phenomenology” (p. 347). Vagle (2014) acknowledges that qualitative researchers have been grappling with this issue for many years and makes reference to other terms that are used in parallel with validity such as trustworthiness. Vagle (2014) proposes that discussions regarding validity within phenomenological research need to begin with “a consideration of the researcher’s sustained engagement with the phenomenon”, an engagement that needs to be evident throughout all phases of the study (p. 66). Vagle refers here to the process of bridling as a reflexive act and as such, a means of addressing validity or trustworthiness of data. Trustworthiness, according to Bryman (2012), includes the notion of reliability renamed as dependability. Bryman notes that reliability, or the ability to replicate a study, is difficult to apply in qualitative methodology as it presupposes an absolute truth about the social world waiting to be revealed.

Husserl’s notions were ground breaking, with significant implications for the field of philosophy and the study of human sciences. However, with any new ideas or ways of thinking, an initial groundbreaking idea lays the foundation for further thinking and analysis, opening the original notions up for ongoing critique and development. Husserl’s ideas, just as they were founded on previous thinking have not stopped with him. The field of phenomenology has been further developed through the 20th century by others such as Martin Heidegger and Hans Gadamer.
5.6.4 Hermeneutic phenomenology

The word “hermeneutics” is the theory of interpretation and was introduced as a systematic method of meaning-making. The aim of hermeneutic phenomenology is to evoke lived experience through interpretation. The difference between phenomenology according to the way Husserl developed it, and hermeneutic phenomenology as it has evolved, lies in this notion of interpretation or the application of meaning. In hermeneutic phenomenology the researcher’s interpretations are inextricably linked with the data and context and as noted previously, researcher-participant intersubjectivity is embraced (Finlay 2011). The process of understanding within hermeneutic phenomenology involves a level beyond description – that of interpretation.

Husserl saw consciousness (of the subject) as always directed towards something (the object). This separation between subject and object and emphasis on the relationship between the two – the intentionality – was questioned and critiqued by one of Husserl’s colleagues, Martin Heidegger. According to Heidegger, as noted in Dahlberg et al (2008) there is more to the relationship between subject and object than the subject’s experience or relationship with the object. Consciousness is not something that is separate from the world. Heidegger sees the two as inseparable – a notion of being embedded in the world. He proposed that self and being were a single entity unlike subject and object. Heidegger was concerned with exploring an understanding of the verb “to be” therefore seeing ontology as a starting point for any explanation of knowledge (Dahlberg et al 2008). Laverty (2003) notes that Heidegger saw understanding as being more than the way we know the world but rather the way we are - a view of people and the world as being entrenched each with the other in cultural, social and historical contexts. He believed it was not possible to simply describe objects as we are conscious of them. Rather, the phenomena that appear to us in our consciousness do so because of our relationship with them.

Heidegger also coined the term hermeneutic circle in which pre-understandings of a phenomenon engage in a “dance” with new understandings as they emerge while
the phenomenon is being explored. “The hermeneutic circle thus moves between question and answer...between understanding parts and the whole. Understanding deepens by going round the circle again and again.” (Finlay 2011 p. 53). Dahlberg et al (2008) note that this concept of hermeneutic circle has been expanded in recent decades with the replacement of the word “circle” with “spiral”. The notion of a circle is one of a closed loop whereas a more accurate description of this whole-part-whole movement towards understanding is found in the concept of a spiral that is open at both the beginning and the end. According to Dahlberg et al, this openness allows a phenomenon to be understood in new ways and to fit into new contexts resulting in the creation of ever emerging horizons of meaning (p. 237).

Hans Gadamer, following in the footsteps of Husserl and Heidegger, also criticised the use of singular methodology within a scientific positivist approach. Instead he stated that a lifeworld cannot be reached through method but through an open approach that is, we must have an open mind in order to discover anything new or to see the “otherness” of something (Dahlberg et al 2008). This discovery is facilitated by dialogue designed to question and provoke our pre-understandings. Gadamer used the concept of “horizon” to describe our location in history stating that an open mind allows us to see beyond our current location, creating a dialogue between past and present, a concept that he named as a “fusion of horizons” (Finlay 2011).

According to Dahlberg et al (2008) Heidegger and Gadamer’s contributions caused a “phenomenological turning point” in which hermeneutics was converted into an existential philosophy. As such the writings and concepts that emerged are complex and dense. In this study the researcher has not taken the stance of any one alone of the leading names in the development of hermeneutic phenomenological thinking. Instead a broad approach is taken that moves across the writings of these foundational philosophers and draws on the contributions of more recent authors such as Finlay (2011), Dahlberg et al (2008), Vagle (2014) and Willig (2012). Terms such as “hermeneutic circle/spiral” and “fusion of horizons” may be used within this dissertation without claiming adherence to any one philosophical position. Finlay’s
and Willig’s writings resonate with the researcher due to these authors’ backgrounds as health practitioners and therapists while Dahlberg et al’s (2008) backgrounds in nursing and education are supplemented by their research in mental health. All these authors have written extensively on the methodology of phenomenology including hermeneutic phenomenology and have been influential in the methods and analysis undertaken within this study.

5.7 Ethics

Ethics approval for this study was sought through the local Human Research Ethics Committee via completion of the National Ethics Application Form (NEAF) online. Conditional approval was initially given with one of the conditions concerning the inclusion of involuntary patients as part of the consumer group. The Ethics Committee had received legal advice that involuntary patients were not capable of providing consent, however a spokesperson for the Committee indicated that advice would be taken about this issue from the facility, given that the Committee had not previously dealt with research requests from a mental health inpatient facility. The Medical Superintendent of the hospital facility wrote a letter of support for the research project and for the inclusion of involuntary patients. The letter outlined the usual practice within the hospital that involved involuntary patients consenting to a number of procedures dependent on their mental status at the time and refuted the idea that inability to provide consent was inherent in an involuntary status under the Mental Health Act. After putting this case to the local HREC, full approval was granted after which the site specific approval was sought and granted. Approval was then automatically granted by Charles Sturt University Human Research Ethics Committee.

All requirements of the Ethics application were adhered to including the provision of information sheets for potential participants of each of the three groups (Appendices 1&3). Consent forms were also provided and completed by each of the participants (Appendices 2&4). The consent forms of those who were involuntary at the time of completion were countersigned by their treating psychiatrist as required.
by the Ethics Committee approval. This procedure was explained to each of these participants prior to their agreement to take part in the study.

**5.8 Preparation of the workplace**

The researcher had been a worker at the chosen site for twelve years at the time of commencement of participant recruitment. The idea for the research had been discussed with numerous members of the executive management in order to gauge support over a period of twelve months prior to commencement. A Guidance Team was formed comprising of members of the executive management including the Medical Superintendent, the Manager of Workforce Planning and Development, the Director of Nursing, Allied Health Manager and the Manager of Promotion, Prevention and Early Intervention. The formation of this Team ensured executive support right from the start and secured the approval for processes such as the participation of workers in research interviews during their working hours and assisting with ethics approval as noted previously.

A Project Team was also formed comprising senior practitioners who had particular skills to contribute on an advisory level for such things as the development of interview questions, suggestions for the recruitment of participants and advice regarding ethical issues. This team consisted of a Professor of Nursing involved in many aspects of mental health research, a Psychiatrist, Consumer Advocate, Aboriginal Clinical Leader and a Clinical Nurse Consultant.

The data gathering was conducted over a period of nine months from August 2013 to March 2014 with a total of 24 interviews recorded and transcribed. The methods employed to gather data are outlined in the following chapter as is the process undertaken to subsequently analyse the date.
CHAPTER 6 - Methods

6.1 Research title and questions

The methods undertaken in this research are in accordance with the phenomenological approach as outlined previously. In order to explore lived experience and the notion of recovery the following core research questions are posed:

• How is an episode of acute mental health inpatient care experienced by consumers, workers and managers in the chosen facility?
• Do consumers, workers and managers in an acute mental health inpatient setting share a common understanding of the meaning of recovery from mental illness?

Additional questions are then posed:

• What are the challenges for an acute mental health inpatient facility in changing to recovery-focused practice?
• What are the implications for social work practice?

6.2 Data gathering

6.2.1 Purposive sampling

Purposive sampling was used to identify participants from three distinct groups chosen for their common experience of the phenomenon of mental health inpatient care. In this way the study is using a form of data triangulation to gather information of the same phenomenon from three different sources. The three groups consisted of:
1. Consumers who were current inpatients of the acute facility
2. Workers of various professional backgrounds who worked on a daily basis in the acute facility
3. Managers who were responsible for the delivery of care in the facility specifically those who had a responsibility for the acute inpatient services.
Purposive sampling was considered to be the most appropriate method of recruitment given that the study is specifically targeting those who have had a lived experience of an episode of acute mental health inpatient care. While “lived experience” in the context of the recovery movement is more often applied to consumer experience, it is a term that is equally applicable to others who share the same experience albeit from different perspectives. This more diverse perception of lived experience is reflected in the definition provided in *National Mental Health Recovery Framework: Guide for practitioners and providers* (2013) quoted previously. Lived experience in this definition covers those with direct experience of mental illness as well as others who experience the consequence of mental illness.

### 6.2.2 Recruitment

The method of recruitment varied across the three groups. For the consumer group consideration was given to a number of factors. First, the researcher was aware of the need for sensitivity around the possible vulnerability of the consumers’ mental health given their current situation of admission to an acute inpatient facility. In an already coercive environment, care was taken not to create a situation in which encouragement to participate in a study could be interpreted as further coercion or viewed in any way as a condition of their treatment. Thus an “arms length” approach to recruitment was taken. A staff member who works closely with the consumers and is perceived as holding a position of trust with them (an Allied Health Assistant), delivered the initial information about the study within the usual morning meeting held on the selected inpatient unit. An invitation to participate in the study was extended to all consumers in this acute unit regardless of their status under the Mental Health Act. As a further precaution those who wished to participate but were involuntary under this Act were informed that participation needed to be discussed with their treating psychiatrist to reduce any possible exposure to risk of further harm and to ensure their wellbeing. If the treating psychiatrist was of the opinion that the person had the capacity to provide consent then participation could proceed. Additionally, consumer participants were informed of the availability of counseling if they experienced any discomfort or distress as a result of the interview.
They were directed to names on the Information Sheet and the Consent Form and informed that they could arrange a referral via the nursing staff.

Recruitment for consumers took place in the 16 bed acute unit from which people prepare for discharge. Information sheets were provided to those who expressed interest and if the person wished to proceed he/she was then introduced to the researcher by the Allied Health Assistant. It was made clear throughout this process that there was no obligation to proceed and that withdrawal could be made at any stage. An interview time was arranged with the consumer and consent forms were signed. The treating psychiatrist countersigned the consent form for those consumers who were involuntary at the time of participation as required by the Ethics Committee. As part of the “arms length” approach to recruitment, it was left to the discretion of the Allied Health Assistant as to when to promote the research in the morning consumer meetings. This recruitment process extended across five months reaching a fluid population of people with various lengths of stay. This meant that the consumer participants were not from one group at one point in time and were therefore not influenced by one particular event or influenced by each other thereby increasing the trustworthiness of the data collected from this group. Over the five month period nine people volunteered. Only one consumer who came forward in response to the initial invitation to participate decided to withdraw after speaking with the researcher.

Worker participation was approached in various ways depending on the professional background of the worker – nursing, allied health and medical – however, all worker participants self selected. The recruitment of nurses was commenced by the researcher’s attendance at nursing staff handovers on the acute unit in which the purpose of the study was explained and information sheets distributed. Following this, the researcher personally approached those interested staff members who had attended the information session to confirm participation. Interview times were then arranged for those who agreed and consent forms signed. For Allied Health staff members, the Head of Department for each discipline was approached to explain the study and request approval for the participation of those staff who
worked on the acute units. This self selection of participants resulted in a limited mix of professional backgrounds within the Allied Health cohort. Only the social workers, of whom there were two, and the Allied Health Assistants, also of whom there were two, were specifically allocated to the Acute units. Other Allied Health professionals such as occupational therapists and psychologists, were spread across a number of different units and were therefore not actively followed up. Of the two social workers, only one was able to participate within the timeframe of the study.

For medical staff, the Director of Acute Services was approached and informed of the study and of the request for worker participation. Individual staff members allocated to the Acute units who indicated an interest in participating were then approached to arrange interview times. The executive management of the facility had provided approval for workers to attend interviews during work hours.

The recruitment of managers was undertaken through a personal approach to individual managers by the researcher. The level of management targeted consisted of those persons responsible for the direct overseeing of the acute inpatient service delivery and included campus nurse managers, the director of nursing and clinical nurse consultants. The professional background of the manager participants were entirely nursing and reflects the dominance of this profession within the management level at this facility. The manager of allied health was to be approached, however this person left the position during the time of the study and was replaced by the General Hospital manager of allied health for whom the field of mental health was unfamiliar. Thus a decision was made not to include this person in the target participant group. This was the only deliberate exclusion of a participant. All the managers who were approached agreed to participate. While the Director of Acute Services (psychiatrist) participated in the study, this person’s preference was to be considered as a worker rather than a manager due to the person’s responsibility for a full clinical caseload and his perception of management as a secondary role.
The numbers and characteristics of the participants are outlined in the following tables:

Table 6.1 Consumers

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>1st Admission to a MH Inpatient Facility? Y/N</th>
<th>Number of Admissions to Current Facility</th>
<th>Number of Total Admissions</th>
<th>Status under Mental Health Act (at the time of interview)</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>F</td>
<td>N</td>
<td>3</td>
<td>3</td>
<td>Voluntary</td>
</tr>
<tr>
<td>39</td>
<td>M</td>
<td>N</td>
<td>1</td>
<td>2</td>
<td>Involuntary</td>
</tr>
<tr>
<td>43</td>
<td>M</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Voluntary</td>
</tr>
<tr>
<td>35</td>
<td>F</td>
<td>N</td>
<td>1</td>
<td>2</td>
<td>Voluntary</td>
</tr>
<tr>
<td>36</td>
<td>F</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Voluntary</td>
</tr>
<tr>
<td>26</td>
<td>M</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Voluntary</td>
</tr>
<tr>
<td>20</td>
<td>M</td>
<td>N</td>
<td>1</td>
<td>2</td>
<td>Voluntary</td>
</tr>
<tr>
<td>61</td>
<td>M</td>
<td>N</td>
<td>10</td>
<td>10</td>
<td>Involuntary</td>
</tr>
</tbody>
</table>
Table 6.2 Workers

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Profession</th>
<th>Years in Profession</th>
<th>Years in Facility</th>
<th>Years in Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>F</td>
<td>AHA*</td>
<td>14</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>41</td>
<td>F</td>
<td>AHA*</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>53</td>
<td>M</td>
<td>Psychiatrist</td>
<td>24</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>26</td>
<td>M</td>
<td>RN**</td>
<td>3</td>
<td>10 months</td>
<td>10 months</td>
</tr>
<tr>
<td>51</td>
<td>M</td>
<td>RN**</td>
<td>9</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>37</td>
<td>M</td>
<td>RN**</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>54</td>
<td>F</td>
<td>RN**</td>
<td>35</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>25</td>
<td>F</td>
<td>Social Work</td>
<td>1 yr 2 months</td>
<td>7 months</td>
<td>7 months</td>
</tr>
<tr>
<td>40</td>
<td>M</td>
<td>Psychiatric Registrar (medicine)</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>64</td>
<td>F</td>
<td>RN**</td>
<td>37</td>
<td>7yrs 6 months</td>
<td>24</td>
</tr>
</tbody>
</table>

* Allied Health Assistant  ** Registered Nurse
### Table 6.3 Managers

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Profession</th>
<th>Years in Management</th>
<th>Years in Facility</th>
<th>Years in Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>F</td>
<td>RN**</td>
<td>8</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>41</td>
<td>M</td>
<td>RN**</td>
<td>6</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>42</td>
<td>M</td>
<td>RN**</td>
<td>9</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>61</td>
<td>M</td>
<td>RN**</td>
<td>20</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>43</td>
<td>F</td>
<td>RN**</td>
<td>6</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>42</td>
<td>M</td>
<td>RN**</td>
<td>3yrs 6 months</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

It is interesting to note that the experience of inpatient care at this particular facility features strongly for all three groups. The majority of workers and managers have spent most of their working lives in the field of mental health in this one facility. Likewise, only three consumers have experienced an admission to a facility other than this current one.

### 6.3. Data gathering strategy – semi-structured interviews

According to Vagle (2014) semi-structured interviews are the most commonly used data gathering technique in phenomenology as it is the most dialogic, open and conversational. The goal of the phenomenological interview is to find out as much as possible about the phenomenon in question from each individual participant (pp 78-79). This allows a full exploration of the phenomenon at hand, while at the same
time keeping in mind the purpose of the interview and the topic to be explored. This aligns closely with the social work attitude of “start where the client is”, exploring client perceptions and experiences while always having the therapeutic goal as a central focus. A skill set including the establishment of rapport, careful listening, the use of open and non-directive questions and the maintenance of a responsive and empathic stance are crucial to facilitating a narrative account of a phenomenon. Finlay (2011) describes the interview as an “encounter” rather than a passive recounting of an opinion or a reporting of facts. During interview the person is actively engaged in exploring the meaning of experiences that have been significant for them (p. 200). Finlay entreats phenomenological researchers to be mindful of the privilege it is to participate in the sharing of someone’s personal experiences. She calls for researchers to uphold ethical responsibilities in order to respect privacy and dignity, ensuring that participants are not harmed in any way through their participation in the interview.

The interview process as a two-way open encounter is a characteristic of phenomenological research. The interviews are “the means for listening to the voice of the lifeworld and at the same time strengthening it” (Dahlberg et al 2008 p. 184). A distinguishing feature of the phenomenological interview is its focus on the phenomenon in question, not the person who is voicing it. Dahlberg et al distinguish this form of interview from a therapeutic, caring or teaching aim where the focus of the interview is squarely on the person who is communicating an experience. The task of the interviewer in phenomenological research on the other hand, is to facilitate the person telling his/her story. This results in a better understanding of the phenomenon by both the interviewer and the participant. According to Dahlberg et al the effect of participation in such an interview brings the person closer to his/her experience, expanding an understanding and awareness of the phenomenon for the person him/herself and bringing the researcher along as a fellow passenger on the ride.

In this study a list of draft questions was created as a guideline for the interviews. The main focus of the interviews, in line with the research questions, centred on the
reporting of the participant’s personal experience of inpatient care and an account of the meanings attributed to the notion of recovery. Examples of introductory questions included:

“Can you tell me about your experience of being here as an inpatient/worker/manager?”
“What is it like for you to be here?
“Can you describe your experience to me?”
“Could you talk me through your time here”?

At a suitable time during the interview the notion of recovery was introduced, or, if this term had already been used by the participant, a further explanation was requested sometimes utilising the following question or variations of the question:

“On the subject of recovery, what does the word ‘recovery’ mean to you?”
“What does ‘recovery’ look like to you?”

6.4 Data Analysis

According to Dahlberg et al (2008) analysis of data in lifeworld research is about understanding the phenomenon in question and finding the meanings inherent within. The process of analysis in hermeneutic phenomenology is not one that follows a strict progression of steps or stages, however, there are essential components of this analysis that draw out new meanings and interpretations. While having no clear path of analysis is a daunting prospect for the novice researcher, it is also exciting and invites new discoveries of meaning by looking *through* the data rather than just *at* it. In deciding on the type of analysis for this study, the advice of Finlay (2011) was taken. She provides “permission to evolve the approach that works for you” (p. 228). In this case the analysis borrowed from a number of authors, principally Dahlberg et al (2008), Vagle (2014) and Finlay (2011), while adhering to essential components of hermeneutic phenomenology. A whole-to-part-to-whole process was followed throughout, moving from considerations of the whole text to
closer investigations of small parts of the text before re-considering their relevance to the whole text again. The moving in and out of the text, while being a fluid and responsive process, is at all times guided and shaped by the research questions. This hermeneutic spiral is described by Dahlberg et al as being similar to compiling a jigsaw where new interpretations are connected to previous interpretations – “Small segments of meaning are put together in order to see structures and patterns that were previously hidden, or partly hidden.” (p. 285). This process is described by Finlay as often “messy”, combining leaps of intuition with a systematic working through of iterative versions.

These three authors recommend developing an engagement or relationship with the data, in this case the interviews. They suggest taking time to absorb, consider and dwell on the impact and effect of the data on one’s self. To begin this process, initial impressions were written down after each interview prior to transcription. This was done to capture immediate responses of the researcher to the interview experience, including observations and thoughts about what the experience was like for the interviewee and any content that grabbed the researcher’s attention. Questions were sometimes posed but no analysis at this stage was attempted. These initial impressions helped to provide a comparison with the subsequent deeper readings as part of the reflexive process.

For this study, initial analysis was undertaken following Finlay’s suggestions of engagement with the data. The key words in this process are dwelling, wonder, evidencing and ambivalence (p. 228). As suggested by Finlay, the researcher chose to transcribe the interviews herself as a means of commencing this engagement and dwelling on the data. This allowed for a reliving of the interview albeit at a slower pace and revealed statements, expressions or silences that had been missed during the actual event of the interview, thus deepening the engagement and understanding. Dahlberg et al (2008) alert the researcher to attend to expressive components of the interviews such as emotion, hesitation, pauses and uncertainty that can all contain clues to the meanings inherent in the data. These expressive components are “heard” loudly through the process of transcription. Finlay
recommends taking the analysis slowly and to “take many passes at it” (p. 229). Each of the transcripts was read many times and the interviews listened to more than once. This was done over a period of time to increase the chance that each of these “passes” would be undertaken with a fresh look and an open stance.

Dahlberg’s notion of bridling was employed throughout this process – putting pre-understandings aside but also gently holding onto emerging meanings in the hope of opening up new perspectives and ways of hearing the data. This was combined with Finlay’s call to listen empathically to the participants’ descriptions of their worlds in order to get a feel for their situation and then lingering over selected passages or “chunks of data” that stood out for any number of reasons. Perhaps the section of data evoked a strong emotion, or was powerful in its intensity, or surprising in its lack of intensity where intensity might have been expected. Perhaps this selected passage was in accordance with the researcher’s view, or in opposition to it, or the passage may have been a statement that was unexpected and seemed not to fit with where the interview appeared to be heading. At this point of encountering the data, the chosen authors caution against moving straight into analysis. Instead they suggest staying with the data, including the literal words and resisting any temptation to import theoretical ideas or prematurely interpret. The transcription of the interviews resulted in further observations, thoughts and questions that were added to the initial impressions.

Where Vagle (2014) suggests a series of line-by-line readings to begin to articulate meanings, Finlay instead proposes a seeking out of the parts that resonate and urge the reader to “wonder about these experiences in awe, curiosity and focused reflection” (p. 230). Finlay cautions against having to account for every word believing this can lead to feeling overwhelmed by the data and “not seeing the woods for the trees”. The researcher however, did complete a line-by-line analysis when the computer software program NVivo was employed to assist with the organisation of the data. It was hoped initially that the use of this software would lessen the burden of analysis by keeping all the notes in one organised process. Difficulties were encountered with the use of this software however, due to the
researcher’s lack of familiarity with it. In hindsight, it would have been beneficial to trial this program first, for example, using it for the literature review to ensure familiarity and confidence with its use. Vagle comments on the use of such software for phenomenological research, stating his concerns about the production of “mechanistic representations” of the data rather than “a deeply embodied crafting” (p.98). His final advice is to state simply that if a program such as NVivo helps, then use it. Conversely, if it feels uncomfortable, do not. The researcher in this study did not feel comfortable nor sufficiently skilled to use such a program and so discarded it in favour of more manual methods. However, the line-by-line analysis did yield a number of themes within the interviews and assisted with the location of the specific participant voices that evidenced these themes.

The process of analysis outlined so far resulted for the researcher in multiple ideas, themes, tentative interpretations and possible exciting discoveries. The final task of bringing all this together in a coherent and meaningful way was still to be completed. The researcher was assisted in this final process by the writings of Dahlberg et al (2008) who liken dialogue with the text (data) to an interrogation or “cross examination” (p. 252). This allows for the exploration of a phenomenon through the illumination of hidden meanings. While taking the stance of Gadamer in stating that there are no fixed rules for conducting methodological activity in lifeworld research, especially in hermeneutics, Dahlberg et al note that it is nonetheless up to the researcher to make conscious choices about how to proceed with methodology. As noted previously, this is a daunting consideration for a novice researcher. Hermeneutic analysis requires the researcher to move beyond the natural attitude to the world. The natural attitude is comprised of our pre-understandings and unquestioned knowledge that determine how we view the world in our everyday lives in an uncritical and un-reflected way. Dahlberg et al call for the use of a “scientific interpretational attitude”, the components of which are based on the following principles of Gadamer:

- The importance of philosophical and scientific openness to human understanding.
• Awareness of tradition including suspicion of oneself as researcher
• Cautious use of theory to prevent pre-understanding from controlling the process of understanding.
• Search for the “otherness” – the search for an understanding of a phenomenon that is not given by one’s pre-understanding. (pp 277-278).

After the initial engagement with the data described previously, the researcher began to identify tentative interpretations – the next level of the hermeneutic spiral as stated by Dahlberg et al (2008). This dialogue involved further listenings to the interviews as well as readings of the previous notes and impressions. This continued until it was felt that no new interpretations or meanings concerning the research questions were found. Dahlberg et al recommend that the validity of the interpretations be continuously evaluated. They suggest that some of the tentative interpretations will not fulfill expectations when they are tried out against the data. The researcher found this to be the case as some beginning interpretations were discarded as the process of writing about them was undertaken. These stages of analysing the data are set out on the following page in Diagram 6.1.
Diagram 6.1 Process of data analysis

1. Interviews transcribed and immediate responses recorded. What stood out and why?

2. Re-listening to interviews. Recording comments and phrases on individual notes

3. Listening with empathy. Responses noted in reflective journal and discussed with supervisors

4. Grouping individual notes with reference to commonalities and contradictions

Tentative Interpretations

Writing about these tentative interpretations – testing them against the data. Discarding or modifying the interpretations to align with the evidence

Final interpretations
Dahlberg describes the higher levels of the hermeneutic spiral as the path to discovering “a new whole” (p. 284). In this stage a comparative analysis is undertaken. The tentative interpretations that are grounded in and validated by the data are compared with each other to seek out similarities and differences. This is where the analogy of a jigsaw puzzle comes into effect – small segments of meaning are put together in order to see larger structures and patterns of meaning that were previously hidden. With this complete, Dahlberg et al state that one main interpretation or common denominator should now emerge that is consistent with the data and with the previous tentative interpretations. They assert that an empirical hermeneutic study should not end with a particular phenomenon being revealed in a new light from a number of perspectives. Instead the end result of a hermeneutic study should include one further step - the production of an interpretation that brings all these perspectives together.

Having outlined the process undertaken to analyse the data generated from the 24 transcribed semi-structured interviews, the next step was to decide the process of reporting the findings. This has been structured according to Dahlberg et al’s (2008) hermeneutic reporting of findings moving from the lower levels to the higher levels of the hermeneutic spiral producing a number of interpretations that are finally encapsulated in a main interpretation offering a new way of viewing “the whole”. For this study this process has been conducted twice – once for each of the core research questions.

The first of the research questions “How is an episode of acute mental health inpatient care experienced by consumers, workers and manager?” is discussed in the light of six interpretations which are then drawn together in one main interpretation that addresses this research question. In the same way, the second core research question “Do consumers, workers and managers in an acute mental health inpatient setting share a common understanding of the meaning of recovery from mental illness?” is discussed according to five interpretations that are then encapsulated by a main interpretation. The researcher has then taken this process one step further. The two main interpretations resulting from the core research questions are viewed
alongside each other to arrive at one overall major interpretation. This is represented in Diagram 6.2.

**Diagram 6.2**

- **Research question 1**
  “How is an episode of acute mental health inpatient care experienced by consumers, workers and managers?”

- **Research question 2**
  “Do consumers, workers and managers share a common understanding of the meaning of recovery from mental illness?”

- **6 Interpretations**
- **5 Interpretations**

- **Main Interpretation 1**
- **Main Interpretation 2**

- **Major Interpretation of the Study**
  “The lived experience of acute mental health inpatient care – what’s recovery got to do with it?”

One of the most important aspects in determining the validity of interpretations according to Dahlberg et al (2008) is that of reflection about the possible effects of pre-understandings. Reflection should be done throughout the whole research process as a way of maximizing openness by identifying and clarifying the inevitable impact of the researcher’s persona on data-gathering and analysis - intersubjectivity. In a similar vein Willig (2012) notes that interpretation is a product of the
relationship between the text and the interpreter requiring an awareness of the nature of this relationship and how it shapes the interpretation of the data.

In this study the researcher undertook to keep a reflective journal throughout the process discussing aspects of the journal with her supervisors. Personal reflections are interspersed within the body of this dissertation to honour the openness of the research process and thereby address aspects of validation or credibility. The following reflection concerns the researcher’s pre-understandings towards the research topic. This provides context to the purpose of the research and prepares the reader for the interpretations arrived at in the findings.

### 6.5 Personal Reflection 2

*Personal Reflection #2*

The first pre-understanding that I had to acknowledge was my closeness to the subject matter. The process of openness requires a non-judgmental stance of curiosity and a position of “unknowing” in order to expand horizons of understanding (Finlay 2011). Given that I had worked in the field of inpatient mental health care in this facility for over a decade before undertaking the study and continued to work within this field during all phases of the research, my impressions, opinions and experiences were going to significantly impact on my approach to data gathering and particularly to analysis. This reflection commences with my motivation for undertaking the study, as inherent in the motivation lie a number of pre-understandings. Some of the content of this reflection is also contained in Reflection #1 but is now viewed with the purpose of identifying these pre-understandings.

Included in my practice experience was a period of time spent as a social worker in the acute mental health inpatient units. During this time observations of patient and staff experiences often left me with feelings of frustration and at times despondency. The cause of these emotions was the opinion that recovery-focused care was absent in the main and that human
dignities at times were ignored in favour of institutional process. Choice was limited, freedom was restricted and staff attention was conditional. Not only did these practices fail to align with recovery-oriented practice but they were also in opposition to my professional social work practice principles. If my personal experience was one of feeling insulted and at times assaulted on behalf of the clientele of this service, I began to wonder how it must be experienced by the clientele themselves who not only had no choice but to accept these practices, but were at the same time trying to deal with the assault on their senses by a mental illness. The first pre-understanding then was that the experience of acute mental health inpatient care must be wholly a negative one.

I wondered too if this negative experience was shared by the staff who were also regularly exposed to assaults, sometimes both physical and verbal, by unwell clientele. In my own experience and through listening to the experiences of other staff, I also felt frustration at the limited opportunities for change that the system allowed. The environment then, in my observations, operated around a vicious cycle of negativity, restricting opportunities for client recovery and limiting job satisfaction for the workers. The questions then arose – is this everybody’s experience of acute mental health inpatient care and is recovery from a mental illness even possible in this environment?

My pre-understandings were also fed by the literature review that reinforced the notion that an episode of acute inpatient care from the consumer perspective is predominantly experienced as negative. I was experiencing this phenomenon in an everyday uncritical and un-reflective way without searching beyond these assumptions, instead being reinforced in these opinions by the events unfolding around me and the expressed opinions of
others like me. While seeking out a methodology that would focus on meaning and take an empathic stance, it must be acknowledged in hindsight that I was strongly of the opinion at the commencement of the study that the process would give voice to those most embedded in the experience of acute mental health inpatient care and that this voice would reveal an intensely negative experience.

Working within a strong medically focused environment one cannot help but be influenced by the learning and knowledge that drives the way in which a service emanating from this focus is delivered. I had undertaken further study in the field of mental health in the years I had worked in this setting and the language of medication, symptomatology and diagnosis were not only familiar but also regularly utilised to converse with colleagues. This results in another uncritical component of the way in which work in this field is undertaken. Although I was aware of the potential labeling function of this language and the issues of power imbalances that this created in the workplace it was nonetheless absorbed and utilised. At the same time the use of this definitive language was further absorbed into a way of thinking – a tendency to view people as their symptoms – no matter how hard one fights against this happening. A second pre-understanding therefore that must be acknowledged here, is that of the use of medical/psychiatric language and its taken-for-granted use and impact on perceptions of the inpatient experience as well as perception of the individual person on whom it is used. As will be revealed later this impacted on the process of engaging with the data, especially the data generated by consumers.

Another pre-understanding that impacts on this study is my training in a counselling role and the knowledge of psychotherapeutic processes. Finlay (2011) talks about pre-understandings such as those generated by training as being able to either help or hinder – she urges researchers to consider what
“blinders” and what “enables” when considering the impact of prior learning. In conducting the interviews I felt enabled through having the skills to empathically listen and to assist with self-expression of the personal narrative. However, combined with my knowledge of the lifeworld under study, challenges were present in that I had to bridle social work responses that would have been appropriate if I had held the position of the unit social worker rather than the position of researcher. Careful consideration had to be given to the different role being undertaken as a researcher as opposed to a clinician in this setting. Aspects of the narrative that may have been otherwise responded to with a clinical action had to be put aside to allow for a full rendition of the person’s situation as it was being experienced by them and without responding with a professionally obligated intervention. This also impinged on my responses as I listened to accounts of particular staff or other consumers that I had prior knowledge about or situations that had evoked a strong emotional response previously, such as perceived injustices.

6.6 The Reporting of Interpretations

The following three chapters outline the interpretations arrived at through the hermeneutic process of analysis. Chapters 7 and 8 present the interpretations that are matched to the first two research questions. These interpretations are then considered alongside each other to produce the major interpretation revealed in Chapter 9. As noted previously, reflexivity as an act of bridling, builds the trustworthiness of the data. Vagle (2014) refers to the work of Macbeth who identifies different expressions of reflexivity. Position reflexivity acknowledges the centrality of the researcher in the research act. In this study the positionality of the researcher is addressed in the personal reflections. Textual reflexivity refers to the written expressions of the lived experiences. This includes both the edited narratives of the participant voices and the reflexive voice of the researcher. In this study, the participant voices (edited narratives) are embedded in the interpretations (researcher’s voice) demonstrating a continuing engagement with the phenomenon and those experiencing the phenomenon. According to Finlay (2008), the use of
participants’ words is a way of grounding analysis empirically in data (p. 231). The data is presented here in a way that combines interpretation with the evidence. Special mention needs to be made therefore, about aspects of data reporting in the following chapters. These include the use of quotes, the use of tense and sequencing.

Quotes from the participants are woven throughout the narrative of interpretation, allowing the voices of those interviewed to take a central place. In doing so, the conventions covering the inclusion of quotations in academic writing for these chapters have been put aside in order to honour one of the values underlying phenomenological methodology – placing the participant voices to the fore. Similarly, comments made immediately following the direct quotes are often in the present tense to heighten the immediacy of the person’s experience and bring the reader more directly into the person’s world. Subsequent discussion of the experience, however, may be discussed in the past tense, putting distance between the actual experience and the beginnings of interpretation. Some quotes may also be repeated throughout as the same quote demonstrates specific aspects of different interpretations.

Some of the interpretations are more fully “owned” by a particular group - consumers, workers or managers. For example, an interpretation may have arisen primarily through worker narratives but may also have emerged throughout the consumer or manager narratives. The subsequent discussion may therefore commence with the worker voice followed by similar threads evident in the consumer and manager narratives. As a result, the sequencing of participant contributions may vary from interpretation to interpretation.
CHAPTER 7 –The Lived Experience of Acute Mental Health Inpatient Care

Interpretations Part One

7.1 Introduction
As outlined in the previous chapter, the interpretations of the data have been structured according to Dahlberg et al’s (2008) hermeneutic reporting of findings moving from the lower levels to the higher levels of the hermeneutic spiral. This produces a number of interpretations that are finally encapsulated in a main interpretation, offering a new way of viewing “the whole”. For this study, the process has been conducted twice – once for each of the core research questions, as represented in Diagram 6.1 in the previous section. This chapter outlines the interpretations for research question 1 and concludes with a discussion of some of the issues raised.

Diagram 7.1
7.2 Interpretations – research question 1

7.2.1 Mutual support overcomes the isolating effects of difference

A sense of mutual connection originating from experiences of difference emerged for participants across the three participant groups. For consumers in particular, the importance of meeting others with similar stories was a significant factor in their initial adjustment to a frightening and for many, an unknown environment. The negative effects of isolation and difference that had plagued them in their everyday life was broken down and dispersed by the immediate connection and sense of understanding that now surrounded them. This was not something that had been expected by them and indeed for many not acknowledged until afforded the opportunity to consider more closely their experience of inpatient care. This emerging understanding is something that is heard in their narratives as they “discover” this aspect of inpatient care that provided comfort and reassurance ... *I think the biggest factor would have to be um, probably the other patients funnily enough to engage with them, to know their stories, to sort of reflect and go ‘hang on this guy’s in here for the same reason’, it’s not just, you’re not here doing this alone. I think that helps a lot ... (Alan, consumer)*

There is a sense of connection heard within these narratives, a shared experience and understanding that does not require explanation or justification ... *I was around other people that understood me. Cause you don’t get that in the society end of life... (Bill, consumer)*. It is automatic and without judgment - something that rarely occurs outside of this insulated inpatient environment, providing some refuge from the sense of alienation and discordance experienced in their everyday lives ... *To be quite honest when I, when I was down the street or anywhere else I quite felt like I was the odd person out at times but when I come here I felt like I fitted in. So it felt quite, quite good for me ... (Sam, consumer)*. For Bill this experience of being understood extended to the whole mental health hospital environment ... *it’s the first time that I’ve been to a...hospital... that the staff understands me, like doctors don’t usually get it, the public hospitals wouldn’t, but this place is tailored for mental illness ... (Bill, consumer)*. For these consumers the mental health inpatient
environment is providing a place of acceptance and automatic understanding, one that encourages support and disclosure ... and I could share quite easily what was going on for me and it felt good to just have it out there ... (Sam, consumer).

For workers also there is a strong collegiate connection that binds them together as a team looking out for each other, or as workers sharing a common experience that is viewed as different from the norm. In talking about the challenges of working in mental health, John identifies what he sees as a defining feature of mental health work...the majority of the time we are fairly supportive of each other and that’s a bonus of mental health ... (John, manager). Like consumers, there is a sense of only being understood by those who share this experience, premised on a mutual understanding of the “differentness” of mental health as a field of work ... and I just think people in mental health are just a little bit different and I mean that in a very positive way ... (Jan, worker). This difference, while cementing a collegiate bond is also isolating ... and it’s also hard because I can’t really, I can talk at home about some stuff but it’s not the same ... as having a chat with someone I work with ... (Joe, worker). This comment mirrors the sense of isolation experienced by the consumers when trying to articulate their situation with those who have not shared their experience of emotional or psychological distress. There is a shared sense of feeling different from the norm – for consumers the difference is centred in their alternative experiences of thoughts and emotions to that of the mainstream. For workers, it is about their perceived sense of experiencing a workplace that is different to the other fields of health. Like consumers however, while this feeling of difference can be experienced as isolating it is, at the same time, responsible for the creation of a common bond that alleviates the sense of isolation.

7.2.2 Reciprocal care is therapeutic generating personal satisfaction and feelings of connection

There is recognition that the personal engagement that occurs and the care provided in this setting is a two-way process – that staff and consumers develop a sense of reciprocity in the helping relationship. From a worker ... you build rapport with them but it’s not only that. I mean she would pick up on things that were happening
with me ... She was very intuitive and yeah, I think it was it was not only the fact that I had gotten to know her, she’d actually gotten to know me ... (Linda, worker). This is reinforced by William, who is a manager, as he reflects on what he’s learnt from his years working in acute inpatient care ... some of the lessons I’ve learnt from people in care, they observe the staff. They can tell you which hand you used to open the door. They can tell you what time you go for your toilet break ... how you pick your nose and there is this assumption that it’s one-way traffic and the irony is (laughs) it’s two-way traffic ... (William, manager).

The experience of reciprocity and the sharing of experience is noted by workers in regard to their relationship with the consumers. There is a recognition that working with as opposed to working for gives rise to a sense of fulfillment, ... we did it together, we made life better ... and ... the hard hills are coming, when the journey’s gonna be hard but um, and I can be there to walk with them through that ... (Tracy, worker). For the more experienced nurses in particular, the concept of working with was a new discovery that ran contrary to traditional training ... I ... started to think about you know, um, ‘doing with’ instead of ‘doing for’ or ‘doing to’ ... (Andrew, manager). This reciprocity develops a connection over a period of time that extends beyond the individual person ... it is something that has sort of kept me in mental health ... that fact that you can establish a bit of a connection and you do know their families and their kids ... (Joe, worker). Likewise, consumers express concern for the workers as they go about their daily work ... I admire ... all the staff in here ... with what youse have to put up with ... (George, consumer). Similar sympathy is shown by Alan who makes a suggestion about patient attendance at morning meeting ... if patients choose not to (attend) it makes it harder for the nurses because they’re already understaffed, it just gives them a bit less pressure ... (Alan, consumer).

Consumers speak about the value they place on being able to help others. As noted previously, many felt they were assisted by other patients when they were first admitted and wished to reciprocate this care, not through a sense of obligation, but because it engendered personal satisfaction ... we help each other out more ... it
makes me happy helping out so, yeah we’re all just sort of helping each other out that way ... (Sam, consumer) ... it helps me as well, it’s really boosted me up as well of talking to the patients and even helping the patients ... (Carrie, consumer) and from another ... I’m going to go and find people that are hurting and make them feel better .... and I can do a lot of good for a lot of people and I’ll just continue on doing that ... (George).

The experience of giving or receiving care is perceived and valued as reciprocal in this environment. Consumers connect with consumers through a desire to reach out to others, to share their common experience. Likewise staff feel a common bond with each other as they perform their daily work – work that they feel is set apart from other fields of health work particularly those that are based in the physical health field. This reciprocity spills over into the relationship between staff and consumers, at times each looking out for the other engendering a sense of connection that transcends patient-worker roles and moves into the realm of person to person.

7.2.3 Listening is fundamental to mental health care but is often absent in the experience of inpatient care

“Nobody listens/there’s no time to talk” – these are two sides of the one coin, a coin that represents the significance of these two seemingly simple actions of listening and talking. A plea to be listened to is evoked strongly in the consumer narratives. Even for those whose period of inpatient care is described overall as positive, most experienced times of feeling negated and dismissed. Conversely, there is acknowledgement from workers and managers that while making oneself available to listen and talk with consumers is a core skill in mental health care, most feel there is little to no time to devote to it in a busy inpatient setting. This results in frustration for workers and feelings of invalidation for consumers.

During an acute inpatient stay consumers are battling to make sense of a condition that feels like an assault on their senses. This may include racing thoughts, hearing voices, fear of harming themselves or an overwhelming sense of emotional paralysis
brought on by deep depression. At the same time, they may be experiencing the
effects of powerful medications that are attempting to counter these very
symptoms. While trying to make sense of this for themselves, they are then
struggling to translate it to others, at times being actively prevented from doing so …
they’re not interested at all with what you say. They just go “oh right, … we’ll give
you something to calm you down”, and it’s actually like you’re not being listened to
at all … (Drew, consumer).

The feelings of powerlessness and invalidation that result from not being truly heard
are evident in Delia’s narratives … I just wish they would listen to me, you know? So
like I said it’s really frustrating, it’s really hard, … and …“I don’t seem to be able to get
that through to them you know … and while ever, while ever I’m like this I’ll never
get home because … . (starts crying) I don’t feel like I’m getting any better … (Delia,
consumer). This experience of being dismissed is amplified by the creation of an
alternate version of events by those around you who are in charge of your care … I
just feel that they think I’m getting better when I’m not … (Delia, consumer). This
alternate version of events is reinforced by diagnostic language … it just seems like
they’re words to have control of me while I’m in here … (Drew, consumer).

Struggling to make sense of what is a complex and nebulous state of being that has
been labelled as mental illness, especially at the very time when this state is being
experienced, is not an easy task. It requires a generous slice of time and a fully
empathic stance from the listener, something that is not evident in the consumer
experience of inpatient care … Yeah, all they did was just sit down and just wrote
everything down and they didn’t ask you any questions about anything else, what
you were going through … they didn’t take the time, they didn’t take enough time
with a one-on-one patient to discover what that person is really going through …
(George, consumer). The opportunity to express how one is making sense of one’s
experience and what ‘that person is really going through’ is identified as one of the
most important needs of the consumer … let them tell their story, let them just feel
like they’re being listened to, I guess that’s probably the most important part …
(Alan, consumer).
On the flipside of this coin, workers consistently lament the lack of time to “sit down and talk with” the consumers within the busy acute inpatient environment. The therapeutic value of talking is recognised as a tool of empowerment ... you know if I had more time I could do another ten things for that person, even just sitting and talking with someone, really talking I mean for an hour about how they can make these changes themselves and giving them the tools to do that ... (Angie, worker).

Talking with consumers is seen as an essential nursing tool ... you can learn so much from reading a book and reading the journals but until you actually go out there and engage with people who are suffering from a mental health problem ... and ask them about their thoughts and emotion ... I don’t think you ever actually start to pick it up until you sit down and have that conversation ... (Rob, manager).

The importance of talking with each person (consumer) is also seen as a necessary part of accurately assessing that person’s situation as noted by one worker ... so then sitting down and talking to them, just getting a feel for what’s going on and, and really just trying to address the problems that pop up ... (Max, worker) ... and from Michael ... I think I get a chance to talk to patients but probably not very much ... I mean my conversations are more sort of assessment conversations. Michael makes the distinction between his short term “assessment conversations” and those ... that maybe take place over a number of times and can lead somewhere ... or those conversations that ... might be much more in line with what the patient thinks is important to talk about. Michael does not see himself as necessarily the most appropriate person to have these conversations as he tells consumers ... look you need to sit down and talk with someone about that and I can’t do that (Michael, worker).

Opportunities for the deeper therapeutic use of talking are seen as limited within this setting ... the talking type therapy doesn’t really have that much of a role unless patients are in for at least a week or two and then psychology can start talking to them ... (Max, worker). Instead, the deeper kinds of conversations are seen as the domain of specific professions such as psychology or other allied health workers or
as more appropriately taking place in the community after discharge. As Michael states ... *look I’m sure the Allied Health staff often have opportunities to have conversations with people* ... but then notes the limitations around the chances of this happening by adding ... *but, you know, they’re often short staffed.* Likewise Michael acknowledges that these conversations used to be the domain of the nursing staff but that this does not happen so much anymore ... *some patients often mention conversations with nursing staff but I think nurses nowadays very rarely get a chance to talk to patients properly.* This opinion is mirrored by the nursing staff and expressed with conviction by Jan when asked to explain why spending time talking with consumers is so important ... *Well I thought that was probably the focus of the industry, myself ... I mean it’s a bit like have a mechanic’s workshop and not going near a car but making sure that your stock’s all there, you meet the standards of the people who come round and give you accreditation and all the rest of it. Everything’s perfect but nobody actually gets to work on the car...* (Jan, worker).

Managers too recognise the centrality of talking and listening as a skill to mental health. The managers interviewed were all of nursing background. Many strive to stay in contact with their clinical roots by ensuring they speak with consumers through the course of their day ... *if I see a client, talk to a client ... that’s my most important part of my role as a nurse, because I’m still a nurse. I might be a manager but I’m still a nurse ... I think that’s the most important part of anything – talk to people ...* (John, manager) ... and from William ... *normally I would sit down and have a chat with a patient in care, just sit down and say ‘oh look my name is W, how’re you going ... and before long they will start ... talking about their own journeys and I get sort of motivated by that ...* (William, manager).

Being able to spend time talking and listening is an important factor in developing positive relationships that can also be drawn on in times of heightened emotions and escalating tensions ... *when it comes to incidents on the ward that have aggression ... I rely on my therapeutic relationship with the clients a lot ... if I have a previous good relationship with that patient well then it’s easier, you know, and the result is better for them* (Thomas, worker) and ... *I must say ... that connection has*
helped me diffuse so many things over the years ... (Joe, worker). If workers are able to fall back on their positive relationship with consumers they feel more able to deal with potentially aggressive releases of emotion and ensure a beneficial outcome for all.

Consumers, workers and managers recognise that talking and listening is an inherent and necessary skill in mental health care. However, participant narratives indicate that this skill is not enacted sufficiently in a way that is beneficial or therapeutic within this acute inpatient environment. Workers feel swept up by the administrative and bureaucratic demands of their job that takes them away from what they strongly believe is their core business - the time to “sit down and talk” with those in their care. Managers refer to opportunities to talk with consumers as something that grounds them and keeps them connected to the purpose embedded within the origins of their nursing profession. Worker/consumer conversations are seen to be on two levels – the ones that fulfill the clinical requirements or attend to immediate needs and those that are led by the consumer allowing space for them to make sense of their situation. Opportunities for the latter kind of conversation are mostly absent, considered to be the domain of “others” who themselves complain of a lack the time to engage in this way. Consumers feel disempowered when their efforts to make meaning of their current distress are being disregarded or dismissed. This deeper level of listening is missing within this setting even though it is acknowledged by workers and managers as an essential core skill of mental health work and decried by consumers for its absence.

7.2.4 Witnessing consumer recovery from a mental illness is a deeply emotional experience for workers and managers

While it was expected that interviews with consumers who have a lived experience of acute mental health inpatient care were likely to evoke strong emotions from the respondents, it came as a surprise that these emotional responses were more frequently evinced by the worker and manager participants. The emotional responses arise from an expressed passion for mental health work. For some this passion for mental health is explained by the sense of reward they feel in their
connection with consumers as they witness the consumers’ struggle to deal with an intense unwell state of being. They acknowledge the anguish experienced by the consumers and share the celebration when the person regains his/her wellbeing. Recalling these moments triggers an emotional response, especially when the person acknowledges the worker for their involvement in this transition to wellness.

... some of the comments I’ve gotten from those patients where you’ve really gotten to know them relatively well ... yeah ... the little note, I actually feel a bit sad because I’m concerned about her ... a little note ... (starting to become tearful), I’ve just got it hidden in my drawer ... (Linda, worker) and from another worker ... I’ve got a collection of letters that clients have actually given me thanking me ... and that’s just so empowering ... I’m getting all teary now (nervously laughs) ... (Susan, worker).

This intense emotional response to a person’s recovery is also expressed by Joe ... just being there and being in a position to help them and see them come in the door you know, psychotic or whatever, see them two weeks later, you know and they’re shaking my hand ... (pauses, becomes emotional and clears throat). Joe then apologises ... sorry, yeah, but that’s um, it’s something that has sort of kept me in mental health ... the fact that you can establish a bit of a connection (Joe, worker). Tracey also surprises herself with the depth of emotion the interview conversation evokes. While describing her work with people and seeing them emerge from a very unwell state she remarks ... they’ll be stories that never leave my memory. When Tracey is asked to explain what impact these stories have on her she states ... oh, I get very emotional (crying and laughing) yeah, that we did it together, that we made life better (Tracey, worker). Recalling a moment when he was working with a person who he felt had been misunderstood, William pauses to catch the emotion this recollection brings ... there was an Aboriginal elder in care and (pauses) it almost brings tears to my eyes, and she was there and I introduced myself and said ‘my name is W, I’m part of the services’ ... (William, manager).

It is this sense of human connection that leads many of the worker and manager respondents to reflect on their thoughts about the nature of their work ... just having
a client come back and say ‘thanks’ ... they’re just open and raw when they come in and ... there’s not many places that do what we do and still have respect for the people that come through and I think that’s where it comes from. I love being here, I wouldn’t be anywhere else (Anne, manager). The language Anne uses to describe her feelings for her work is very emotive and parallels language usually reserved for describing intimate human relationships ... I got here and I was literally only going to stay for a year and I ended up just falling in love (Anne, manager). This language is matched by others. Jan laments the fact that she didn’t start her career in mental health nursing until her forties ... so I was actually, what, forty before I got to do mental health nursing and it’s like I’ve died and gone to heaven ... I love my job, I do, I love it ... (Jan, worker). Likewise Joe came to mental health nursing at a mature age after trying a variety of other vocations ... I did the twelve months as an enrolled nurse ... and then I just loved it. I couldn’t get enough of it ... I’ve loved it ever since ... and ... to me it’s been probably the most enjoyable job that I’ve ever done. It’s a shame, I always wished that I’d started it earlier ... Joe also explains the possible reasons behind this attachment to his work ... but honestly I love the whole ... thing about it all and I think ... just the fact that I have ... some sort of effect on people, you know, on the outcomes in some little way ... Likewise, Max attributes his period of locum work in mental health for restoring his faith in the field of medicine, a sentiment that even surprises him...over the past six months or so ... I’ve realised that I actually like coming to work which is surprising in that all the rest of medicine I’ve hated. When asked to explain his surprise Max states ... I do, I enjoy it. I enjoy people ... and that every patient is different, every person is different and they’ve all got their own stories ... (Max, worker).

Tracey explains her connection to her work in a similar way ... if you can make a tiny bit of difference in that person’s day, in that person’s moment it’s um, ohhh, it’s empowering, you achieve something ... and if you multiply that with an interaction ... with fifteen different people in the day it can be fabulous ... (Tracey, worker). Feeling part of the process that has enabled positive change for a person afflicted with symptoms of a mental illness is a highlight for many of the workers ... one of the highlights definitely is when you see some huge change and it happens more than
you think ... you take people so far ... and you walk with them ... you know I haven’t ever seen that change before in my work (Angie, worker).

Working in mental health and specifically in an acute mental health inpatient unit exposes workers to human experience at its most vulnerable and raw. Perversely, this offers a positive opportunity to witness profound change as people emerge from a fragile and wounded state to one that is increasingly strengthened and whole.

Acute mental health inpatient care represents for workers, an emotional investment in human experience during a time of vulnerability. It is an experience that is deeply poignant and grounded in a connection that perhaps results from one human being’s vulnerability being matched by another’s desire to care. This experience evokes visible and powerful emotions in the workers when they are asked to reflect on the nature of their work. The emotions range from humility that comes from sharing a difficult time in someone’s life, to high declarations of love for the work they do.

Witnessing and feeling part of another person’s transformation to wellness goes to the heart of human connection.

7.2.5. Safety and the notion of asylum – a multi-layered issue in acute mental health inpatient care

The issue of safety emerged for respondents across many levels. A sense of safety is paramount but is experienced and commented on in differing degrees. The inpatient experience for some consumers is life-saving, with care providing sanctuary and asylum reinforced by rules that clarify boundaries. For others, particularly workers, there is a feeling that the provision of safety spills over into a realm of custodial and restrictive containment. Safety is a concern for consumers unsettled by fellow patients’ unpredictable behaviours or unable to trust their own strong urges to harm themselves. Safety is a concern for managers who are charged with the responsibility for the safety and wellbeing of both staff and patients and who begin their day with feelings of apprehension about what may have occurred during the night shift. Safety is provided through the provision of 24 hour care and through trust arising from developing positive relationships – worker to consumer, worker to
worker and consumer to consumer – within an environment tailored to understand the complexity and isolation engendered by mental illness.

For Carrie the admission to hospital is attributed with saving her life … *I was very suicidal, if I didn’t get in when I did … you wouldn’t be sitting here talking to me today…I would have been six foot under for sure, definitely ...* (Carrie, consumer). Ensuring safety by protecting people from themselves is also recognised by staff as Thomas states … *patients who are acutely suicidal ... that safety of I suppose taking the power away from them to commit suicide ... is in some way empowering for them ...* (Thomas, worker). For those experiencing the sometimes frightening symptoms of a mental illness, the lack of safety felt within themselves originates from a distrust of their highly charged emotions … *yeah I was just scared of what could happen … like taking all my tablets, just taking all them, like I’m scared that would happen although I know it wouldn’t but it’s still, the thought was in my head. That’s what scared me ...* (Sam, consumer). For Sam, as for other consumers, the availability of 24-hour care within the inpatient setting provides him with a significant feeling of safety … *just by having nurses here 24/7 ... when I was at home going through this ... I was like yeah, just scared of what could happen. For Carrie too, the 24-hour care is a significant factor in her sense of safety …* having so much support around you 24/7 knowing that you can go and ask for help anytime ...* like just knowing that it’s there ... (Carrie, consumer).

The identification of the role of inpatient care as keeping people safe during an acute phase of mental illness is shared by respondents across all three groups. Workers and managers are also able to see the inpatient admission as affording safety to those in need … *that’s one thing we provide so beautifully, safety, and someone else is going to look after me for a while ...* (Tracey, worker) and from Anne … *I think that we have a very powerful place to play in that when people are that acutely unwell, we’re their sanctuary ...* (Anne, manager). Thomas agrees … *we’re very good at keeping people safe ...* (Thomas, worker). Within these responses there is a call to those who are unwell to relinquish responsibilities for a time, to relieve themselves of burden. There is an implied trust in handing over this care, a trust that someone
else “knows better” at least for a temporary period of time. Consumers also see inpatient care as a form of respite or safety ... just being here, just having time to think, a time, a place to recover ... a time away from out of society, out of the rat race, a time here to just reflect (George, consumer) and from Alan ... It takes a lot of pressure off you ... it takes you away from the outside world so you focus more on yourself ... (Alan, consumer).

The provision of safety by the use of containment and rules is commented on as both a negative and positive feature of acute mental health inpatient care. A level of control is seen as necessary for those who require protection from themselves whilst experiencing harmful thoughts or behaviours brought on by their mental illness symptoms. Safety provided through custodial means, however, evokes many negative responses and concerns on the part of workers and managers who feel a need to speak out as a way of advocating for consumers. Andrew believes that safety need not be provided solely through custodial means ... safety would be based around the systems not the locks ... and sees a risk for the acute units as ... becoming so focused on safety ... that we really do forget about creating an environment that works for people ... (Andrew, manager). Angie recognises the safety provided by a secure, contained environment but this comes with some wonderment as she reflects on an apparent clash with her profession’s values ... you know we’ve had people come from a private hospital to here because the private hospital has unlocked doors in the mental health ward and they don’t feel safe and that’s really interesting because we tend to argue ... that locked doors are really negative and we’re keeping people closed in but people ... feel safe here. (Angie, worker).

The closed-in, locked environment of one of the acute inpatient units with its associated custodial procedures draws strong reactions from some workers, seeing forced containment as increasing the likelihood of trauma ... it’s like being in a jail and that’s because of all the security that you’re going through ... (Linda, worker) and even more forcefully ... it’s suicidogenic, I mean it’s just awful ... (Michael, worker). Matthew is concerned that the custodial environment has an effect on
nursing staff who are responsible for letting consumers in and out and for checking them with a metal detector on return. He believes this sends out a mixed message about trust ... OK we believe this person is right to go out on unescorted leave, so we’re saying we have this level of trust but when they come back we don’t have that level of trust, we’re going to swipe you down ... (Matthew, worker). Linda also comments on the use of a metal detector believing it detracts from a level of human connection ... oh for goodness sake, I’m not a correctional officer... I prefer to stand there and say ... ‘I’m a person, you’re a person, let’s talk about this’ ... (Linda, worker).

While some of the consumers were critical of the security arrangements, there was a surprising acceptance of the custodial rules and processes. For some this was related directly to their feelings of safety. Bill talks about his gratitude for the rules of the acute inpatient unit ... you have to have a worker to let you out, so that’s what I needed ... you have to follow the guidelines, it’s a good thing ... I’m the sort of person that adheres to rules and regulations. I love it because I feel safe ... (Bill, consumer).

While Mandy had a difficult time initially with what she saw as an overuse of security guards during her admission, she felt that it was important to have rules ... you’ve got that trust and if you break it well then you know, your punishment’s fair I think ... (Mandy, consumer). Carrie takes a more extreme approach calling for even greater security measures including more scanning as well as strong measures to ensure that patients are taking their medications ... but I just think it would be more rewarding and better outcomes if they really do get them to open their mouth, lift up their tongue and make sure it’s definitely gone. Yep, absolutely ... (Carrie, consumer).

Drew, however, is still experiencing the security in a very negative way ... I felt very let down...I’m locked in here, I’m taken away from society ... I felt like I’d done something wrong ... (Drew, consumer).

All groups acknowledge the important role inpatient care plays in providing a sense of safety during a time of emotional fragility and need. There is comfort and security in the provision of an all encompassing 24-hour safety-net and in the ability to “hold” responsibility on behalf of someone too overwhelmed to continue to bear it.
There is a level of discomfort for workers, however, with the security measures they are required to perform and with their role in providing forcible containment in the name of “safety”. Surprisingly from the receiving end, only one consumer matches workers’ concerns in this respect. Consumers appear able to derive a sense of safety from the very security measures that some workers feel are custodial, oppressive and potentially harmful to consumers’ well being. There is a picture created of workers advocating strongly on consumers’ behalf to alleviate the atmosphere of oppression and harm created by the institution’s need to ameliorate risk. Consumers on the other hand, have either absorbed the organisation’s culture of custodial measures as a way of creating “safety” or have found exactly what they were looking for when they entered care in a vulnerable state and in need of protection. There is a mixed picture involving the need for risk management and the provision of asylum.

7.2.6 Inpatient mental health care is defined by its comparison to inpatient general health care.

Throughout the participant narratives a comparison emerges between the nature of care received in a mental health facility to that offered in a general inpatient facility. In seeking to explain the nature of mental illness or the experience of receiving or providing mental health inpatient care, participants often resort to setting one experience up against the other. For consumers this comparison helps to make meaning of their feelings of difference and estrangement from the mainstream. For workers it is a means by which to separate out their specialist skills and claim their professional identity.

Consumers are surrounded by others with common experiences in this inpatient setting as noted previously. This goodness of fit extends to the inpatient environment as a whole and is differentiated from the general health inpatient setting ... like it’s the first time that I’ve been to a ... hospital ... that the staff understands me, like doctors don’t usually get it, the public hospital wouldn’t but this place is tailored for mental illness ... (Bill, consumer). Alan also compares having a mental illness with having a physical condition in his efforts to explain the complexity of the former. He takes the example of mental illness and a broken leg ...They both
can be mended but people would understand the broken leg more than depression, anxiety, bipolar anything like that, ‘cause it’s tangible ... you can visually see it ... (Alan, consumer). Mandy provides a similar comparison ... your kidneys and your body, your organs so everybody can accept that you’re sick ... However when mentally unwell, Mandy feels that there is an element of being judged in seeking inpatient care ... you feel ... you’ve failed your family ... that kind of judgment or you know you get a bit embarrassed that you’ve had a crutch ... (Mandy, consumer).

This comparison between mental health and general health is also a defining feature for many of the workers. John supports consumer Mandy’s thoughts about judgments associated with an admission to a mental health hospital as opposed to admission to a general hospital ... you know people say ‘oh I wouldn’t want to work in mental health because those patients never get better, which isn’t correct. The patients get better, they go home and have a relapse of an illness ... if I have an unstable diabetic in a general hospital I get them better, they go out but they come back because their diabetes is still unstable ... which is the same in mental health ... what’s the difference? ... (John, manager).

Max refers to differences between general health and mental health specifically in the way diagnosis is considered ... in general medicine you tend to treat the problem that’s in front of you much more than the reason for the problem in front of you ... Whereas in psychiatry you treat the underlying causes, ‘cause if you don’t treat them then you’re not really helping the issue... In this way Max is saying that diagnosis in the field of mental health involves a level of complexity requiring one to delve below the surface of what can be seen ... the background is much more important in mental health than it is in mainstream medicine ... (Max, worker).

Having worked across both general and mental health settings, Angie observes the difference in formality between the two in relation to accessibility and communication ... people aren’t afraid to talk to us like you might be in a general hospital ... where they’re telling you in medical terms that you don’t understand. In comparison in this mental health setting she maintains that consumers are ... happy
to walk up and say ‘when can I have leave’ ... ‘what are you doing about this’, so that’s really positive ... (Angie, worker). Workers also comment about the lack of hierarchy in mental health that fosters a more individual and human element to matters of treatment ... a lot of the doctors ... just say their first name to the clients ... we’re all just the same ... I hope they see us as a team ... (Angie, worker). The theme of teamwork in mental health is expanded by Max ... it’s very much more a team effort in mental health as opposed to the rest of medicine ... there’s different hierarchy whereas that’s blurred quite a lot in mental health and a lot of it depends on how you get on with the patient ... I suppose in mental health you sort of work with the patient a lot more ... (Max, worker).

Workers question whether or not mental health attracts the employment of a different kind of person, one who values a more individual approach to care or seeks human interaction. Rob reflects on his experiences in both a general and mental health setting ... I guess it (mental health) was about the person and you didn’t have that as a general nurse and my background was in an operating theatre and everyone was anaesthetised and nobody spoke to anyone (laughs) ... (Rob, manager). Jan’s comment referred to earlier about people who work in mental health being “a little bit different” in a positive way, is mirrored by Max who reflects on the nature of mental health work and comes to a tentative conclusion ... I don’t know how to explain that but maybe people that like that sort of stuff can ... enjoy the personal interactions where they gravitate more towards mental health ... (Max, worker). For workers this difference resides in the very nature of being human and there is a sense of pride attached to this difference as expressed by Jan ... I don’t know, I feel that general nurses are very task focused. They forget that this stuff here (pulling up the skin on her arm) is just wrapping, there’s actually something alive, a personality, a being inside ... This sense of difference for the workers is almost worn as a badge of honour – it separates them from other health workers, makes their skills distinctive and strengthens their collegiate sense of identity.

A comparison between mental health care and general health care is used by participants to help them make meaning of their experience of acute mental health
inpatient care. For consumers it assists with their understanding of what it is they are experiencing as they try to make sense of changeable and sometimes frightening emotional and psychological states. At times it is helpful to draw similarities between mental health problems and those of a physical nature making a claim for commonality as a means of dissipating stigma. For others, particularly workers and managers, it is a way of defining their specialist skills and knowledge differentiating them from the general health branch of medicine or nursing and generating a sense of pride in their professional identity.

7.3 Main Interpretation – research question 1

Mental health inpatient care is a shared experience of human connection.

A central thread that runs through these six interpretations regarding the experience of mental health inpatient care is that of human connection and sharing. Within these narratives human connection is signified by both its celebration and its mourning. It embodies those aspects of care that are positive and affirming while those aspects that are negating and adverse are attributed to its absence.

Human connection is the essence of the workers’ attachment to their chosen vocation in mental health and is expressed through a sense of pride, achievement and even declarations of love. The human connection evokes strong emotions in workers and managers as they recall having been part of and having contributed to another human being’s emotional restoration. Human connection is found in the accounts of consumers who discover commonality, acceptance and understanding from each other, something that is alien to their experiences outside of this intense and closed environment. Human connection allows for heightened emotional tensions and behaviours to be de-escalated or avoided as workers count on their established relationships with consumers to negotiate on a person-to-person basis. It is imputed to be the defining feature of mental health work – the feature that sets it apart from the narrowed focus of general health and the field of medicine that is confined to physical health alone. Human connection underpins the satisfaction derived from the reciprocity of helping. The concept of helping others and being
helped in return elicits emotional responses from workers and is therapeutic for the consumers who are able to reach out to others through sharing their personal experiences.

The centrality of human connection is also highlighted in the narratives by the intensity of responses felt through its absence. A sense of human connection fuels the protest felt by workers on behalf of consumers when they criticise the overuse of security measures or lament the emphasis on risk management over provision of care. These feelings of injustice about procedure and process taking precedence over individual care are based on the perceived lack of respect for human dignity and rights. There is an appeal to the human connection, *I’m a person, you’re a person*, in preference to a “one size fits all” approach to ensuring safety. The majority of consumers do not share the outrage felt by some workers and managers about the custodial measures. However, consumer outrage is present in the magnitude of feelings expressed at the sense of dismissal and invalidation experienced when they are not listened to. Hopelessness, sadness, frustration and powerlessness are present throughout the consumer narratives as they try to express their viewpoint in an environment that shuts them down or overrides their input. This is matched by workers who acknowledge the absence of time to be able to “sit down and chat with” the consumers in order to connect. Feelings of frustration and sadness are present within worker narratives as they recognise this absence while at the same time acknowledging their inability to enact a core skill of mental health work.

Human connection as a core element of mental health work is prominent in an episode of inpatient care. It allows consumers to restore their wellbeing through finding understanding and being able to give back to each other and underpins the emotional attachment of workers and managers to their work in mental health. For both consumers and workers human connection is integral to the experience of inpatient mental health care.
7.4 Discussion of Findings Part 1

7.4.1 The experience of acute mental health inpatient care

An unexpected outcome of this study for the researcher is the predominantly positive accounts of the inpatient experience reported by consumers. The surprise attached to this finding arises not only from the researcher’s observations of practice prior to undertaking the research but also from the primarily negative descriptions of the experience of inpatient care evident in the literature. While it was noted that examples of research in the acute inpatient setting were limited, those that were found portrayed the experience of acute mental health inpatient care in a gloomy light. Expressions like “unremittingly bleak” (Quirk & Lelliot 2002), “myriad of micro-aggressions” (Deegan 1999), “anti-therapeutic” (Holmes 2002) “pervasive culture of custodial care and control” (Bartholomew & Kensler 2010) and “a necessary evil” (Ajayi et al 2009) highlight an experience that appears incompatible with hope and optimism and therefore with a recovery focus.

In this current research the narratives of the consumers for the most part contain positive accounts of their experience of inpatient care. Negative experiences are the exception rather than the rule. When examples of negative experiences are related, most are subsumed within a more positive overall perspective. Criticisms in the literature of an excessive focus on risk management (Nolting 2010; Quirk et al 2004) and of a preference for custodial care and control (Bartholomew & Kensler 2010; Tsai & Salyers 2008) are reframed by consumers in this study as strategies providing safety and asylum. Some consumers even call for further restrictions to ensure that others conform to practices they see as enhancing recovery such as compliance with medication. In this study, in contrast to the consumer accounts and contrary to the literature, it was the workers and managers who railed against some of the custodial measures that they saw as dehumanizing and working against a recovery focus. One worker even described the experience on behalf of consumers, as “suicidogenic”.

While workers and managers were outspoken in their criticism of the perceived overuse of custodial and risk aversive measures, there was strong agreement from
participants across all groups in support of the need to assume a degree of control in the early phases of an acute admission when a person was not capable of keeping him/herself safe or if a risk to others was a factor. Representatives of all three groups acknowledge the safety provided by the inpatient setting’s contained and structured environment. The nature of this environment is credited by a number of consumers as being instrumental in saving their lives – a factor that is often not given its due. This provision of a safe place accords with the discussion of Casher (2013) who applies Winnicott’s notions of a holding environment and attachment theory’s notion of secure base to the setting of inpatient care, as does Holmes (2002). Casher views the inpatient experience as providing temporary substitute care, holding the person safely while he/she moves from the throws of an acute illness to regain a sense of self and to once more take on the issues and responsibilities of life.

The literature indicates that custodial and controlling measures prevalent in the acute inpatient setting render this setting incompatible with recovery-focused care (Holmes 2002; Sainsbury Centre for Mental Health 2006; Swarbrick & Brice 2006; Tsai & Salyers 2008). This prompts the question of whether or not the inpatient setting would be more conducive to recovery if such practices were removed or at least minimised. It would appear from the findings of this current study that such practices would in fact be missed by consumers and may increase fears and safety risks thereby inhibiting their eventual recovery. Why then do the responses of workers and managers take a different path to the consumers in the overall perception of custodial care? They are at one and the same time strongly supportive of the use of such measures when necessary, particularly in the early stages of admission, but are also strongly critical of the impact such measures have on the overall milieu of inpatient care.

Perhaps the overwhelmingly positive accounts of consumers arise from feelings of relief that their episode of mental distress has passed. Their accounts are being delivered from a retrospective position reflecting on their state of distress when first admitted to the inpatient unit and reveling in their current state of a regained sense
of self. Perhaps it was this positive stance and sense of wellbeing that motivated these particular consumers to volunteer to be a research participant in the first place. In a setting of unequal power such as an acute inpatient setting, consideration must be given to other reasons for the positive accounts of experience. These may result from a consumer’s desire to conform, to match the expectations of those who are the decision makers regarding matters of great significance such as discharge or further treatment. From this perspective the positive accounts could be viewed as an example of “testimonial smothering” (Dotson 2011). Whatever the reason for the mostly positive accounts, these are not the consumer voices that are usually found in the literature. This supports the call for more research involving consumer voices (Walsh & Boyle 2009; Kogstad et al 2011; Turton et al 2011; Nordfjaern et al 2010; Johansson et al 2013) allowing new perspectives to be revealed.

7.4.2 The importance of human connection
This study unearthed a significant level of emotion on the part of workers and managers as they shared accounts of their experience of providing care to people undergoing an episode of acute mental distress. Underlying these emotional responses is a sense of connection to another human being. Many are significantly moved by the privileged sharing of the profound change experienced by people within their care that they have witnessed firsthand. This emotion is driven by the acknowledgement of their part in facilitating this change. Others identify the opportunity of witnessing or hearing narratives of consumer lived experience as the defining moment in their understanding of recovery-focused care, triggering practice change from “doing to” to “doing with”. Workers and managers, in the main, preference their lived experience of care over their formal training, identifying it as the significant factor in underpinning their raison d’etre as workers. It is this component of humanity that workers and managers put forward as the defining feature of mental health care, one that sets it apart from the field of general health.

Consumers reference human connection in relation to their discovery of others who share their world of psychological and emotional disturbance. This discovery lessens feelings of alienation and heightens a sense of valued connection to a human
experience that, prior to hospitalisation, was thought to be abnormal and unique to themselves. The ability to share these experiences and reach out to each other in a spirit of reciprocal helping has profound therapeutic value. Workers and managers speak of the satisfaction gained from being able to “walk with” the consumers and there is expressed sympathy and understanding between the groups for each other’s situation. Patient-worker divisions morph into person-to-person encounters.

The notion of common humanity is fundamental to recovery-focused care and is peppered throughout the literature. Early on in the development of the recovery movement Deegan (1995) declared that the recovery approach is based on the simple but powerful tenet that people diagnosed with a mental illness are first and foremost human beings. Anthony (1993) acknowledges this common humanity viewing recovery “as a truly unifying experience” noting commonalities across all people, “helpers included”, as everyone experiences life crises (p. 527). Common or “shared humanity” is a key dimension of inpatient care revealed by Wyder et al (2013) in their meta-ethnography that brought together the findings of qualitative studies on the topic on involuntary health admission. Those inpatients who felt they were treated respectfully as a fellow human being had a more positive and therapeutic experience of inpatient care while those who felt their rights had been violated were left feeling invisible or an object of care devoid of value. Kogstad et al (2011) conclude in their study on a humanistic approach to mental health care that an essential factor in the process of recovery from mental illness is the satisfaction of human needs, both material and emotional. Walker (2006) in writing about language as creating the social construction of mental illness states:

We human beings are all struggling with our feelings, thoughts, impulses and habits. The illusory difference between clinician and client evaporates like a bad dream leaving us with one condition – the human condition. p. 86

The value of human connection was a feature in the incidental opportunities for mutual support. For consumers their discovery of others going through similar experiences is a surprising and uplifting revelation that breaks down their sense of
alienation and feelings of disconnection from the “normal” world. Workers and managers see the world of mental health care as a unique space in which membership brings a sense of belonging and support, clearly separating themselves from those who work in the field of general health. This is an interesting foil to the usual connotations of stigma attached to mental illness. Difference to the norm is celebrated and is perhaps what bonds those in the mental health setting, both consumers and workers.

The value of mutual support is also noted in the literature. Deegan (1988) calls for more consumer-run mutual support groups while Steinberg (2010) asserts that mutual aid is holistic, strengths driven and accords with anti-oppressive practice. Johansson et al (2013) emphasise the importance of “the company of fellow patients” to those in a locked psychiatric ward in providing support, diminishing loneliness and providing opportunities for the sharing of coping strategies. They call for further research into the therapeutic value of this support. Stenhouse (2011) also reports on consumer accounts of inpatient care including mutual support, however it was cautioned that while peer support was valued there was a risk that emotional vulnerability could be increased in taking on the burden of others’ problems. In this current study mutual support was highly valued as was the ability to reciprocate care, a feature that Smith & Bartholomew (2006) note as having “a powerful curative affect” (p. 95). While the value of mutual support is evident in the participant accounts in this current study opportunities for its enactment in this setting is serendipitous.

The notion of common humanity was also the underlying factor in the most criticised aspect of inpatient care. In this case the notion of common humanity was conspicuous by its absence. The strongest plea from consumers was to be listened to, to have their opinions and experiences validated and affirmed. This missing component of inpatient care was supported by workers and managers who revealed their frustration at not being able to be there more for the consumers. The importance of listening has been documented in other studies highlighting consumer voices. Listening to patients was a significant theme identified by Ridley & Hunter
(2013) in their study on subjective experiences of compulsory treatment and Tooth et al (2003) report that health professionals are not good at listening to consumer perspectives. Tooth et al note consumers’ feelings of invalidation through not being listened to as an example of the potentially negative impact of health professionals. Listening is fundamental to a recovery approach. Davidson et al (2016) in their article on the management of risk within mental health, state that recovery-focused practice and supported decision-making “needs to start with really listening and responding to what service users say they need” (p. 163).

Lelliot & Quirk (2004) note that the lack of someone to talk to in both inpatient and community settings is a common source of consumer complaint. They also state that in the inpatient setting it was other consumers who often met this need – a finding that aligns with this current study that identifies the value of peer or mutual support. The report on acute inpatient care published by the Sainsbury Centre for Mental Health (2006) in the UK provides service user descriptions of inpatient care including the criticism that staff were inaccessible, did not listen and were unresponsive to needs (p. 16). The current study reinforces the existing literature in identifying the continuing absence of opportunities to listen or be listened to as a feature of acute mental health inpatient care despite its significance to consumers and its centrality to a recovery approach.

By hearing the lived experience of workers alongside that of consumers an appreciation of a common humanity has been revealed. This finding is congruent with a recovery approach that is prevalent throughout the literature. It constitutes, however, another surprise for the researcher given that the motivation for undertaking the study originated from observations that this component of care was in fact lacking in the everyday practice observed within this system of care. Perhaps the workers and managers are not aware of its intensity on an everyday basis and although its presence is lurking beneath the surface it is not universally being converted into practice decisions. Identifying a shared sense of common humanity among the players within this setting uncovers a platform on which lies extraordinary potential for organisational and practice change to reflect recovery
principles. The players it seems, are willing, but remain single pieces of a large jigsaw that continues to be unassembled due to a lack of clarity about what the completed picture could look like – the picture of an acute mental health inpatient service that supports and maximises the individual recovery of all who pass through its doors.

7.5 Personal Reflection 3

**Personal Reflection #3**

I considered my surprise at the level of emotion demonstrated by workers when asked to talk about their work in an acute mental health inpatient facility. I noted here that I expected a level of emotion in the interviews with consumers given their likely vulnerability at the time of interview when they were recovering from an episode of mental unwellness. However when I put myself in the place of the interviewed workers and managers and asked myself the same questions that I was expecting them to answer in an honest and thoughtful way, I found myself also becoming emotional. I could feel the emotion welling up as I recalled my involvement with certain consumers and I tried to delve further into the why of such a reaction. For me the only explanation was a wonder at the ability of a person to come through such an experience where inner turmoil brings you to a level of unknowing yourself and distrusting your own thoughts and behaviours. There’s a feeling of extreme humility as I realise I may never be truly able to say “I understand” and as I contemplate how I might react in that situation, while at the same time feeling guiltily grateful that I have never had to face such a personal crisis. This results automatically in a suspension of judgment as I take the position of “the lesser being”. For me, it is this deep emotional reaction that spawns the passion for the nature of this work. The still inexplicable nature of mental illness creates a mystery – one that can only begin to be unraveled through a respect for those fellow humans who experience it. There’s a reaching out that is underpinned by a sense of connection based on a common humanity.
7.6 Personal Reflection 4

**Personal Reflection #4**

In the personal reflection contained in the Methodology chapter I stated my pre-understandings of the experience of acute mental health inpatient care. I fully expected the experience to be negative for both the consumer and the worker. Therefore my second surprise in the analysis of the data was the overwhelmingly positive recounting of the inpatient experience from those consumers I had interviewed. While many of them had begun their period of inpatient care on a negative note, whether because of their symptoms at the time or because of inappropriate practice, it seems as if these experiences were put aside once they had been stated and acknowledged in favour of the more positive outcome of their hospitalisation. The positive outcome transcends these negative aspects and reveals itself when the opportunity is presented for them to recount their experiences. Likewise the workers, despite being frustrated by lack of time, bureaucratic process or perceived powerlessness in being able to change some things for the better, state their almost undying love for their work. On reflection, I realised I too declare my love for the work regardless of the power of the negative experiences that I am part of and that had originally catapulted me into this research project. Workers transcend the frustrations of their everyday work lives to reveal a deep-seated passion and connection to their work and to those they care for. I realised that this passion for the work I do was the fuel for the outrage I felt at the perceived injustices I observed in the workplace that in turn drove my motivation for undertaking the research. The outrage at the perceived absence of human dignity and connection led to a revealing of its presence.
CHAPTER 8 – The Meaning of Recovery

Interpretations Part Two

8.1 Introduction

The following interpretations relate to the second research question that explores the meaning of recovery. The concept of recovery was introduced into the interviews variously as “what does recovery from a mental illness look like for you?” or “what does recovery mean to you, can you describe it?” The interpretations that follow highlight the differences and the similarities of the perspectives of recovery as it is experienced and expressed by consumers, workers and managers within an acute inpatient setting. The chapter again concludes with a discussion on some of the issues raised, making links to the literature.

Diagram 8.1
8.2 Interpretations – the meaning of recovery

8.2.1. Recovery from a mental illness entails a return to a previous state of being or place.

Consumers speak about going “back” to a state of being they once experienced, of being able to regain the ability to do things they used to be able to do or of returning to a desired place. This is described in various ways … I had a good job, I was, as my granddaughters used to say, I was the ‘cool grandma’. I used to dance with the girls and play with them and everything. When I got like this I couldn’t do anything with them (crying) and it really frustrates me and upsets me … (Delia, consumer). Delia conveys a palpable sense of loss for the person she used to be, judging her progress to recovery by how far she feels presently from this hoped for state. A previous state of being for Bill entails regaining the confidence to go … back into the main part of the world…to do all those things he used to be able to do like … hop on a bus on my own … be better at being in crowds … even visit the Centrelink building to change my address rather than doing it on the phone … (Bill, consumer). Mandy describes her understanding of recovery as a transition from a state of tiredness and exhaustion … to now being Mandy who feels like I’m back on my feet … yeah that’s the only way I can explain it … Mandy’s sense of self has been affected by her illness but she is now experiencing a regaining of her self … I feel the last two weeks I feel myself … (Mandy, consumer). Sam, like Delia is gauging his recovery on his ability to return to his family in a healthy state … being home … with my family at home with wife and kids … and now I’m focused on getting back there and having a healthy relationship … (Sam, consumer).

The notion of “returning” or “going back to” a former state is also present in the narratives of the workers and managers as they describe the notion of recovery. Mental illness is seen to have taken something away from the person experiencing it – a way of life, an ability, a state of being. Recovery involves a restoration of these components of the person’s life. For some of the workers and managers, recovery is about regaining a quality of life or regaining a sense of self … getting some quality of life back is recovery … (John, manager) and … you start to … gain some sense of self
back, some sense of who you are ... (Rob, manager). Sometimes the return to a previous state is couched in more clinical terms such as ... returning to a premorbid level of function ... (Michael, worker) and for others the return is to a designated place such as home, work or community ... being in the community ... maintain their own life ... and possibly go back to work ... (Thomas, worker) or being able to ensure ... that the person ... can go back out into the community and can function quite well ... (Matthew, worker). The process of regaining what has temporarily been lost is reflected in further comments about assisting someone to recover ... to be able to get someone back to, to some sort of form of being able to be normal or you know carry on their life ... (Joe, worker).

The word “recover” assumes a regaining or a reclamation. When speaking about recovery from a mental illness, the consumers describe finding a state of being where they are able to recoup something of which they have been deprived or something that has been taken away. There is a feeling of having lost aspects of life or of self that are of value to them – relationships, a job, a sense of well-being, a feeling of personal control, activities that gave them pleasure, a contributing place in their community. Mental illness has temporarily dispossessed them of these life treasures and recovery involves gaining the ability to claim them back. Workers and managers share this perspective of returning to a former desired state or place and see their role as being able to assist in achieving this restoration.

8.2.2. A sense of personal responsibility is required for recovery to be achieved

Consumers speak about the need to take personal responsibility for achieving an improvement in their well-being. In support of this, workers speak about needing to provide opportunities for consumers to be more involved in their own care. Again there is recognition of complementary meanings shared by care-givers and those being cared for. Consumers comment on a need to take control of their transition to wellness and believe this is necessary for them to truly regain their sense of self or to “recover”. Contained within the workers’ narratives is a recognition that in the role of care-giver there is an obligation to include and involve the consumer in decisions
relating to care – a handing back or handing over of control and responsibility to the individual consumer for his/her recovery.

According to consumers the transition from a state of psychological distress to one of stability involves a preparedness to take responsibility for self. Bill struggled to overcome his apprehension about being hospitalised, especially an admission to a mental health facility, before he was able to take hold of the experience and use it to his advantage... so at first I had a negative view on it, yeah, because I didn’t want to be in a mental health hospital, but you get to a point in life that you realise your outlooks are wrong, they’re not practical, you can’t leave your own bedroom, you can’t eat, you need help. Put yourself out there and go for it... (Bill, consumer). Carrie has also resolved to do whatever it takes to get better... if that’s what I needed to do, that’s what I needed to do... I’m going to beat this... (Carrie, consumer) while Alan echoes these words... I accept what I’ve got, I’m going to do my best to accept the help that’s coming towards me... (Alan, consumer). George’s hospital admission was involuntary, however at the time of interview, he strongly expressed his belief in self responsibility as a crucial factor in a person’s recovery... God helps those who help themselves. You have to get off your backside and do something about it... everybody can, even with the worst mental illness, can make themselves better, they can...I know what to do, I’ve got to look up to myself first... (George, consumer).

While the ready availability of help in an inpatient environment is an important factor for the consumers in their steps to recovery, they speak about the need to deliberately and consciously take hold of this help. There is evidence of steely resolve and determination to turn the inpatient experience into one that will be of value to themselves. This does not happen by accident – it needs to be deliberately grasped and shaped to work for them individually.

For workers and managers this responsibility for self is fostered through their role in providing encouragement for consumers to be active participants in their care... if they see themselves as a passenger then they’re not on a recovery road... (Linda, worker). Travel or journey analogies are often used when workers and managers are describing how they view recovery and the role of the consumer as the lead player...
I’m the map and they have to conduct the journey … they have to do the distance … (Tracey, worker) and … it’s a journey led by the person … an effective environment for me is an environment that allows people to take some ownership of their admission, of their journey … (Andrew, manager). Workers and managers feel a duty to ‘give’ to consumers the ability to ‘take’ responsibility for their care … actually giving them ownership whilst they’re here … (Anne, manager) … and … I think there is some opportunity for us to give some sense of unit governance back to the people who are receiving care … (William, manager). For Angie when a consumer is seen to take ownership of his or her recovery process it is something to be celebrated … I walk in there and people say ‘I want to see you’, I think that’s really positive because … it’s about them really taking charge … (Angie, worker).

While there is recognition from the workers and managers that consumers need to take responsibility for their own recovery and to lead the process, there is also recognition that this does not happen as it should. When Joe talks about the inclusion of consumers, it is as a result of his view that decisions are too often made without the consumers’ involvement. There is a tentativeness in his expression … maybe take the patient’s perspective into view … or even ask them and say ‘listen this is what we’re thinking but … what do you think’ or ‘what’s going to work’ (Joe, worker). Manager Andrew is adamant that such opportunities do not exist as they should … give the person the opportunity to be involved in their planning … and we don’t do that at all. I was going to say we don’t do it well but as an inpatient facility … we don’t do it at all … (Andrew, manager). Andrew identifies a gap between the rhetoric and the reality which is reinforced by some of the consumers who had to assert their rights to be included and heard … I really fought for me to have my fifteen minutes (of leave) that I was entitled to … (Mandy, consumer) and Alan … I … just sort of put my foot down saying ‘I want to be part of this as well’ … (Alan, consumer). Even Drew, whose experience of inpatient care at the time of interview was highly negative, tenders advice about the importance of acknowledging the person’s own experiential account in order to provide the space for the person to work it out “in their own time”, that is, to take some responsibility for their own recovery. At the time Drew was struggling to explain the difference between what
perceptions were real and what was perhaps skewed by his current state ... *Don’t question the bloody patient, take it as, well, that’s what you are, OK? And if you accept that, the patient will turn round and go, in their own time, that was a lie and then you’d know that they were feeling healthy ...* (Drew, consumer).

The consumer narratives indicate a readiness and acceptance of the need to take responsibility for their recovery, however the opportunities to enhance self responsibility within this setting do not appear to exist as they should and depend on the ability of the consumer to forcefully assert him or herself. Workers and managers acknowledge this and lament the lack of opportunities provided to consumers to be truly involved in their own care.

**8.2.3. Recovery requires a sense of agency in the relinquishment of control**

For many of the consumers the notion of taking responsibility for self ironically involves a relinquishment of control, trusting themselves over to others (those providing the care) during a period of time in which they feel unable to make appropriate choices. For these consumers the relinquishment of control ultimately works in their favour, providing them with the space to find their own recovery path and allowing them to be receptive to the concentrated help available in the inpatient setting. For others, this loss of control is imposed on them and is something they are unable to come to terms with, still finding themselves in a position of disempowerment at the time of interview. A polarised view of control emerges from these consumer accounts of inpatient care that impacts on recovery. A difference becomes apparent between the loss of control that is imposed and is continuing to be experienced as disempowering, and the relinquishment of control that is a choice and ultimately becomes empowering. An explanation can be found in viewing loss of control as different to relinquishment of control. In the latter state a person’s agency remains intact.

For two of the consumers the loss of control is a disempowering experience generating feelings of anger, frustration, dismissal and helplessness ... *I felt very let down so you know ... I’m locked in there, I’m taken away from society ...* and later on
... oh shit, now I’m in a long term facility ... they’re locking me up and throwing away the key again ... what have I done wrong? ...(Drew, consumer). This is an extremely isolating experience for Drew compounded by a feeling of having committed an offence deserving of punishment. Drew is at odds with the opinions of those holding the power of decision making within the inpatient world in which he involuntarily finds himself. He is being controlled by a system that has deemed him in need of care contrary to his own opinion and feels the only option open to him is to comply ...

... I’m doing what I have to do, that’s it ...(Drew, consumer). Similarly for Delia there is a sense of feeling trapped, locked into something that is out of her control and that is affording her no benefits ... while ever I’m like this I’ll never get home because ...

(starts crying) I don’t feel like I’m getting any better ... but that really upset me to think that they just thought it was in my head, you know, yeah ... I just feel that they think I’m getting better when I’m not (Delia, consumer). Like Drew, Delia feels at odds with the opinions of those within this environment who hold the power and who control the provision of treatment. As such she feels dismissed and helpless. For both Drew and Delia the experience of inpatient care is one of forced containment with little acknowledgement and even disregard of their own alternative opinions. Delia feels compelled to go along with medication treatment that she experiences as being of no benefit and even detrimental, while Drew opts for compliance because he perceives there is no other choice.

The experiences of Drew and Delia in relation to control are in contrast to those of the other consumers for whom the experience of mental health inpatient care is viewed as a temporary relinquishment of control rather than control being forcefully removed. The admission may initially commence on an involuntary basis but as the period of inpatient care continues, an awareness of the availability of help develops. The ensuing acceptance of this help is done with a sense of agency. It becomes a purposeful handing over of control rather than a forced submission to external control. This is a significant difference. The value of being in a controlled environment is present in Alan’s narrative. Alan had previously had an admission to an open mental health unit in another town. When speaking about his current admission he notes that it is “more strict” than his admission to the other mental...
health unit that he states is “fair enough” given the serious nature of his condition at the time. He accepts that he needed to be removed from his usual situation ... *it takes a lot of pressure off you ... ’cause they cook for you, they take all the technology away which is a good thing I think, it takes you away from the outside world ...* (Alan, consumer). Alan’s interpretation of having items being taken away and of himself being taken away from “the outside world” is in stark contrast to the interpretation of Drew who is feeling controlled and powerless when experiencing similar conditions. The difference for Alan is that he is complicit in this deprivation of freedom and choices, accepting that it is for his benefit.

This relinquishment of control not only concerns the deprivation of items and choices. For some of the consumers this involves being forced to do things beyond their comfort zone ... *Yeah, I’ve been very fortunate ... and my doctor and psychiatrist they know when to be hard, and I need that ... I needed assertive professionals at certain times so they reckon I could walk the extra ...* (Bill, consumer). In a further example, Bill’s interpretation of a medical decision to refuse his request for a sedative to calm himself down is seen by him as a demonstration of belief in his own ability to manage his anxieties – a belief in himself that he has lost ... *the only thing that I had a complaint about was when they cancelled my relaxing tablets but they believed in me, and I hopped on the bus and went into town ...* (Bill, consumer). Sam also notes that the tight rules and constraints in the acute unit forced him to get out and socialize ... *what’s helpful down there ... you couldn’t really go anywhere else but that ward, so you sort of had to make conversation ... I quite tend to stick to myself if I’m not comfortable in a situation but if I’m made to do it, it’s totally different ...* (Sam, consumer).

The temporary removal of responsibility and control is also noted by workers and managers in their comments about the provision of safety and asylum as mentioned previously. For consumers who have been suicidal, in particular, it is noted that the handing over of responsibilities assists them in their recovery ... *as soon as they get in here they know they’re not even going to try to harm themselves again simply because that responsibility of looking after themselves has been lifted ...* (Tracey,
worker)... and from another... *I suppose taking the power from them to commit suicide or make an attempt, you know, is in some way empowering...* (Thomas, worker). Anne describes it in terms of a temporary “taking the reins”... *I think we give them that security when it is so critical, you know, it’s acute, we do take some reins and get them to a point where they’re able to think...* (Anne, manager).

Being “made to do” things and having freedoms or choices “taken away” are experiences that are interpreted very differently among the consumer group. For some their sense of agency has prevailed even in times of high distress, leading them to actively choose hospitalisation and the deliberate handing over of control and decision making as a way to recovery. Sometimes this conscious acceptance of the need to relinquish control occurs after a period of hospitalisation when they reach a state of mind where they are able to acknowledge the necessity for help. For these consumers, a sense of agency kicks in when a measure of self-awareness and clarity begins to emerge and when their developing awareness aligns with the opinion of the wider system of care. In contrast, those who feel controlled against their will have lost their agency, feeling powerless against a system of care that is at odds with their own perceptions and that is imposing restrictive and custodial conditions. For them recovery feels unattainable in this hostile environment.

### 8.2.4 Acute inpatient care is part of a broader recovery continuum

The period of acute inpatient care commences at a time when a person finds him/herself *in extremis*. The care required at this point is intense and focused but changes as the admission progresses. The responses of workers and managers draw attention to recovery as a process that begins at admission but which must continue post discharge. It is a changing process with initial recovery from the acute phase different to long term recovery that continues to evolve beyond the period of inpatient care. At times, this appears to divide the responsibility for recovery in two. The core business of acute inpatient care is to ensure some form of recovery from the extreme state and while it is acknowledged that this process of recovery must continue post discharge, it is not clear how this is facilitated and whose responsibility it is to ensure this continuation occurs. There is even some questioning about
whether the care provided in an acute facility can be viewed within a recovery context.

The role of an inpatient unit as expressed by Michael seems to distance the term “recovery” from the environment of inpatient care ... I think what we have nowadays is rapid assessment and discharge planning units ... you’re really anticipating that the recovery is going to be outside the hospital ... (Michael, worker). This position is supported by Thomas ... I don’t think people recover from mental illness in hospital ... the true sense of recovery happens when they are supported well in the community ... you know, we’re just managing the absolute acute phase ... (Thomas, worker). Tracey also echoes this viewpoint ... here in an acute service we bandaid and then we send them back out and the healing happens out there ... (Tracey, worker). For these workers recovery does not happen in the hospital environment but instead occurs in the community setting after discharge. They make a distinction between recovery as treating the acuity of a mental illness and the longer-term recovery that occurs once the acute crisis is over.

Others see the inpatient experience as having a role in starting the recovery process, linking the ongoing recovery with a foundation for recovery that is begun during the inpatient admission. John describes the function of inpatient care in recovery as “starting the ball rolling”... you’re only just starting. Your real recovery comes into place when you leave ... (John, manager). John sees the role of the inpatient facility as getting the crisis over and done with in order for the person to move on with the recovery process, but recognises the importance of this crisis management to a person’s eventual recovery. Angie also explains this function in her quote from the consumers with whom she has worked ... a lot of people say ‘look I’ve recovered up to this point now but I’m ready to go home and I need to keep recovering at home’... (Angie, worker). Recovery in this sense is broken down into smaller steps. It is embedded in the intensive care given to ease the acuity resulting from the crisis that brought the person to acute inpatient care. It is enacted in the move from the contained mental health intensive care unit to a more open unit and its continuance is expected in the community post discharge. However, the breaking down into
smaller steps perhaps conceals the existence of a recovery focus in this acute setting ... we don’t look at it as recovery ... because everybody sees recovery as ... the big picture of the recovery process, not the small picture and the small picture is where it all starts ... (John, manager). Joe, who primarily works in the mental health intensive care unit, also sees recovery in the small steps a person takes to the next level of care ... to see someone well enough to move on in a period of time is some form of recovery I think ... (Joe, worker). There is a distinction between the idea of recovery as an endpoint involving long-term contextual or social factors as opposed to an ongoing process, the start of which can be made in the acute setting where the crisis is being managed and resolved.

Due to the intensity and short-term nature of its care, the significance of the acute inpatient experience and its contribution to a person’s recovery is not readily recognised. Instead, a distinction is made by some between acute care and “real” recovery or recovery “in the true sense of the word” as noted in the quotes above, that is perceived as occurring only when the person is discharged. Others are at pains to ensure that the place of acute care within the recovery process is recognized ... I think that we see actual recovery already in our service but we don’t recognise it as that ... (Jacquie, manager). For Matthew the experience of having previously worked in the community afforded him the ability to appreciate the importance of the acute inpatient experience and its contribution to a person’s longer-term recovery. He explains how he had been able to see consumers he had nursed in the inpatient environment functioning well in the community setting and responds with ... Wow! You know that to me is recovery. That’s where we say ‘shit, we’ve made a hell of a difference’... actually, yeah we did a good job (in the acute inpatient unit) ... (Matthew, worker).

Consumers too, see recovery as an ongoing process that needs to continue beyond the acute inpatient experience. Carrie wants to transfer the sense of safety she has enjoyed in the inpatient setting into the community, aware that she will need to try to bridge these two worlds taking what she has learnt along with her... so they can teach me how to deal with getting back into the community, back into my workplace
so then I feel just as safe as being in here ... (Carrie, consumer). Bill likens his continuing recovery to the notion of a car being fixed and serviced. The professional staff have assisted him by “putting the motor back together again” and now it is his responsibility to “run the motor in”... recovery’s after the engine and my brain and my emotions ... after the doctor, the psychiatrist and all the nurses and social workers have put the motor back together ... I’ll be driving it slowly like, slowly running the motor in ... (Bill, consumer).

When viewed only as a long-term journey, recovery from a mental illness can be overlooked as a concept present within an acute mental health inpatient facility. The experience of inpatient care is acknowledged as crucial in a time of crisis where the purpose of admission is to reduce distress caused by the acuity of symptoms. With this as the main focus of admission the significant role of inpatient care within the longer process of recovery can be minimised. For some workers, acute inpatient care is acknowledged as recovery only in terms of a reduction of acuity and it is not until discharge when this acuity has been reduced that “real” or “actual” recovery can occur. For others, the work of recovery is recognised as commencing at the point of admission, preparing the ground for ongoing recovery post discharge. Whether recognised or not, inpatient care is a significant part of a continuum of recovery for a person who has been acutely unwell. This reflects the two-part definition of recovery distinguishing between clinical recovery that alleviates the immediate symptoms and personal recovery that is individual, longer term and takes in social and cultural factors.

8.2.5 Recovery from mental illness involves continuing change or management

Participants put forward the notion that once a diagnosis of mental illness has been made, an acceptance is required that this condition is likely to require lifelong management or at least ongoing vigilance of its possible return. As such, recovery involves an ongoing adjustment to life in order to integrate this new and perhaps enduring condition or state. Some participants, notably workers and managers, spoke about mental illness as a condition from which no-one fully recovers however,
the notions of permanency do not feature in many of the consumer narratives. While there is an acceptance by consumers that the condition or symptoms may develop again in the future, it is not expressed as a lifelong affliction requiring enduring change.

Linda views recovery as ... learning to work through what happens ... rather than ... a high aspirational thing ... (Linda, worker) ... while Joe and Matthew do not believe that recovery from a mental illness will ever mean an absolute cure ... I suppose we all know with mental illness there’s not that many people that recover to 100% or to what they were ... (Joe, worker) and from Matthew ... I don’t think there is ... a perfect cure for mental illness where people are going to have, you know 100% no symptoms and never have to take medication ... (Matthew, worker). Angie states her preference for the word “recovering” rather than “recovery” to fit her idea that recovery from a mental illness is not a final point but rather ... just about managing them (symptoms) and making it work for them ... it’s going to impact maybe always but ... doesn’t always have to impact in a way that really you know, debilitates them ... (Angie, worker). John agrees that recovery is likely to be ongoing for a person with a mental illness comparing the process to a circle ... the recovery process is a circle unfortunately. It would be nice if it was just a little loop and it stopped on that side and you didn’t have to worry about it coming back ... (John, manager). Anne also subscribes to the idea that mental illness, once diagnosed, is a lifelong condition that requires adaptation ... I don’t think they ever recover, they’re just on a path of being able to live with what they’ve gone through and actually trying to re-integrate, I suppose with what their mental health issues or incapacities have left them ... (Anne, manager).

Analysis of the consumer responses yielded only one that clearly echoed the sentiment of mental illness being a condition to which one must adjust on a lifelong basis. Alan’s comment reflects a learned understanding of recovery ... so from what I know you can’t really recover from depression or anxiety. You just develop new ways with dealing with it ... It’s still always going to be there but you just learn how to work with it more ... (Alan, consumer). Other consumers recognise that a time may
come in the future when they could again need inpatient care, but none declare with absolute certainty that their life has forever changed. Instead there is an acceptance that a similar episode may occur in the future, but it is expressed within a sense of relief that help exists should they ever find themselves in such a low place again. Bill has made plans to ensure that he seeks help in the form of inpatient care in a timely way in the future, again utilising a motor car analogy ... *I’d like to have a safety backstop ... Someone’s there to open the front door, out we go, back to the workshop, get the head sorted out ... (Bill, consumer)*. Sam, when expressing what he would do in future should things start going bad again, states ... *I probably won’t hesitate to come straight here ... the help you get is just on hand and it makes you ... feel a lot safer ... (Sam, consumer)*. Mandy is also considering her plans should she need this level of care again ... *I don’t want to curse myself in coming back but if I had to come back I’d love it to be in my records that I could come here because ... it helps me to heal ... (Mandy, consumer)*. In discussing the trepidation and fear experienced when she first realised she was coming to a mental health facility, Carrie now puts this option of care high on her list if she needs it in future ... *I’ll come back in a hurry if I need it. Definitely! ... (Carrie, consumer)*. George, on the other hand, was adamant in a positive way that this would be his last episode of inpatient care. He had had multiple admissions prior to the current one but it was on this last occasion that he felt confident that he would have no further need of hospitalisation ... *I won’t come back in here anymore. This’ll be my last visit ... but I’m just so thankful ... (George, consumer)*.

When seen as an affliction, disability or incapacity, recovery from mental illness is viewed as an enduring and permanent condition requiring ongoing adaptation to integrate into one’s life. While workers and managers are more likely to describe recovery in this way, these characteristics are mostly absent from the consumer accounts. It could be that the consumers interviewed had already confronted a need to make permanent changes and were just busy “getting on” with their individual response to the experience, including a fall back plan should they again need help in the future. Workers and managers, on the other hand, are viewing the notion of recovery from their perspective of having worked alongside a great number of
people experiencing the phenomenon of mental illness. They may be amassing these multiple experiences into their own individual explanations of recovery. When viewed from this perspective, a theme of lifelong adaptation is evident to them. This is perhaps evidence of the existence of a chronicity paradigm within mental health services as noted by Slade (2009a).

8.3 Main interpretation – meaning of recovery

Consumers, workers and managers have common perceptions of the meaning of recovery but “recovery” is not a shared term. When reviewing the data for understandings of the notion of recovery, it was quickly evident that on a quantified basis the number of uses of the word “recovery” were lowest for the consumer group. The analysis revealed that the term “recovery” did not emerge in the consumer data until introduced into the interview by the researcher. It was not a term that was initiated by the consumers nor taken up once introduced. One consumer clearly distances himself from the term attributing it firmly back to the researcher ... I don’t know if it would make the process of recovery, as you put it, faster ... (Alan, consumer) or more strongly from Drew who when asked what recovery looked like stated ... It’s a foreign word ... (Drew, consumer). On the other hand the term “recovery” and its usage in the mental health field is obviously familiar to both workers and managers, many of whom introduced the word very early on in the interview without any prompting from the researcher.

Interestingly, a number of the workers clearly separated themselves from the formal definitions of recovery preferring instead to attribute their understanding of recovery to their practice experience. This is summed up by Joe ... I guess you can have that model on the wall but what’s on the wall and what really happens are probably two different things and I guess personally it’s more about experience, what works if that sort of makes sense ... (Joe, worker). Tracy also falls back on her practice experience as the origin of her understanding of recovery ... recovery’s a title to a belief I’ve had for many years, to something I’ve done for many years, it’s just given it
a label...while at the same time acknowledging that the ... label’s really important, so from a label we develop a framework ... (Tracy, worker).

Managers have a more formal understanding of recovery one that mirrors the language of the official documents and literature. This is evident in their descriptions of recovery ... road to recovery in partnership ... about being as good as you can possibly be in the confines of ... your illness ... (Jacquie, manager) ... and from another ... recovery’s a journey led by the person ... (Andrew, manager). In a similar vein William describes recovery as ... seeing a person ... have a meaningful and contributing community life with or without mental illness ... (William, manager) and from Anne...(recovery) is more about them actually taking ownership of their management whilst they’re in there and ... how they re-integrate with the community ... how they can shape their careplan ... (Anne, manager).

Perhaps it is the more formal learning environment of workers and managers, that is, their exposure to required training and official policy documents and/or literature, that inserts the term “recovery” into their vernacular. Their lived experience of mental illness and inpatient care is shaped by their training as well as their everyday experience of providing care in this setting. Sometimes there is tension between these two aspects of their lived experience with some, primarily those from the worker group, preferencing the practical provision of care over the notions of recovery as defined by the formal training and literature. This component of formality is something that is absent from the consumer lived experience. Consumers don’t see the experience of getting better necessarily as “recovery” and describe it instead, not as a separate concept, but according to their life situation at the time – rejoining family, getting back to work, thinking clearer and feeling once again in control.

Despite a marked difference between consumers and the worker/manager groups regarding the use of the term “recovery”, it is the similarities of meaning embedded in the responses across the three groups of participants that rise to the surface in this analysis. The commonalties lie in the experience being described, not so much as
recovery from a mental illness, but as a transition from an unwell and vulnerable state of mental health to one of confidence and control that does not include a defined endpoint. For all three groups this transition involves a return to a previous state of being or life situation such as a return to family, work or community or recovering a sense of self. This transition is sometimes described through complementary notions. For example, consumers speak of the need to take ownership of their own mental state including the acceptance of a level of care. Likewise, workers and managers speak of ensuring the provision of opportunities to facilitate the consumers’ ownership or responsibility for self and of the proffered care. For workers and managers however these opportunities are seen to be limited thereby inhibiting recovery. The inpatient experience for all groups is seen as only part of a longer-term recovery, albeit playing a significant role in dealing with a highly distressing time – a state of *in extremis*.

For workers and managers, the term “recovery” provides them with a more standardised reference for a framework of practice, a way of understanding and describing this transition to mental health from their common standpoint as care givers and from a perspective of having witnessed multiple individual experiences of mental illness and inpatient care. For consumers, the uniqueness of their experiences shapes the meanings of recovery resulting in more individual and diverse expressions of the recovery experience. Yet, when taken apart, the term “recovery” yields shared core components of meaning across the three groups.

### 8.4 Discussion of main interpretation 2

#### 8.4.1 Recovery is not a shared term

The word “recovery” is liberally used by workers and managers in recounting their experiences of inpatient care despite the fact that most attribute their understanding of the term to their practice lived experience rather than on their readings or familiarity with formal literature. Consumers on the other hand, rarely use the word “recovery” prior to its introduction by the researcher. Despite this difference in word usage, commonalities of meaning attributed to the experience of
recovery were present across all three groups. These included – the recognition of a process of transition from an unwell state to a well state; a return to a previous state of being, place or role; the need for personal responsibility to make this transition happen; the provision of opportunities for increasing autonomy to support personal responsibility; and the identification of different manifestations of recovery across the acute inpatient experience.

Aston & Coffey (2012) also reveal service users’ discomfort in using the word “recovery” with one service user pointing out that some people were “dead against the word” (p. 260). The authors caution against instilling the word with professional meanings thus creating or further promoting a divide between important participant groups, namely consumers and health professionals. Similarly Tooth et al (2003) concluded that many of the consumer participants in their study were uncomfortable with the word “recovery”. The authors state that many of the consumers instead preferred to think of themselves simply as “getting on with their lives” (p. 76). The findings from these studies support that of the current study in which the word “recovery” was also unfamiliar to consumers and not their word of choice.

Tooth et al (2003) noted that there was a “vast difference” between consumers and health professionals in the way they spoke about recovery identifying that consumers speak about recovery in a more personal way. The current study also confirms this perception of consumers viewing recovery according to their individual experiences. It is asserted here however, that further analysis unearthed more commonalities between consumers and health professionals than there were differences about the phenomenon of recovery or the process of “getting better”. The study by Tooth et al did not provide examples of health professionals’ perceptions of recovery as it was consumers’ opinions only that was the sole focus. In this current study, viewing both consumer and worker accounts of a shared phenomenon side by side provides a more direct and validated comparison of experiences.
8.4.2 Clinical and personal components of recovery

The two-part definition of recovery proposed by Slade et al (2008) and Slade (2009a) with a similar version from Walsh and Boyle (2009) encompasses both a clinical and personal component. In this current study only a few participants, predominantly managers and workers, use this terminology of “clinical” and “personal” to describe the notion of recovery. While not declared as such by the majority of participants, this distinction is nonetheless present in the accounts. The notion of clinical recovery is seen in consumer accounts as they speak of achieving clarity of thinking through a reduction in anxiety or a cessation of distressing voices that allow them now to concentrate on the immediate and long term future. Likewise, workers and managers describe instances of consumer transition from an unwell state of mental distress to one of stability and clarity through the reduction of clinical symptoms. There is a recognition that the consumer will continue recovering after discharge thereby delineating between the recovery that is a focus of hospital care resulting in the reduction of distressing symptoms (clinical recovery) and recovery yet to unfold involving reconnection with family, community or the workplace (personal recovery).

While workers and managers attribute their understanding of recovery predominantly to their practice lived experience, they use a language that is more commensurate with clinical recovery. Their frame of reference draws from their own and consumers’ lived experiences, their formal training and the practical learning absorbed from the workplace. Consumer accounts, on the other hand, centre on each individual’s unique experience as the major frame of reference thus delivering a personal account of recovery.

This study supports the literature in noting different descriptions of recovery between consumers and health professionals and in particular the reluctance of consumers to describe their experience using the word “recovery”. What this study reveals however, is that hidden beneath these differences in expression, the notion of recovery holds similar meanings for both consumers and the workers/managers. Whether labeled as recovery or not, the experience of moving from a distressed and
mentally unwell state to one of wellbeing contains the common notions of a transition, a return to a previous state, the importance of personal responsibility and a recognition of its different manifestations as the process unfolds. Contrary to other studies, the commonalities in the understanding of recovery between consumers and workers/managers are evident. This locates a platform from which recovery can become a collaborative process within an inpatient setting involving shared understandings between health professionals and consumers.

8.5 Personal Reflection 5

**Personal Reflection #5**

*In collating these findings I am reminded of a significant moment that challenged my somewhat smug opinion of myself as a champion of recovery-oriented practice. The moment involved my analysis of the interview with Drew. At the time of interview I had some concerns that Drew was “unwell” although the psychiatrist had deemed him able to make the decision to participate in the research. Due to this judgment of mine I approached his interview analysis with trepidation and some superficiality “knowing” that he wasn’t really mentally well when he was speaking with me. Drew would head off into what I considered delusional recounts of his experiences and I could feel myself shutting down, diagnosing and dismissing, replacing listening with thoughts of concern for his mental health and questions of whether or not I should exclude this interview from my research as I questioned its reliability. I adopted this stance when I transcribed the interview, when I first analysed it and when I went through it again for NVIVO analysis. It wasn’t until I went back to it using Finlay’s suggestion of listening with empathy that I truly heard what he was saying. I had to consciously “bridle” my pre-understandings to listen to Drew’s account. Drew was telling me that he felt no-one was listening to him or helping him to understand his story or act on it. While I had recognised this the first few times I listened back to the interview, what I hadn’t realised was that by questioning his reliability as a participant, I was now acting out all that dismissal and invalidation just as everyone else had done. I was allowing my formal training in mental health to sum him up,*
diagnose him and consequently dismiss him. I was not allowing myself to open up and hear what he was saying or to accept his account of what was happening for him. When I really listened I heard him give the best advice I’d heard from anyone – basically that we should listen to the patient and “in their own time” the person will “turn around”. I missed this and many other insights as I was too busy diagnosing and subsequently dismissing. This showed me how entrenched I was in the mindset of a medically focused mental health perspective and how this acted as a barrier to truly hearing his story, of his claims as a “knower”. There is nothing wrong with having a formal mental health perspective as it too contributes to the overall explanation of what’s happening, but it’s not the only version and this has shown me how easy it is to dismiss and to not hear and acknowledge a person’s position as a knower. It wasn’t until I sat back and put a very strong empathy filter on to my hearing that I could enter his world more fully. This is so important in order to achieve full collaboration with a person with a mental illness, and not easy to do. I absolutely heard his plea to be listened to when I was conducting the interview but did not realise just how much I was at the same time dismissing his explanation of the experience and looking no further for meaning than my conclusion that he was mentally ill. I now question whether this is a barrier to clinicians in the quest to find common ground. Instead of tuning out once a diagnosis is arrived at, we need to stick with the roller coaster ride of disjointed thoughts to provide the space and acceptance for the person’s own processing of his/her thinking, then leaping on any common ground that may emerge.

What did I need to bridle to really expose myself to the other’s world? I feel I was bridling

- my knowledge of Drew as a mentally unwell person (his status of involuntary under the Mental Health Act probably contributed to this)

- my explanatory language that had been formed by my training and years of experience as a mental health worker including my interpretation of what he was saying as “delusional” and my knowledge of symptoms and behaviours that fitted this conclusion.
- my position as a worker with expectations and responsibilities to provide care

My belief at the time was that a “true” account of Drew’s experience was being hampered by his state of mind when in fact this “in the moment” account was actually bringing the experience to the fore. I was hearing someone in that raw state of battling their mental distress and trying to convey it to another. I was using my formal knowledge of mental health to summarily dismiss Drew as a “knower ‘ instead of using it to increase my own understanding and knowledge. This led me to reflect on how much my pre-understandings might impact on my ability to truly empathise and understand those people with whom I work on an everyday basis. The act of bridling and listening with empathy challenged my work practice and led me to re-evaluate how embedded I was in the mental health worker mindset to the exclusion of another’s knowledge. Despite my proclamations of working from a respectful and empathic standpoint I was inadvertently practising epistemic injustice.
CHAPTER 9 – Alignment of Clinical and Personal Lived Experience

Interpretations Part Three

9.1 Introduction

The two main interpretations of this study are now considered alongside each other producing the final main interpretation. The hermeneutic analysis according to Dahlberg et al (2008) should ‘cut through’ all previous interpretations and create an umbrella under which the researcher’s “aha” experience is encapsulated. Rather than just ending with the phenomenon being viewed from a number of different perspectives, hermeneutic analysis ends with a final interpretation that connects these perspectives to produce a new whole (p. 286).

Diagram 9.1

Main Interpretation 1
Mental health inpatient care is a shared experience of human connection

Main Interpretation 2
Consumers, workers and managers have common perceptions of the meaning of recovery but ‘recovery’ is not a shared term

Major Interpretation of Study
Two types of lived experience are evident in an episode of acute mental health inpatient care. When these are aligned recovery is optimised
9.2 Two Types of Lived Experience

The analysis of the data revealed that consumers and their caregivers (represented here by the workers and managers) bring their own lived experiences to an episode of acute mental health inpatient care that subsequently impacts on recovery. The two-part definition of recovery (Slade 2009a; Slade et al 2008) allocates two meanings to the notion of recovery from mental illness - clinical and personal. A similar separation is evident in this study of the lived experience of the phenomenon of acute mental health inpatient care. Workers and managers define recovery according to their formal and learned experiences enhanced by their practice within this system of care – clinical lived experience. Consumers during a period of inpatient care define recovery according to what is happening for them individually, their own goals and hopes after living through an episode of acute mental illness – personal lived experience.

9.2.1 Clinical lived experience

The lived experience that workers and managers bring to an episode of acute inpatient care is comprised of a combination of formal learning and practice. Participants from these two groups place different weightings on each of these components when explaining their understanding of recovery. For some the language of recovery that has entered the mental health vernacular in recent decades has provided a label to their existing practice as Tracey (worker) noted earlier. Some acknowledge the recovery language as a characteristic of contemporary mental health practice guidelines but reject the necessity to familiarise themselves with it, seeing it as the domain of others such as policy makers and managers. When asked if he was familiar with policy or official documents outlining recovery-oriented practice, Max states ... no, not at this stage ... that’s more for the upper echelons of training I suspect ... more for the consultants and the decision makers further up the chain ... (Max, worker). As quoted previously, Joe sees a difference between the “model on the wall” and “what really happens”, believing that practice experience and practice wisdom override formal models of care in shaping the way he works. For Angie there is a hint of apology for not using the word “recovery” very much throughout her interview ... I don’t use it.
(“recovery”) very much (laughs), I should ... and when asked if she was aware of recovery principles as they are laid down in the literature Angie states ... No, not a lot (laughs) ... (Angie, worker) ... attributing her understanding of recovery-oriented practice to her incidental contact with professional colleagues and not through her own deliberate efforts.

For some workers and managers it was their practice that first underwent a change, pre-dating the placement of a recovery label to their way of working. This change is attributed to their opportunities to practice in a variety of mental health care settings or through working alongside a role model who did things differently or attending training that made them think carefully about their practice and see it in a new light. After leaving the hospital setting and experiencing community based care, Andrew questioned the traditional role of a mental health nurse as ... somebody who made all the decisions, somebody who contained ... somebody who knew best for the person and would try and influence people with their knowledge of what was right for that person ... He began to think about a different way of approaching his work aided by others whose work practice he admired ... I had a really good role model in the community...I started to think about you know, ‘doing with’ instead of ‘doing for’ or ‘doing to’... (Andrew, manager). For Tracey, it was after being exposed to aggression minimisation training that offered an alternative to chemical restraint ... one of the best things in the world was to negotiate and talk down someone ... when there was fifteen blokes there ready to jump on the person and give the ‘triple C’ ... if you could negotiate and just do it passively it was like ‘wow’, there’s your trophy ... that’s about the individual, that’s about patient care ... (Tracey, worker). Rob talks about the impact on him of hearing consumer lived experience when he attended training ... it was a lady who had the most amazing story ... I think she was diagnosed with everything in the DSM ... and now she manages her life her way ... and she was able to stand up in front of a group of strangers and to be able to tell her story ... so that’s been a really important drive for me ... (Rob, manager).

For Rob and another manager, Anne, it was important to have a combination of both the practice and the literature. Practice was an important starter or mover of
change, with the emerging literature then consolidating this change, giving it voice and legitimacy ... I lean towards ... my eight years in admissions probably is more what my recovery knowledge is and the documents just sort of add substance to ... what I’ve learnt ... (Anne, manager). While acknowledging that listening to consumer lived experience was critical to the changing of his work practice, Rob adds ... but I think you have to want to read and learn more ... a lot of it comes down to having the interest and the motivation to have further reading ... (Rob, manager). The collective consumer lived experience witnessed and shared by workers over a period of time has “leaked” into the worker lived experience of inpatient care, creating a clinical lived experience for them that is made up of a fusion of formal training and practice wisdom. It may be argued that clinical lived experience is just another term for practice knowledge, however, it is the belief here that the term “lived experience” more fully recognises and acknowledges the strong emotional content of the workers’ and managers’ narratives revealed in this study transcending the level of formal learning or practice.

Regardless of whether the lived experience of workers and managers in an acute inpatient setting is shaped predominantly by practice experience or by more formal learning, it is evident that their descriptions of the concept of recovery utilise a common language. This is a language that has been absorbed through their direct or indirect exposure to the literature and policy documents that now prevail in the field of mental health. Mental health workers are being asked to integrate their usual practice with what they are now being told is “recovery-oriented” practice. Some are finding this a natural progression with their practice easily fitting into or being shaped by the emerging formal notions of recovery. Others are sticking to their practice style, acknowledging the formal statements of recovery but uncertain about the need to adjust their practice to fit an imposed model that they see as the domain of managers or policy makers.

Regardless of the level of acceptance of the formal channels for the understanding of recovery-oriented practice, a language of recovery has been absorbed and is readily used by the representatives of this system of care - the workers and
managers. It is a language and rhetoric that now comes with the territory when working in the mental health field and is mirrored in their descriptions of recovery. The use of journey analogies and descriptions such as “being the best they can be within the confines of their illness” evident in both the worker and manager explanations of recovery are reminiscent of the original definitions of recovery from the pioneers of the modern recovery movement. These definitions of William Anthony and Patricia Deegan continue to be the cornerstone definitions used in current mental health policies and guidelines.

9.2.2 Personal Lived Experience
The lived experience of inpatient care as voiced by consumers includes two components. The first involves their efforts to describe the state of being mentally ill. The second component consists of their articulation of the here-and-now inpatient experience including what they need to do to re-establish their sense of self and their immediate futures. The term “recovery” does not feature in their narratives until it is introduced. Their experiences of moving through an episode of mental illness and the subsequent treatment through inpatient care is not reduced to one phrase or definition but is instead described according to their individual circumstances.

Consumer descriptions of the illness or the condition that resulted in the act of seeking help, whether voluntarily or involuntarily, are at times vivid. There is a sense of fear and vulnerability associated with a loss of control ... *I had to get out, like I call it the invisible walls, like I thought ... I can’t get through the door...* (Bill, consumer) ... and from another ... *like I started babbling on with stuff that wasn’t true just because I was scared ... I really tried to just keep anyone away from me ...* (Mandy, consumer). The illness is an embodied experience ... *I just couldn’t take any more in my head, it was just spiraling down ...it was not knowing and all this stuff running in my head ...* (Sam, consumer) while similar language is used by Carrie ... *my heart was all over the shop, it was pacing ... I really felt like I was gonna have a heart attack ... my head was so, it was just spinning, spinning and spinning and spinning and it felt like it was just going to blow up ...* (Carrie, consumer). For Alan there is a strong sense of aloneness
... I actually started planning ways to kill myself ... I sort of felt I couldn’t cope being alone or being with myself ... (Alan, consumer) while George tries to deal with a racing mind and multiple voices ... I blurt out things a thousand miles an hour because my mind races at times ... you could hear a thousand voices speaking in your head at once ... you have no control over them, it’s just like you’re being bombarded by things outside this world ... (George, consumer). There are descriptions of being pushed over the edge, of blowing up or exploding that bring to the fore a sense of the self shattering apart. George describes his psychosis as like looking in a mirror but being unable to see through it ... you just see everything black ... the self has disappeared.

From these descriptions each consumer is then able to plot his/her own individual recovery. This recovery is articulated variously as the point when discharge to family is being planned, when the voices have ceased, when the mind has stopped racing or when answers have been provided that have assisted in making sense of this previously nonsensical and terrifying state. The way forward includes in varying degrees, psychological therapies, medication, recreational and diversional activities, someone to listen or contact with family, all within an environment providing 24-hour care that takes them temporarily away from the stresses of the “outside world”. This is the personal lived experience of an episode of inpatient care that cannot be reduced to a single definition or explanation. Each individual story must be acknowledged.

9.3 An aligned world or a world of difference?

At times there is alignment between the lived experiences of those representing the system of care (workers and managers) and the lived experiences of the consumers, each group sharing a common perception of the phenomenon of mental illness and the circumstances required to alleviate or treat the distress/symptoms accompanying it. This alignment affords a positive recovery outcome and accounts for the experience of a number of consumers within this study. These consumers feel aligned with the system of care as soon as they pass through the doors, seeking a solution to their distress and opening themselves up to whatever decisions are
arrived at on their behalf regarding care and treatment. Others transition during this time from a perspective that is oppositional to that of the system of care, to one of agreement and acceptance, both of the naming of a condition and its proffered treatment. For yet others, the two lived experiences remain at odds with each other, the resulting disparity prohibitive to a positive recovery outcome. For these consumers the difference in lived experience continues throughout the period of admission, resulting in reluctant compliance with the offered treatment as one means of ending the episode of inpatient care.

The clinical lived experience of the workers and managers creates a perspective of mental illness and inpatient care, and subsequently of recovery, that is acquired through a combination of formal learning and practice. This includes an international language of symptoms and diagnosis that are matched to treatment regimes usually favouring a pharmacological focus. Expectations of illness progression and outcomes are influenced by a global collective of literature and practice experience, with treatment decisions drawing on this world of evidenced knowledge. The personal lived experience of the consumer is formed through individual responses to manifestations of psychological distress. This results in a jumbled collective of experience and knowledge, some of which may mirror that of the clinical lived experience but which, at other times, is fiercely at odds with it. Clear articulation of this personal lived experience is hampered by the very symptoms that define the phenomenon resulting in the personal lived experience taking a back seat, or being absent altogether, in the acknowledged world of psychiatric disorder.

Emerging from this study is a picture of acute mental health inpatient care that can be viewed in three ways according to the matching or mismatching of the two lived experiences:

1. An immediate alignment of the personal and clinical lived experience consisting of agreed explanations and language
2. A gradual coming together of the two lived experiences through the movement of one or both parties to settle on agreed common ground
3. A continual non-alignment of the two lived experiences with no agreed common ground emerging.

Each of these positions has implications for clinical practice and for the understanding and experience of recovery. They are discussed here in more detail.

9.3.1 Immediate alignment of clinical and personal lived experience

For some of the consumers their admission to a mental health inpatient facility provides them with the answers for which they were desperately searching. The admission provides them with a safe 24-hour environment of care and support, giving meaning and explanation to an experience that was previously beyond their control or understanding. Despite their apprehension and deep misgivings at having to come to hospital, Carrie, Bill, Alan and Sam were at a point of desperation, seeking explanation and relief from their harrowing emotional states. For Sam, the admission to hospital was prompted by his need to actively seek answers to why he was experiencing distress and to source help that he could not find in the community ... I was quite freaking out because I just, I know I needed help and so that’s why, yeah, I decided to put myself into here ... (Sam, consumer).

Treatment in the form of medication initially and then supplemented by psychological input and recreational or diversional activities, were welcomed and eagerly accepted. An unexpected benefit came in the form of shared peer experiences that lessened the isolation, providing a ready and empathic ear to listen and affirm. For Sam, his sessions with the psychologist provided him with the answers he sought ... he came back to me on the second day ... and everything he said was what happens in my head and I’m just like ‘Oh, this is great’ ... so it will take a bit of practice but I’ll get there ... (Sam, consumer). Carrie was resolved to use every bit of assistance that was available to her throughout her inpatient stay ... all I was thinking in my mind was ‘I’m going to get better, I’m going, I’m going to beat this, I am ... (Carries, consumer). Bill recounts the advice given to him by a psychologist about gradually gaining confidence in himself ... know your limitations
and if you’re facing a weakness it’s not a shame to retreat and try another day, yeah ...
(Bill, consumer). The positive outcomes experienced throughout their admission continued to gather confidence and hope like a snowball. The formal language of diagnosis and psychology provided much needed explanation, while treatment in the form of medication and psychological strategies resulted in relief and a regained feeling of control. The inpatient experience allowed a sense of recovery to take shape that now, despite some misgivings about moving from the safe environment of the hospital world, was leading to preparation for discharge and return to community and/or family.

Sam, Carrie and Alan reflect on the position of other consumers who have not reached this point of alignment and who did not actively seek inpatient care. They note that acceptance of an illness or a distressing condition and the acceptance of the subsequent need for help, is a crucial factor in the success or otherwise of inpatient care. As Carrie states ... you can only try and help them and guide them the right way but they have to be really wanting to do it ... (Carrie, consumer). Alan mirrors Carrie’s thoughts ... people who don’t acknowledge that they have a mental illness will find it a lot more harder to deal with in a place like this where everyone’s trying to help them. They’re going like ‘I don’t need the help, I’m fine’ ... (Alan, consumer) ... and from Sam ... I just think really you’ve got to want to be able to get any answers basically because it’s like anything really if you don’t want it you’re just going to push it away ... (Sam, consumer).

In this situation the clinical lived experience of workers and managers is a perfect match for the personal lived experience of the consumers. The offered help is eagerly accepted and absorbed with little challenge to the system of care that is predicated on clinical practice and knowledge. There is no call to justify actions or seek agreement for the proffered diagnosis and treatment regime. The epistemic and practice foundations of the formal world of the system of care are affirmed and reinforced, having provided the much sought after missing pieces of the puzzle identified as an episode of mental illness or disorder.
9.3.2 Transition to alignment of clinical and personal lived experience

The experiences of other consumers unfurl somewhat differently. For Mandy and George their entry into the world of acute mental health inpatient care by their own admission, is laced with far more opposition. George and Mandy have been made involuntary under the Mental Health Act and the decision to seek hospital care is not of their making. Mandy’s explanations for her current state are not initially listened to and she feels unsafe and vulnerable. Mandy resorts to defensive behaviour that is then interpreted as part of her “condition”. This in turn increases her fears, causing further behaviours that result in a vicious cycle that is only broken when an understanding nurse takes her hand and stays by her side. George is being bombarded by voices and racing thoughts causing him to experience frustration that leads to anger ... you become that frustrated that you just explode ... and you just go off ... (George, consumer). Both Mandy and George paint a picture of resistance fueled by fear and intrusive internal stimuli that cannot be controlled. Their perspectives of their situations do not align with the system of care that is taking control and determining the nature of the problem and the required treatment. An agreement between the providers of care and the individual consumer about what action to take is considered unnecessary at this point. The situation is deemed to have sufficient urgency to call for external control, with the ensuing enforced treatment legitimised and administered through the power of the legal system. At this point, the clinical lived experience of those representing the system of care and the personal lived experiences of Mandy and George are at odds, with one by necessity, taking control over the other.

Despite this non-alignment of lived experience at admission, at the time of their interviews Mandy and George both retrospectively considered their experiences of inpatient care as positive. They express deep gratitude for the outcomes that see them now with a sense of a complete and whole self. Mandy speaks about feeling like “myself” again while George celebrates feeling like “the real me”, a state of being free from voices that he reports he is enjoying for the first time. Mandy primarily attributes a medication change to her ability to regain her self. More importantly, however, this medication change has resulted from medical staff
listening to her concerns about the mixing of two different medications and the effect she believes this had on her... *I explained to him (the doctor) which drug I wanted to be on... and it helped just to be listened to*... *(Mandy, consumer)*.

George is able to attribute the point of change for him as being the dissipation of the distressing and demanding voices. At the time of interview he remained an involuntary patient but was looking forward to being discharged in the coming days. When asked what he thought was the cause of the disappearance of the voices he is unable to say... *I have no idea, I don’t know, I’m not God (laughing)... I just had to wait until I sprung out of my mental state...* While unsure of exactly to what he attributes his extraordinary improvement George questions... *whether all the drugs they’ve invented have helped or whatever it was, I just sprung out of it...* *(George, consumer)*. With his newfound clarity George paints an illuminating picture of what it is like to experience a mental illness. He feels he has transitioned between worlds... *like you’re living in two separate worlds, you know, when you go from one world to another world... moving between the “real” world and a world of madness and sometimes... those two worlds crash at times and ah, that’s why I end up in here (laughs)...* *(George, consumer)*. George describes his transition back to this “real” world as “fantastic” but it leads him to contemplate the difference between his understanding of schizophrenia (the diagnosis attributed to his presentation) that originates from his own lived experience and from his witnessing of the experience of others, to how it is understood by the medical profession. He believes there are many forms of schizophrenia and criticises the medical profession for putting everybody “in the same basket” and not acknowledging the different lived experiences. Despite this, George is very grateful for the work of the staff during his hospitalisation, recognizing now that he had needed care and protection and that this had been delivered on during the inpatient stay.

Both Mandy and George moved from an unwell and disturbed state of mind in which they vigorously protested the enforced hospitalisation and treatments, to a stance replete with gratitude and a determination to stay well. The shattered and out of control pieces of self are now recaptured and reassembled. This is not without some
continuing criticism of the system of care – Mandy believing the system needs to be more welcoming and reassuring with better communication, while George would like the psychiatrists in particular to acknowledge individual lived experience and have the time for people “to explain your viewpoint”. Their personal lived experience is now a better fit with the clinical lived experience. There are pockets of disagreement that remain but these are expressed within an overall respect for difference and some experience of flexibility within the system to hear and respond to their input. Both George and Mandy appeal to other consumers to be patient and trusting in order to benefit from the offered help ... even though they might not get it right now ... they will get it later on like I did. I got it later on ... (Mandy, consumer). George also provides advice of a similar nature ... they won’t understand what’s going on in their own mind ... they have to learn to trust people ... who only have their best wishes at heart ... (George, consumer).

Where there is an initial non-alignment of the clinical and personal lived experience, the challenge for workers to provide effective care is heightened. Analysis of the data indicates that from the perspective of the clinical lived experience, this transition to alignment is viewed as both a one-way and a two-way shift requiring change on behalf of both consumer and/or worker. In order to be a two-way shift, effort is required from the worker to search for common ground from which to engage with the person, even if initially the only purpose in common is a desire to leave the hospital. Michael accepts that this may be the only agreed path to recovery between the consumer and the system of care at the beginning of the admission ... most people are compulsorily here and probably the thing that they most want is to leave (laughs) ... even for people who very vocally don’t want to be in hospital usually there’s something you can find they would like improved that you can work with together ... (Michael, worker). By stating that this common ground “is something you can find” Michael is emphasizing his own responsibility in searching for agreement. Max on the other hand, reveals a different stance to Michael when he describes the transition that occurs with some of the consumers who are initially involuntary ... you do see that even a lot of patients that are treated involuntarily just in their initial presentation ... when they do start to get better they can look back and sort of say
'well, I was pretty mad you know’ so even that’s just working with them in some way ... (Max, worker).

A difference is evident in how Michael and Max view this transition to alignment. Michael appears to be proactive in his efforts to find some commonality, shifting his priority of focus to better match the focus of the person with whom he is working – a two-way process. Max on the other hand has a more passive approach waiting for “insight” to develop on the part of the consumer. That is, Max is waiting for the consumer’s perspective to move to a position of agreement with his own. Max’s position as ‘expert’ is reinforced by his further comments ... you can sort of sit down and ... have a chat to them and sort of say ‘look, these are your issues, that’s what you need to do’... and ... So for me that’s sort of being able to look at people and ... tell them what their problems are ... (Max, worker).

For the lived experiences to be aligned when the admission is of an involuntary nature, movement of position is required from either or both parties to find a common ground on which to base a collaborative recovery pathway. From the perspective of a clinical lived experience, Michael provides an example of how this movement may occur as he steps into the world of the consumer and shifts his position to find agreements no matter how apparently minor. In contrast, Max demonstrates a fixed position of expert placing the responsibility for change onto the consumer. He appears to take a more passive stance while waiting for insight and acceptance to emerge on the part of the consumer. His stance is embedded in a clinical lived experience that for Max is very new. He is relying on his clinical learnings to provide structured descriptions of the phenomenon of mental illness, thereby positioning himself in a fixed and safe position as knower and awaiting a shift from the consumer in order to reach a point of agreement.

In an example of personal lived experience, George’s new-found clarity of thought furnishes him with the space to consider his past behaviours in the light of his psychotic symptoms. He moves from an antagonistic position to one in which he exudes empathy for his caregivers ... I feel sorry for youse ... what they cop
sometimes ... (George, consumer). While he is unable to identify the exact reason for this shift other than the possibility of new medication, George is able to provide definite advice as to what would assist in this transition as he criticises psychiatrists for not taking more time to understand the consumer’s viewpoint that would allow more give and take. Mandy also attributes her change to a medication review, however, the significant factor in her move from resistance to collaboration lies in her experience of being listened to by the doctor. The finding of common ground can be incidental but is greatly facilitated when consumer and clinician are able to step into each other’s worlds in a spirit of empathy and respect.

9.3.3 The continual non-alignment of clinical and personal lived experience

Two of the consumers, Drew and Delia, at the time of interview remain firmly at odds with the explanation of their conditions and treatments being offered by those charged with the responsibility of providing care. Their narratives are replete with feelings of frustration, helplessness and despair. While both accept that they are experiencing a state of being that requires healing or restoration, their personal understanding of this state is in opposition to those holding the power to make decisions about how this healing should occur. There is a vast gulf between the conclusions of the individual or personal lived experience and that of the clinical lived experience.

A common criticism from consumers as noted earlier is the frequent failure of caregivers to listen. Drew who is involuntarily detained at the time of interview expresses this emphatically throughout his narrative ... they just give you drugs ... it’s actually like you’re not being listened to at all ... Drew is pleading for help but feels his story is being dismissed ... I’d like to be helped to go through the situation ... in here they’re just saying ‘oh well you’ve got to forget your story’. Being told to forget his story is a dismissive action leading to further frustration and anger on Drew’s behalf ... It writes you off and makes you angry. Drew feels he’s being left to deal with his issues himself ... I’m helping myself get through it because the doctors aren’t helping me get through it. I’m helping myself. The system of care for Drew is an enemy that utilises a foreign language to oppress and disregard him. He refutes the
diagnoses that have been placed on him during his contact with mental health services that include schizophrenia and bipolar disorder. When asked for his response to the idea of having a mental illness he states ... well, it just seems like they’re words to have control of me while I’m in here. He instead explains his current state as ... I’m a normal human being that has emotions that sometimes are disturbing which I believe every human being on this planet would have ... (Drew, consumer). It is important for Drew to continue to feel human, reacting against the implication that he is somehow “abnormal” and deserving of labels that de-personlise him and define him as set apart from other human beings.

Delia tries to remain positive throughout the interview praising the nurses for the level of care they are providing and speaking highly of the physical environment of the ward in which she is currently residing. However, her emotions come to the fore when she speaks about her current state of being and how it is at odds with the opinion of the treating team. While she accepts a diagnosis of depression, Delia is adamant her throbbing neck and shoulder pain, that she believes is a consequence of an injury sustained at work some years previously, is the cause of her depressed mood. After numerous tests it appears the doctors have ruled out a physical cause of her depression ... they don’t seem to want to look into it any further ... despite Delia’s insistence that none of these tests have been conducted on her shoulder and neck. She would like further tests to be done but instead, Delia’s treatment now involves the administration of several drugs, the effects of which she finds disturbing ... I’m on that many drugs it’s not funny ... they help me sleep but they cloud my mind a lot, make me feel away with the fairies and I don’t like that feeling... The clouding of her mind further blocks her attempts to explain her situation. She is feeling ignored in this world in which decisions about treatment are occurring without recourse to her own opinions. Instead of being an expert in her own experience, she is a bystander unable to press her point home. She is feeling physically separated from the decision-making arena, cast away through the effect of drugs to another world that is disregarded, a fantasy world easily ignored – “off with the fairies”. Her opinion of self is being overridden despite her pleas to the contrary ... I just feel that they think I’m getting better when I’m not. Delia feels cast in a role of hypochondriac which she
vehemently protests ... *I keep telling them ... the problem but they don’t want to listen to me, and I’m not a hypochondriac. People who know me know that I never had a sick day at work ...* (Delia, consumer). Her knowledge of self is being contradicted and her protests are going unheeded. She is powerless and helpless in this environment.

Drew believes the only way out is to succumb to treatment, to do as he is told despite this being contrary to what he thinks will assist. He does not accept that he requires the heavy-handed approach of involuntary hospital care, but he does state clearly that he is experiencing distressing emotions and is seeking assistance for that. Delia also acknowledges that while she yearns to go home she accepts that she is not looking after herself adequately and believes hospital is currently the right mode of care for her. However, this acceptance has not translated to a sense of trust in the system responsible for their care. Drew resignedly stays in hospital knowing that the alternative is to be brought back by force ... *if I walk home from here they’re just going to have the police chasing me ... so of course I stay ...* (Drew, consumer). Delia passively succumbs to fate hoping that things will turn out in the end and concludes the interview with sad resignation ... *it’s really frustrating, it’s really hard so, but (pause) we’ll see what happens ...* (Delia, consumer).

For the workers in this setting this is the most challenging situation. There is no alignment between their considered clinical opinions and those of the person him/herself. Without this common ground, recovery is difficult to pursue whatever that recovery may look like to the individual. Michael says as much when he speaks about the sometimes difficult task of finding common goals ... *I mean, it’s hard to know where you go from there ...* (Michael, worker). Angie echoes this sentiment noting the difficulty that arises from a consumer’s objection to being in hospital ... *because if people don’t want to be here the resistance means that their recovery is inhibited hugely.* William also notes the significant challenges that non-alignment presents to those providing care in this setting ... *I know that sometimes a number of people that are here against their will, they don’t want to be here and that engagement phenomena is a real challenge for the staff ...* (William, manager).
The wider the gulf between the clinical lived experience and the personal lived experience during an episode of acute inpatient care, the less likely a recovery goal can be achieved. This gulf can be widened further by the message of dismissal that appears to be inherent in the clinical responses to Drew and Delia when no attempt is made to actively search for common ground. In Drew’s case his account of having distressing emotions may in fact align with a clinical description of schizophrenia, albeit using different language. However, no effort is evident on behalf of the clinicians, to flesh out the meaning behind his explanation. On a superficial level, the differences can appear insurmountable. When efforts are made to explore at a deeper level, commonalities may be discovered that can build a foundation for a collaborative pathway to recovery.

9.4 Conclusion
Consumers and workers bring different lived experiences to an episode of acute inpatient care. When the clinical and personal lived experiences align in this setting the chance of a positive outcome for both consumer and worker are greatly increased. It is evident that when answers are being actively sought, when there is respectful listening and acknowledgement of the lived experience of both consumers and those providing care, when time is taken to understand and explain each other’s language and inherent meanings, a recovery outcome is optimised. It is possible for relationships between workers and consumers to move from an adversarial stance to one of collaboration and for the focus towards discharge to become one of hope and optimism. If an immediate alignment of lived experiences is evident from admission, a collaborative relationship is nurtured with little effort from either party. If there is non-alignment of the clinical and personal lived experiences, then some movement is required for common ground to be discovered and harnessed. Given that the consumer at the time of acute inpatient care is in a vulnerable and raw emotional state, it falls to the clinician to make the effort to identify and capitalise on the possibilities for agreement. Intense listening skills and the use of empathy are brought to the fore for clinicians to seek out and step into the consumer’s world, to embark on a voyage of discovery to find shared meaning. This finding draws
attention to a locus of practice change and the focus of Chapter 10 – the responsibility of mental health workers to maximise the alignment between these two lived experiences.
CHAPTER 10 – The Discovery of a “Shared Space”

Major Interpretation of the Study

10.1 Introduction

The motivation for this study emerged from the researcher’s observations of practice within an acute mental health inpatient facility. The observations indicated that recovery-oriented practice was mostly absent in favour of adherence to practices that supported institutional function. Questions were raised about the understanding of recovery as it was applied to an episode of mental illness and the role of the inpatient setting in facilitating recovery. Is the experience of acute mental health inpatient care the same for those on the receiving end as it is for those responsible for the provision of care? How is recovery from a mental illness viewed by the different players in the phenomenon of acute inpatient care? The choice of hermeneutic phenomenology as a methodology was aimed at moving beyond description of this phenomenon into the realm of interpretation in order to reveal new insights and understandings. A number of interpretations have been put forward culminating in a main interpretation for each of the two key research questions.

1. The first research question explored the phenomenon of acute mental health inpatient care as experienced by consumers, workers and managers. Six initial interpretations were made that highlighted the value of mutual support and reciprocal care, the absent but significant role of listening, the emotional experience of witnessing recovery, the multi-layered notion of safety and the defining of mental health care through its difference to general health care. From these interpretations the following main interpretation evolved:

“Mental health inpatient care is a shared experience of human connection”

2. The second research question looked at the meaning of recovery in this setting as perceived by consumers, workers and managers. Five initial interpretations evolved
including the view of recovery as a return to a previous state that required a level of personal responsibility and a sense of agency in relinquishing control while inpatient care is seen as one part of a broader continuum of recovery that also involves continuing change or management. These interpretations led to one main interpretation that found common core components of the notion of recovery within different descriptions:

“Consumers, workers and managers have common perceptions of the meaning of recovery but ‘recovery’ is not a shared term”

3. When the two main interpretations were considered alongside each other one major interpretation took shape:

“Two types of lived experience are evident in an episode of acute mental health inpatient care. When these are aligned recovery is optimised”

This major interpretation now leads the thesis to its final destination – the identification of a shared experience of mental health inpatient care where the lived experiences align. The following discussion reveals how these interpretations contribute to the thinking around mental health inpatient care and the way in which recovery can be optimised through the enhancement of practice in this setting and through consideration of the role of inpatient care. The concept of lived experience within mental health is re-examined in the light of these interpretations, leading to a questioning of the possible perpetuation of dichotomies in the field of mental health recovery. The notion of lived experience and the three positions of inpatient care as described in the Major Interpretation are revisited to identify the domain of practice change.

10.2 The notion of lived experience in mental health revisited

By taking a phenomenological stance this study expanded the notion of lived experience as it is usually viewed within the mental health field where the concept
has traditionally been applied only to consumers. That is, lived experience in the
area of mental health currently implies a personal experience of a mental illness and
subsequent treatment for the same. The definition of lived experience quoted
previously from the National Mental Health Recovery Framework (2013) however,
incorporates “the experience people have of their own or others’ mental health
issues” (p. 79), recognizing the impact on those connected with the individual
experiencing the mental health issue especially family and friends. In this study the
notion of lived experience has been broadened a step further to incorporate the
lived experience of the health professionals. This is in keeping with
phenomenological studies that explore the lived experiences of a range of
phenomena. In this case the phenomenon under examination is acute mental health
inpatient care. The study has acknowledged the lived experience of all those who
share this phenomenon including consumers, workers and managers.

As noted previously the expansion of the notion of lived experience within mental
health may draw criticism in the form of accusations of appropriating the concept
away from consumers (Byrne et al 2015). The recovery movement was born from
the struggle of those with lived experience of mental illness to be heard as a
legitimate voice – the struggle to inform mental health service delivery as a central
and defining expert voice, rather than a position relegated to the sidelines shouting
to be heard or silenced into submission. The use of lived experience to incorporate
the voices of mental health professionals within this study in no way diminishes the
importance of consumer voices, nor is it an attempt to hijack the consumer
component of mental health recovery. It is argued rather, that if recovery in acute
inpatient care is to be a truly collaborative partnership between health professionals
and consumers, then all voices of the experience need to be listened to in order to
facilitate a common understanding. The lived experience of the phenomenon of
acute mental health inpatient care exists as a product of the interactions between all
those involved. It is important to capture this shared lived experience while at the
same time respect the delineations that surround it.
10.3 Dichotomies within mental health

The concept of lived experience as applied exclusively to consumers in mental health reflects a number of dichotomies that may have unintentionally arisen within the mental health domain in the process of explaining the complex notion of recovery. References are made throughout the literature to

Biomedical model/recovery practice
Clinical recovery/personal recovery
Expert-by-training/expert-by-experience

Each of these implies a division between those who are delivering a mental health caring/treatment role and those who are the recipients of this care/treatment. This has been an important division to make on the way to unpacking the notion of recovery. It is recognised, however, that the contribution of the formal, clinical knowledge traditionally based on scientific positivist sources of evidence in mental health, has traditionally taken precedence over the contribution of the narratives of those who have, first hand, lived through an episode of mental illness. This has led to a dismissal or “silencing” of consumer lived experience resulting in epistemic injustice (Fricker 2008, Dotson 2011).

Acknowledging and validating this previously disregarded source of knowledge has been an important part of redressing the epistemological and power imbalance embedded in the traditional, paternalistically-delivered system of mental health care. As noted previously, Bracken (2014) entreats the discipline of psychiatry to have as its primary focus the making of meaning, values and relationships, thus moving the epistemological base of the profession towards hermeneutics and away from science. According to Bracken this move involves attention to context, the use of empathy and good listening. The uniqueness and value of the contribution of consumer lived experience has been emphasised through a comparison to the dominant clinical (biomedical) contribution. Slade et al’s (2008) two-part definition of recovery is an attempt to recognise, respect and acknowledge the significant
contribution of both the clinical and personal perspectives. In fact Slade (2009a) states that rather than achieving a balance of power, the notion of personal recovery needs to be the primary goal of mental health services relegating clinical recovery to a subordinate position. His notions of expert-by-training and expert-by-experience (Slade 2009b) are included as basic concepts in his explanation and comparison of traditional mental health care and recovery-oriented practice (p. 6). The expertise contributed by health professionals is seen as providing support for an individual’s personal recovery rather than being the key component of treatment.

The categories of “clinical” and “personal” have assisted in the clarification and definition of the complex notion of recovery in mental health. It is asserted here however, that there is a risk that each of these components will be viewed as a separate entity leading to the creation of a dichotomy. This may unwittingly perpetuate a gulf between consumers and health professionals through an emphasis on difference. This can work against a collaborative approach to care especially where consumers and clinicians are, sometimes unwillingly, bound together in the psychologically intense environment that is an acute inpatient setting. This does not dismiss or invalidate these different perspectives or suggest they have become redundant. They will remain as the unique and defining contributions of each important player, but perhaps there is a new way forward.

10.4 The Overlap of Clinical and Personal – a Shared Space

The interpretations in this study were arrived at in response to the continual and persistent voices that called to the researcher to recognise the strength of the similarities, the shared experiences and the commonalities emerging from the data. Differences between the three groups of participants were present and reflect the need to recognise divergent perspectives, however as the hermeneutic process of analysis deepened, these differences were viewed as being driven by core components encased in agreement and similarity. Human connection motivated and energised both workers and consumers in their responses to another human being’s need for help. Recovery was seen to be a transition to a previous state of being or
life situation, requiring a need to take personal responsibility. Each participant brought his/her own unique experience and knowledge of illness or care to a situation requiring a helping response. Workers and managers proclaimed their practice experience as highly significant in their roles as mental health professionals, enhancing their formal learning. The strong emotional responses of workers and managers in speaking about this practice experience highlight a very personal component to their practice. This was in recognition of the centrality of “the person” within the mental health field, a concept vividly conveyed by the image of one worker pulling the skin up on her arm and saying ... *this stuff here is just wrapping, there’s actually something alive, a personality, a being inside ... (Jan).*

The collective lived experience of inpatient care has distinct “clinical” and “personal” components but the attention of this argument is on the overlap. Each of the participants draw on a lived experience that has been influenced in different measures by previous and current learnings whether attained through personal or formal means. Workers and managers incorporated knowledge gained through their observations and personal responses to consumer experience into their more formal learning. Consumers incorporated formal knowledge into their personal experience, for example, through their adoption of psychological strategies or through their understanding of the effect of medication. What is revealed here in the phenomenon of mental health inpatient care is a space of shared experiences – the shaded area represented in Diagram 10.1.

**Diagram 10.1**
The intersection of the two circles in Diagram 10.1 represents the shared space experienced by consumers and those responsible for providing care in the inpatient setting. It is not to be interpreted as the same experience but rather where the two experiences align in purpose each bringing its own unique perspective to the one phenomenon. Clinical lived experience has in the past been imposed over personal lived experience “smothering” its epistemological contribution and perpetuating a power imbalance between the providers of care and the recipients of care. The shared space presented here is created through an overlap of lived experiences and should not be viewed as the imposition of one over the other. It is in this shared space that the potential for a recovery outcome can be maximised – a space ripe for practice scrutiny.

The size of this shared space can change across the experience of inpatient care. As suggested in the Major Interpretation of the study, the shared space may initially be small or non-existent or it may enlarge as it moves to a more aligned position. The three positions of lived experience alignment described in the Major Interpretation are revisited here to reveal the nature of this shared space.

10.4.1 Immediate alignment of lived experience

Diagram 10.2
For some there is an immediate alignment of lived experience (Diagram 10.2) creating a large shared space from which to work collaboratively towards a recovery outcome. Perceptions of symptoms are similar between the players, diagnoses actively sought and explanations gratefully received and absorbed. The shaded area is a space in which collaborative partnerships can be readily forged between consumers and those responsible for providing care. Answers and explanations are provided by the formal knowledge of the clinical experience matching and satisfying the questions raised by the personal lived experience. This alignment makes for fertile ground in which collaboration is enhanced and principles of recovery such as respect, responsibility, self-direction and empowerment can be enacted. In this situation little effort is required from clinicians other than business-as-usual. The diagnoses and suggested treatments arising from formal clinical knowledge provide the pieces that are missing in the consumer’s temporarily shattered world.

10.4.2 Transition to alignment of clinical and personal lived experience

Diagram 10.3
For others this shared space comes into being and then enlarges throughout the period of inpatient care as circumstances change. Initially there is no common purpose or understanding (Diagram 10.3), however eventually there is a shift that allows an alignment to get underway. Perhaps distracting symptoms have been alleviated for the consumer, or anxieties and feelings of isolation have been reduced as stories are shared with others in similar circumstances or when stories have been listened and responded to. The circles move closer together creating the beginnings of a shared space (Diagram 10.4).

**Diagram 10.4**

The move to alignment requires change. This change may be facilitated by effective medication that results in an improvement in mental state, however it is argued here that reliance on medication alone is not sufficient. This change can be actively facilitated by clinicians stepping into the world of the consumer’s experience to find common ground from which to work together. Rather than relying on the haphazardness of medication effectiveness alone, this shared space can be deliberately and consciously enlarged through the actions of clinicians, for example, through careful listening and facilitating opportunities to experience mutual support, thereby maximising a recovery outcome.
10.4.3. Continual non-alignment of clinical and lived experience

The third position (represented in Diagram 10.5) as identified in the Major Interpretation, is that of continual non-alignment of clinical and lived experience where the perspectives of consumers and caregivers remain at odds. This is the most challenging position for both consumers and caregivers as change towards recovery is inhibited. An outcome eventuates through reluctant compliance of the consumer to proffered treatment rather than through a collaborative partnership between consumer and clinicians. Clinicians take a passive stance waiting for the medication to “kick in” or for the psychotic episode to pass. Little attempt is made to step into the consumer’s world to hear and acknowledge their personal “in-the-moment” account of their experience, to seek commonalities and find agreement.

10.5 Clinician Responsibility - Focus on Practice

Consumers seek out or are involuntarily directed to acute mental health inpatient care due to their vulnerability at a time when they are at the mercy of out of control emotions and psychological disturbances - symptoms of a mental illness. It is beholden then on the health professionals in this situation to take the initiative to create an environment in which recovery can take place. It is their responsibility to adopt practices that will alleviate this distress and actively establish an environment in which difference and conflict can be overcome. While this is surely the role of any mental health professional, it is the contention here that too often this shared space
develops through happenstance in an acute inpatient setting, rather than being actively created. For instance, medication is administered and genuine concern and care applied, but it is then often a matter of passively waiting until the desired effect takes place or “insight” is developed before collaboration is possible. The alignment of lived experiences therefore does not automatically imply good practice. The shared space is identified here as a position to which clinicians’ attention can be drawn to reveal the opportunity for critical reflection on practice. It presents the opportunity to consider how a shift in power can be realised in order for the clinician’s input to take a subordinate position existing only to support the consumer’s direction regarding care and treatment (Slade 2009a).

This thesis argues that the task of the clinicians/health professionals in an acute mental health inpatient setting is to actively and deliberately draw the clinical and personal experiences towards each other, to “grow” the shared space until a sufficient overlap is created in which a respectful partnership can be formed and a recovery outcome maximised. The next step now is to look at the constituents that facilitate the creation and development of this shared space – the practice domain. This is the subject of Chapter 11 in which practice implications and the role of social work are discussed.
CHAPTER 11 - Implications for Practice and the Role of Social Work

11.1 Introduction

The health professional/clinician in an acute inpatient setting has the key role in maximizing opportunities for a recovery outcome through the active development of the shared space that is created where the personal and clinical lived experiences align. The areas of practice that will facilitate this alignment have been referred to throughout the interpretations but will now be highlighted for further scrutiny. Two skill areas emerge from the data as the most prominent – listening and the facilitation of mutual support.

The shared space allows for the creation of an environment in which a collaborative partnership between consumers and clinicians can be nurtured – an essential component of a recovery focus. Collaboration presupposes a relationship, therefore the starting point for this discussion is a consideration of the relationships that exist within a mental health context using a framework proposed by Slade (2009a). The two skill areas will then be discussed in terms of their components and their relevance to recovery-focused practice. Woven into the discussion will be references to how social work can contribute to practice improvement. Finally, consideration is given to the barriers that exist within an acute mental health inpatient setting that may work against the implementation of such practice improvements and impede a recovery-oriented focus.

11.2 The notion of professional relationships in mental health

A key factor in actively bringing the circles of personal and clinical lived experiences together to form the shared space is an understanding of the relationship between consumers and clinicians in this setting. This is a key concept identified by Bland et al (2015) and detailed by Slade (2009a). Slade identifies three different types of professional relationships that exist in the context of mental health service delivery. He places professional relationships along a spectrum that includes real, partnership
and *detached* relationships. A *real* relationship requires genuineness and authenticity where context is de-emphasised. A *partnership* relationship is defined by the mental health context but involves collaboration between consumer and clinician and requires some elements of a *real* relationship. In a *partnership* relationship the expertise of both the consumer and the clinician need to be activated to make it work. At the other end of the spectrum is the *detached* relationship in which expert knowledge flows from the clinician to the consumer. It is a relationship in which the clinician determines the agenda.

Slade centres this discussion on a distribution of power. *Detached* relationships locate the power to interpret, define and control the experience of mental illness with the clinician, while *partnership* relationships involve shared power. Slade asserts that traditional mental health services of which an inpatient setting is a prime example, emphasise *detached* relationships over *real* relationships with *real* relationships being considered unprofessional. A *detached* relationship may have been required at the commencement of inpatient care due to the consumer’s disturbed mental state when admitted. At this time the power needs to be located with the clinicians who diagnose, make decisions and treat according to clinical judgment in order to reduce risk of harm. When the crisis has passed and the risks are reduced, the challenge becomes how to actively move this relationship from *detached* to *partnership* to develop a collaborative environment and grow the shared space. The strongest challenges to good recovery outcomes are evident in this study when there is no aligning of the lived experiences, where no shared space exists or is nurtured. In this case the relationship remains detached with the power situated firmly with the clinicians. Consumers and clinicians remain at odds with each other with consumers left feeling helpless, powerless and disregarded. There is no movement towards alignment and no opportunities created to generate a shared space.

*Real* relationships are based on genuineness and authenticity and are independent of context. The nature of *real* relationships and how far the characteristics of this kind of relationship infiltrate a formal helping relationship confronts the very notion
of professionalism. This issue is raised by a number of authors on the subject of recovery in mental health (Longo et al 2002; Borg & Kristiansen, 2004; Henderson, et al, 2010). The study by Borg & Kristiansen (2004) in Norway explored the nature of helping relationships as experienced by people with a severe mental illness. Informants in the study spoke about the importance of small gestures on the part of workers who were willing to stretch professional boundaries. These gestures generated trust and allowed consumers to experience themselves “as an equal human being, way beyond the service-user role” (p. 500). According to Borg & Kristiansen the value attributed to helpers who exceeded professional boundaries creates a significant paradox that questions the notion of professionalism. In the same way, Slade (2009a) calls for a reframing of the notion of professionalism to better reflect the formation of partnership relationships. He acknowledges the anxiety this engenders as boundaries are challenged and issues around ethics, decision-making capacity, clinical considerations and matters of risk come to the fore and must be carefully appraised. Slade suggests that this anxiety needs to be held and managed by the service and not the individual worker, for example, through ensuring an explicit values-base and understanding real non-negotiables such as legislation, policy and professional codes of conduct. This implies organisational understanding of the issues behind a move to recovery practice and a commitment to support the changes required.

The questioning of professionalism is a natural consequence of a move to recovery-oriented practice that calls for collaborative partnerships as opposed to the traditional professional relationship involving a one-way flow of information from expert to recipient. The impact of this relationship change on recovery outcomes is becoming more evidenced, for example in studies such as Kogstad et al (2011) and Gandi & Wai (2010). Both studies set out to explore the elements of a helping encounter from a service user perspective. Kogstad et al state that recovery factors are not always compatible with professional approaches, noting the clients’ placement of relationships as central to recovery. Gandi & Wai’s study examined the outcome of a partnership approach in mental health compared to medical care alone. They describe a partnership relationship as one that features unconditional
positive regard, empathy and genuineness, creating a synergy between the principles of recovery practice and the use of the therapeutic alliance. Findings from their study indicate that a partnership relationship between the consumer and the mental health professional, when combined with social support and appropriate medical intervention, is essential for successful recovery. This finding is reinforced by Wyder et al (2015) who concluded from their study on therapeutic relationships and involuntary treatment orders in an inpatient setting, that the helping relationship between consumer and nurse is central to the healing process and needs to be based on collaboration.

The experience of inpatient care is likely to commence with a strong medical focus and with it a high probability of the creation of a detached relationship between consumer and clinicians. This is appropriate for the level of care required, however, as the admission progresses, the nature of this relationship needs to change to reflect the recovery process. Equipped with an awareness of the nature of relationships existing in the inpatient setting, clinicians will be better able to facilitate an environment conducive to recovery and allow for a flexibility of their relationships with consumers. Understanding how each player is positioned throughout the experience of inpatient care, the clinician can take an active role in moving the circles of lived experience closer together to create the shared space.

Two skill areas emerge from the data as significantly contributing to the development of partnership relationships in an inpatient setting – listening and mutual aid.

Inherent in these skills are elements that are fundamental to recovery principles. The lack of opportunity to establish partnership relationships is most evident in the consumer accounts of not being listened to and the accounts of workers/managers in which they lament the paucity of time available to “sit down and talk with” consumers. As noted previously consumer narratives are united in their call for their stories to be truly listened to especially when the clinical and personal lived experiences do not align.
11.3 The absence of listening skills – keeping the circles apart

“I just wish they would listen to me”

The skill of listening is intrinsic to good practice in all fields of health work but there is a special significance for mental health. For mental health practitioners, listening is a core skill that is relied upon to accurately ascertain a person’s state of being given that symptoms of a mental illness do not necessarily manifest as observable physical traits. In addition to this, consumers struggle to communicate their state of being and their needs while experiencing symptoms that impede their thinking processes. Despite the central importance of listening as a skill in mental health practice, consumers in this study commented almost unanimously on their experiences of not being listened to, an experience that evoked feelings of dismissal and invalidation. Sadly, this echoes the consumer experience found in other studies of acute inpatient settings including Tooth et al (2003), Lelliot & Quirk (2004) and Ridley & Hunter (2013) as noted previously.

Slade (2009a) distinguishes between the different types of listening present in detached professional relationships compared to partnership relationships. He states that within a detached relationship the purpose of listening is to fit the person into a clinical model and not the other way round. The result is that the person does not feel understood, a feeling that was echoed loudly in this study by consumers. The current research reinforces the existing literature in identifying the continuing absence of opportunities to listen or be listened to as a feature of acute mental health inpatient care despite its central significance to consumers. As the research indicates, however, consumers are not alone in noting this absence. It is a deficit of care that is also recognised by workers and managers as they lament the lack of opportunities to “sit down and talk with” with consumers. The responsibility for having deeper conversations or engaging in talking therapies is seen by some as being the domain of specific staff or occurring outside the inpatient setting post discharge. Others identify a lack of time as the reason they are prevented from listening to consumers, as client time is diverted to administrative tasks. Whatever the reasons for the absence of listening opportunities in the inpatient setting, respondents were loud in their collective declaration that listening is a key
component of good mental health care and significant to a positive recovery experience. They were also loud in their declaration that such opportunities were largely absent in their experience of inpatient care.

Social work has always valued listening skills as central to practice. According to Trevithick (2012) the skill of listening is often taken for granted or considered to be innate and requiring no training. Quite the contrary, she states that good listening is about “how to reach the emotions and thoughts of others” and is not easily taught (p. 173). Trevithick stresses the importance of providing a safe and unhurried environment that allows people time to express their thoughts and feelings. Significantly for mental health, Trevithick states that good listening is essential for “people who have been silenced or have lost confidence in their ability to express themselves” and proclaims that listening is the way to “understanding another human being and being able to express that understanding in words and gestures” (p. 172). Many of the elements of good listening, as identified by Trevithick, speak loudly to the notion of human connection that permeates the data of this study. These include genuineness, empathy, avoiding imposition of judgment, preconceptions or labels and recognizing the importance of allowing people to find their own words in their own time (pp. 172-173).

While Trevithick is writing broadly about the significance of listening as a core social work skill for all areas of practice, Walsh (2013) specifically draws these social work skills to a focus on mental health practice. Utilising a biopsychosocial approach within a stress-vulnerability model, Walsh emphasises the quality of the relationship between the consumer and the social worker as critical to enhancing the consumer’s personal growth. Fundamental to developing this relationship is the ability to communicate effectively. Walsh maintains that much of the focus in mental health practice literature is on how to communicate with a person once their psychotic symptoms have stabilised. He stresses the importance of being able to communicate with a person, even when they have active symptoms, as this forms the basis of an ongoing collaborative recovery partnership. What follows in Walsh’s book, is a practical guide on how to communicate with a person experiencing unusual
thoughts, delusions or loose associations. The interpersonal strategies put forward including active listening, reassurance, acceptance and attending are familiar to all social workers, however they are challenging to utilise with someone who is not reciprocating as one would expect. Walsh embraces this challenge stating that the situation also affords opportunities, “The consumer with psychosis often feels marginalised and discounted by others, so any evidence of the social worker’s acceptance will be perceived and eventually welcomed.” (p. 104)

Walsh refers to the social worker-consumer relationship as the “sustaining link” between the person and his/her social world identifying ‘sustainment’ as a key intervention. Through this sustainment the consumer becomes increasingly aware that the social worker is appreciating the “threads of meaning in his or her fragmentary statements” (p. 105). The concept of sustainability harks back to the notion of “secure base” discussed in an earlier section of this dissertation when looking at the context of inpatient care (Casher 2013). The social worker is providing a form of secure base founded on acceptance and patient listening – “hanging in” with the person during a time of difficulty when communication skills are being impaired by the symptoms of psychosis.

This notion of “hanging in” and the challenges it presents was evident in the researcher’s reflection of the interview with Drew (Reflection #5). In order to closely attend to Drew’s story the researcher had to deliberately, and as an afterthought, bridle her retention of psychiatric knowledge to truly hear through these filters of formal learning. Only then did an opportunity for alignment and collaboration become obvious. While Drew did not agree with the diagnoses that had been placed on him, he did agree he was in distress and required help. He mirrors Trevithick’s words as he struggles to express himself. Drew issues a plea for the consumer’s (patient’s) perspective to be accepted until they realise themselves that these perceptions may not align with the reality of others, perceptions that Drew terms as the “lie”...and if you accept that, the patient will turn round and go, in their own time, that was a lie and then you’d know that they were feeling healthy (Drew).
As demonstrated in this reflection, the level of listening required to step into the other’s world in this situation is a highly reflexive experience involving genuine and deep listening. Rather than standing by in the smugness of being a “knower” the worker needs to leave this position of epistemic security and be open to other ways of knowing (Fricker 2008). Borrowing from the processes inherent in the phenomenological methodology one needs to bracket or bridle one’s pre-assumptions such as belief in the superiority of a clinical model and its accompanying language. The consumer’s world needs to be listened to with a fullness of attention to language, emotion and content. It requires a genuine respect for the personal stance of the “other” and a readiness to hear the experience of this world in all its apparent muddled and convoluted untidiness. In the busy and sometimes frenetic environment of an acute inpatient setting this is difficult to achieve. It is indicated from this study however, that if good and deep listening occurs, distress can be alleviated and a position of collaboration reached at an earlier time. It is the responsibility of the worker/clinician to step into the consumer’s world to truly hear what is being said, find the common ground, connect to the consumer and gently draw the consumer, or be drawn by the consumer, to the shared space.

11.4 The importance of mutual support – drawing the circles together

“you’re not here doing this alone. I think that helps a lot.”
Consumers expressed surprise at the impact of their incidental meetings with others in the inpatient setting who shared their experiences of disturbing and inexplicable emotional and psychological states. The discovery of others who shared these experiences immediately dispelled feelings of isolation and alienation, replacing them with a sense of belonging and connection. The subsequent feelings of relief generated a willingness to disclose and a desire to help others in a similar situation. This in turn, contributed to strengthening personal identity by creating purpose and satisfaction. Interestingly, for workers too, there was a prevailing feeling of difference that was at times experienced as isolating. The field of mental health was viewed as set apart from the field of general health and with this a sense of not being understood except by those who shared this workplace.
Peer support is a key component of the recovery philosophy as noted by a number of authors including Slade (2009a and b), Tsai and Salyers (2008), Loumpa (2012), Tew (2013) and Bland et al (2015). Peer or mutual support aligns with recovery principles as it is strengths-based, anti-oppressive and promotes empowerment. Steinberg (2010) states that mutual aid as a concept is inherently strengths-based as any encounter that focuses primarily on deficits is not able to catalyze mutual aid. She argues that being strengths-based, mutual aid has exceptional goodness of fit with anti-oppressive practice. She states that a focus on “what’s wrong” is unwittingly oppressive as it conceals and negates those very aspects of a person that can promote growth and change. Mutual aid as an intervention is best enacted through the practice of group work. Group work practice focused on mutual aid challenges traditional power hierarchies that separate consumer and worker. In mental health this separation promotes the normal/abnormal divide. Mutual aid group work provides a forum that is consumer-led and therefore opportune for empowerment. According to Steinberg, mutual aid “keeps practitioner and practice honest by requiring all participants to share in power over what is, what should be and how to get there” (p. 59).

Loumpa (2012) mirrors Steinberg’s ideas about the benefits of mutual aid groupwork but particularly highlights the connection between mutual aid groupwork and recovery practice in mental health. Loumpa states that while groupwork as a practice provides a fitting context for mutual aid, this is not a natural consequence and believes groupwork methodologies do not offer explanations of how peer support can be enhanced. She adopts concepts from narrative, social constructionist, dialogical and systemic therapy approaches to identify and strengthen ways in which mutual aid groupwork can be actualised. From narrative therapy Loumpa takes the notion of dialogue as a way of validating and sharing stories that have been disqualified by dominant discourses, in this case by psychiatric knowledge. The retelling of stories assists in the reconstruction of personal identity by privileging the consumer narrative. This can be further reinforced by another concept attributed to narrative therapy, that of “witnessing”. Loumpa contends that the group context is
ideal for the witnessing of the stories allowing for affirmation by peers who inherently understand the shared narrative, thus facilitating and strengthening personal identity and the realisation of recovery outcomes.

Loumpa (2010) draws on social constructionism in the recognition of power hierarchies between consumer and clinician in traditional mental health service delivery. She maintains that a social constructionist view advocates for the validation of consumer expertise, shifting power to create a more collaborative approach. In a mutual aid group the clinician needs to relinquish much of the control for group process to the participants, making way for a shared agenda to facilitate mutual support. The facilitator’s role becomes that of ensuring exchange of dialogue between participants rather than a monologue to impart information from a leader or “expert” position. The stance of the facilitator is one of curiosity rather than leadership, a term borrowed from systemic theory. The facilitator as a curious listener uses questions that enhance meaning rather than questions to seek out a “truth”, enriching understanding and promoting further dialogue.

Both Loumpa (2012) and Steinberg (2010) are writing from a social work perspective highlighting the skill set of social workers in the promotion of mutual aid or peer support groupwork. Steinberg maintains that mutual aid groupwork is a hallmark of social work practice stating that “no other helping profession places it at its very epicenter (sic)” (p. 55). Loumpa highlights the shared values between social work and the recovery paradigm as well as social work’s tradition in the use of groupwork that is also a recommended strategy of contemporary mental health practice. Mutual aid groupwork is a way in which social workers can promote recovery principles through their clinical practice. It is a social work skill that is especially suited to the acute inpatient setting.

The inpatient setting is a ready-made environment for peer support that, as seen in this study, already occurs spontaneously. It is a natural community of support where people are drawn together by their shared experience of a phenomenon that in any other setting is viewed as, at best, unusual and, at worst, abnormal. This provides a
rich opportunity for clinicians to maximise the value that consumers already identify and utilise to their advantage – the value that comes from their sharing of personal experiences with others in a similar situation. There are also dangers inherent in this, however, as noted by Stenhouse (2011) with some consumers seeing the experience of helping others as an increase of emotional burden. Such dangers can be managed through careful facilitation and monitoring by skilled clinicians. The deliberate creation of opportunities to take control, seek out affirmation and validation, put aside power hierarchies, develop supportive relationships, foster a sense of belonging and promote self responsibility, encompasses most domains of recovery practice and can be actively facilitated through mutual aid groupwork. The researcher’s own practice experience suggests that the skills of mutual aid groupwork are essential in the field of mental health (Hyde 2013). It is the contention here that these skills also significantly contribute to the movement towards alignment of the clinical and personal lived experiences and the creation of a shared space in which collaborative partnerships become reality. Mutual aid groupwork is the embodiment of collaborative/partnership relationships.

Listening skills and mutual aid groupwork are two skillsets that significantly enhance the recovery experience of mental health inpatient care as shown in this study. They are skillsets that are fundamental to social work practice. This places social workers in a prominent position to turn what is usually portrayed as the profoundly negative experience of inpatient care into one that greatly intensifies the likelihood of a positive recovery outcome. Clinician skills are a key component of the movement to a shared space, however they will remain dormant and unused unless the broader context of the organisational setting encourages and supports the development and manifestation of these skills.

11.5 Barriers of organisational context – keeping the circles apart

The lived experiences of the workers and managers within this study reveal a humility and appreciation, even strong admiration, of the consumers’ lived experiences, that for many produced an outward and unexpected show of emotion.
Likewise, many of the consumers demonstrate sensitivity and concern for the staff around them even as they criticise aspects of care. This ambience of humanism suggests a significant potential for the creation of partnership relationships within this setting however, there is no sustained evidence that this is occurring. This is seen in the experiences of consumers that left them feeling dismissed and unacknowledged. For the workers/managers it is evident in their recognition of the lack of time to spend with consumers and the paucity of opportunities for consumers to participate fully in their care. It is also evident in the strongly expressed opinions of workers and managers about the emphasis on custodial and controlling measures they see as a feature of their workplace. The few examples from consumers of feeling listened to are noted and treasured but do not appear to be business-as-usual and the positive experiences of peer support are incidental and random.

A possible explanation for why this potential for collaborative partnerships is not being realised begins with a consideration of the acute inpatient mental health setting. The circles of lived experience exist within a wider circle of organisational structure and culture – the mental health inpatient setting (Diagram 11.1).

**Diagram 11.1**
The mental health inpatient setting is a place where mentally distressed people are temporarily located due to concerns about the potential risk or actual occurrence of harm to themselves or others. As stated before, it is a setting of *in extremis*. Here, traditional clinically focused relationships or detached relationships abound. The exercising of power by those who represent this system occurs in the context of relieving extreme distress and very often of saving lives. It is not a setting conducive to the establishment of collaborative or partnership relationships when one side of the partnership is so vulnerable and at risk and the other side, by necessity, exercises power and takes control. The question arises then as to how the exercising of power *over* can be transformed to a sharing of power *with* once the life is saved or the distress conquered.

While care that focuses on custodial and controlling measures is crucial for many in the initial stages of an acute inpatient stay to ensure safety and alleviate risk, there is a limit to its use. Opinions of the three groups are predominantly congruent about the provision of safety through custodial measures at the initial stages of admission. The trust in the system of care however then begins to dissipate. The move to a model of care that encourages increased autonomy is not so evident. Workers and managers express disappointment and frustration at the lack of opportunities provided for consumers to be involved in their care once the acuity has passed and the need for the more intense custodial measures has subsided. This may be the reason for the strong opinions of workers and managers about the use of custodial measures and the perceived over-focus on risk management. They are protesting the predominance of risk aversion as a “one-size-fits-all” ideology and the unnecessarily prolonged use of these measures, rather than their actual existence.

This finding correlates with that of Smith & Bartholomew (2006). They acknowledge the central role that hospitalisation has in an acute phase of illness but note that when a person’s mental state has improved, the utility function of the hospital diminishes and needs to be replaced with a recovery focus. This entails a move from a model of restrictive care to one of increased client autonomy, a process they name as “progressive empowerment” (p. 91). Instead of questioning whether inpatient
care is or is not compatible with a recovery focus it can be viewed as a continuum of care that needs to accommodate both restrictive care when required, followed by a move to recovery-focused care that encourages and supports emerging autonomy. According to Smith & Bartholomew the milieu required for progressive empowerment is lacking in an inpatient setting. This is due to the absence of an effective mechanism for accommodating change from the functional mode of restrictive care to one that is client-centred and ultimately recovery-focused. Slade (2009a) as noted previously, encapsulates this idea when looking at the safety net function of hospitalisation being “springy” rather than “saggy”. This lack of an effective mechanism to ensure flexibility or “springy-ness” may explain the frustration felt by workers and managers about the perceived overuse of custodial care and the limited opportunities for consumers to be actively involved in their care. For an acute inpatient setting the default position is one of restriction and custodial measures with few options for alternative systems of care. Once the need for custodial and controlling measures pass, there is a vacuum of care options and the potential for developing and sustaining partnership relationships dissipates.

This research has revealed a shared space of consumer and worker lived experience within the setting of an acute mental health inpatient facility. What do we find when we open up this shared space? Rather than two separate and distinct categories of personal and clinical lived experience we find a space where all those sharing this phenomenon seek help, offer help, share confidences, connect with each other, learn about resilience and tolerance and discover new information and skills for coping. They also plead to be listened to, to have more say in what happens to them, to be able to spend more time with each other without the strictures of bureaucratic and administrative requirements and advocate for more humane treatment. The shared space holds within it a mix of high emotion based on respect, humility and a desire to reach out to a fellow human being in a time of need and extreme vulnerability. It contains connection through mutual support, reciprocity of helping and the sharing and witnessing of stories that involve personal struggles to overcome pain, trauma and emotional disintegration. It is made up of the ability to take responsibility for self, of reclaiming personal identity and of transitioning to a
place of well-being. It is a space where boundaries can be dissolved in favour of common humanity. In short it is a place that is exceedingly conducive to recovery. However, the challenges for this potential to be realised are significant.

In order for these challenges to be overcome, the acute mental health inpatient setting requires the integration of two purposes. Acute mental health inpatient care needs both a strong biomedical model of care to effectively deal with acutely unwell people whose behaviours and level of distress create significant risk of harm to themselves or others, while at the same time, be able to support a client-directed model of care in which a biomedical approach takes a back seat and exists only to support client self determination. Should such a mechanism exist to accommodate both models of care as pointed out by Smith & Bartholomew (2006), the next challenge is to ensure the workers within this setting are flexible enough in their practice and in their attitudes to be able to make the switch between these models of care and to be alert to the nuances that indicate when this is appropriate. Social workers through their strong alignment with recovery principles, and other workers versed in recovery-oriented care, are well positioned to demonstrate how this can be done. Chapter 12 outlines recommendations shaped by these considerations.
CHAPTER 12 – Recommendations and Conclusions

12.1 Introduction

As this study progressed it unintentionally began to reflect the principles of a recovery approach. The initial stance of the researcher arising from the natural attitude, was to expose and focus on the deficits of acute mental health inpatient care. Instead the study has unearthed unexpected strengths. The analysis of the data through the hermeneutic phenomenological process, extracted a number of interpretations that led to the uncovering of the “shared space” within the lived experience of inpatient care. There are two main implications arising from the study.

First, inpatient care is cast in a new light revealing opportunities for recovery-focused practice to flourish. It exposes the prevailing view of mental health inpatient care as one overtaken by a discourse of negativity. Instead, a positive perspective emerges that stands in opposition to the predominantly negative image of inpatient care that was apparent from the literature and reinforced by the researcher’s own experience. While the potential exists for recovery-focused care in this setting however, the reality falls far short. One of the reasons for this may be the lack of clarity about the purpose of acute inpatient care that hinders the move to a recovery focus of care.

Secondly the study reveals significant opportunities for social work to effect workplace reform in the field of mental health. This is a reform that is already mandated and articulated on a state, national and international level. Social work as a profession is poised to make an extraordinary contribution to the changing of practice and to workplace reform by grasping the opportunities that lie waiting to be harnessed. It is not the case in many work environments that the mandated approach to practice and service delivery is one that matches that of the workers’ professional values and principles, let alone includes a direction to produce major reform.
The following implications arising from this study are described with an emphasis on practice rather than on policy. This is because it is the contention here that the existing policies and guidelines at state, national and international levels on the mandating of recovery-focused mental health service delivery are already explicit, unequivocal and abundant. The challenge lies in the implementation of these policies and guidelines such that the hoped for changes to service delivery will eventually come into being. The policy recommendations arising from the study therefore are situated at a very local, facility level, emphasising implementation and practice requirements.

12.2 Transforming the inpatient setting to reflect recovery-focused care

While seen as a necessary component of mental health services for those experiencing extreme and acute distress, hospitalisation is presented as a mode of care to be avoided for as long as possible, a last resort or a necessary evil that has traditionally diverted resources away from other preferred forms of care, especially community-based services. Few would disagree with the push for better resourced community-based mental health services but this does not diminish the significant role inpatient care plays as part of the necessary suite of mental health services. Despite this, there is little research that investigates ways in which this essential but somewhat maligned service can be improved and reflect recovery principles. In the absence of this research, the inpatient setting remains fixed in a traditional mode of service delivery, uncertain of its continuing status or value and confused about its purpose. Workers feel pressure to work from a recovery focus within an organisational setting that is founded on work practices and ideology seemingly antithetical to recovery.

Evident in this study is a lack of clarity about the purpose of mental health inpatient care. This was noted back in 2006 by the Sainsbury Centre for Mental Health (2006) in the UK in which it is stated that more needed to be done to “address the growing uncertainty over what role it (acute inpatient care) plays in a modern mental health service” (p. 7). A decade on and this uncertainty remains. Those workers and
managers in the study who feel it is a place of “rapid assessment and discharge planning” only, are firm in their belief that recovery happens “out there” in the community. Descriptions such as “real” recovery or “the true sense of recovery” were reserved for community locations post discharge. This is a mindset that hampers the possibility of practice change in the inpatient setting from the traditional treatment mode. Other workers and managers see the inpatient setting as establishing the beginnings of recovery, a process that then continues into the community setting. There is lament from some that the acute setting is not viewed within a recovery paradigm nor its contribution to recovery fully recognised. This is not a debate that consumers engage in. They are clear in what works for them in this environment and also what aspects are lacking that impede their recovery. In a rapid assessment and discharge planning framework, time is precious and precludes the fostering of opportunities for deep listening or facilitation of peer support - two ways in which consumers articulate how recovery is achieved in the acute mental health inpatient setting.

If the acute inpatient setting declares its purpose as a rapid assessment and discharge unit only, then restriction of service delivery to a traditional biomedical focus of treatment will prevail and desired outcomes will be limited to the reduction of symptom acuity. If, however, the purpose of the service is agreed on as more than this, that is, it is a service with a focus of care beyond symptom reduction to one that encompasses a recovery focus based on partnership relationships and collaborative care, then the service must embed strategies or a “mechanism” (Smith and Bartholomew 2006) by which this transition can be supported. Without this clarity of purpose the acute inpatient service will continue to be obscure in its aims and the service will remain fixed in its functional mode of restrictive care, unable to adjust to a flexible, consumer-driven recovery focus. Not only should clarity of purpose be established, but also, according to Shera & Ramon (2013), the model of recovery to be employed needs to also be clearly stated taking into account the role and power of consumers.
The evidence from this study indicates that workers and managers give a mixed understanding of the role of the acute mental health inpatient service they are employed to provide in relation to its recovery purpose. Consumers, on the other hand are clear about what works for their recovery and what impedes it. Taking the lead of the consumers then, the acute inpatient setting needs to have a two-pronged purpose. It is a purpose that addresses immediate symptom reduction as well as embeds a recovery approach in which consumers actively participate in their care through careful listening and acknowledgement of their lived experience. In this way the inpatient experience provides not only relief from distressing symptoms but also a foundation of security and healing from which to embark on life again beyond hospital care. It is a system of care that encompasses an understanding of both clinical and lived experience. In keeping with the recovery philosophy it is the stance of this thesis that consumer experience should be the prominent voice in determining the purpose of acute inpatient care. Thus, the following recommendations have been crafted.

**Recommendation 1**

Significant reforms are required to realise the potential for recovery-focused care within acute mental health inpatient facilities. This involves fundamental shifts in purpose and process in particular:

- clear commitment to and articulation of the purpose of the service as one that provides recovery-focused support beyond the clinical assessment and treatment essential for the initial crisis
- transformation of the system of care to one that is recovery-based and integrated with the existing biomedical treatment approach by prioritising and supporting consumer self determination and inclusion in treatment processes through, for example, the creation of spaces for deep listening and the facilitation of peer support
- commitment to the continuing development of recovery-based skills and knowledge for all staff through support for attendance at recovery practice education and related professional development opportunities
- strengthening opportunities for further practitioner research on mental health inpatient care

**Recommendation 2**

Medical, nursing and allied health staff should commence their mental health professional experience with knowledge and skills grounded in recovery-focused care. Educational institutions responsible for the training of medical, nursing and allied health professionals need to include as part of the mental health component, significant attention to:
- the principles of recovery-based care including the importance of human connection and the centrality of relationships through attention to the skills of deep listening and empathy
- the current state, national and international policies and guidelines mandating recovery principles as the driving force of mental health reform

**12.3 The significant role of social work in the inpatient setting**

The significant alignment between social work principles and those of the recovery movement place social workers in a prominent position to actualise the workplace potential to support recovery outcomes for consumers who require this level of care. This study unearthed specific and practical contributions of social workers in the move to recovery-focused practice in the traditionally challenging setting of acute inpatient care. Social workers can take a leadership role in a reform that is already mandated by legislation and existing policy at state, national and international levels through their capacity as practitioner role models, advocates, educators and researchers. The recovery movement offers a ready-made platform for practice change and service reform that has been developed and led by consumers. It is anti-oppressive, strengths-based and human rights focused – all the ingredients for reform on many levels. Social workers however, may remain ignorant of this potential for effecting reform if they come to the setting unaware that they are in possession of a skillset eminently suited to the mental health workplace and its mandated push for change to contemporary modes of care – modes of care that are
enmeshed with their profession’s values and principles. It is beholden on social work education to prepare mental health social workers for this task. It is questioned whether there is there any other field of social work practice where the mandate for change is so explicit, embedded and just waiting to be actualised. Social workers must be made aware of potential that exists within the skillset and ideological position of their profession. This is also true for other health professionals as noted by Shera & Ramon (2013) who call for the engagement with educational institutions responsible for the training of doctors, nurses and psychologists as a way of promoting mental health reform.

**Recommendation 3**

Social workers bring a wealth of knowledge and skills grounded in recovery principles to the mental health professional practice table. However, the link between recovery principles and existing social work skills and knowledge is not sufficiently recognized and therefore under utilised in the process of mental health reform. This needs to be addressed by educational institutions responsible for mental health social work undergraduate and postgraduate education through clearly explicating:

- the alignment between recovery principles and social work principles
- the current state, national and international policies and guidelines mandating recovery principles as the driving force of mental health reform
- the significant role of social workers in leading practice and service reform across all mental health settings, for example, through advocating for peer support and modeling deep listening.

- the significance to mental health reform of foundational social work skills that emphasise the centrality of relationships and human connection
- the importance of social work led practitioner research to contribute to mental health reform
12.4 Limitations

The findings and recommendations resulting from this study must be viewed within the inevitable limitations that are present. These limitations will now be outlined along with suggestions for future research.

- The current study was conducted in a single site located in a rural area in Australia. Restriction to a single site does not allow conclusions to be drawn about similarities or differences to other rural locations nor can the findings presume to be applied to acute mental health inpatient settings situated in urban locations in Australia nor applied to either urban or rural locations internationally.

- The participants were drawn from the three groups of consumers, workers and managers and the analysis of data considered within a broad perspective for each of these groups. This did not allow differences within the groups to be considered in depth, particularly between the various professions represented in the worker group. In a similar vein the group of managers who participated represented only one profession - nursing. While this is generally representative of the management level within this organisation, it may be seen to provide a monochromatic view of the issues from a management perspective. All the managers interviewed fell back on their clinical practice experiences when relating their thoughts and opinions possibly concealing any issues from a specifically management perspective.

- Only one interview was held with each participant. This may be seen as a limitation within the chosen phenomenological methodology that recommends three interviews as the ideal. The restriction to one interview only was driven by the inclusion of the consumer group who were unlikely to be available for three interviews across a period of time. It was considered beyond the ability of the single researcher to conduct follow up interviews post discharge, the difficulties exacerbated by the wide geographical distribution of the consumer’s home locations. This difficulty of location
would most likely have necessitated the use of telephone interviews and would have increased the likelihood of incomplete data collection if participants could not be located. It was felt that using a mix of interview strategies, that is, multiple interviews for two groups and one interview for one group or the use of both face-to-face and telephone interviews, would have complicated and compromised the data collection and analysis process.

- For similar logistical reasons carer and family perspectives were not included in the study. This would have required a more complex recruitment process and the organisation of interview times outside of the workplace. There was a strong likelihood that interviews would have required the medium of telephone contact. As such the carer perspective of inpatient care, despite its significance to individual recovery has not been included.

- It was noted that participants across the three groups had little experience of other acute mental health inpatient facilities limiting any comparisons with experiences of other like facilities. The accounts of inpatient experience may therefore be considered restricted.

- The researcher’s position as practitioner-researcher or insider may be viewed as both a limitation and a strength. Familiarity with the setting and with many of those interviewed, workers and managers in particular, may have skewed the interpretations, however this position was made explicit. The methodology was chosen with this positionality in mind to ensure the reader was left in no doubt of the stance of the researcher and the possible implications for analysis and interpretation. From a positive perspective there was a sense of trust towards the researcher from those workers and managers who chose to participate. This may explain the depths of emotion that were unexpectedly revealed from these participants. On the other hand consumers may have felt constrained in their disclosures and concerned about how this could affect their care.
12.5 Suggestions for future research

The study gives rise to a range of possibilities for future research.

- The findings of this study conclude with a more positive perspective of acute inpatient care than was expected and than what has up to now been documented. The question arises as to whether this is specific to the chosen single site. It would be interesting to discover if these positive aspects of inpatient care and the resulting opportunities to focus on recovery are present across different settings. Further research could be conducted at both urban and rural sites across a range of international settings.

- As there is a mix of professions in the acute inpatient setting, many disciplines are potentially contributing to mental health reform through the introduction and embedding of recovery-based practice. Specifying these contributions could also inform the education of medical, nursing and all allied health professions. Research that is discipline specific or allows for more in-depth presentation of recovery perspectives across different professions would further inform the challenge of practice and service delivery change.

- It is suggested in this dissertation that a strategy or “mechanism” needs to exist within the inpatient setting that facilitates a transition from a biomedical focus to a more recovery-focused model, generating client self determination and empowerment once the crisis that precipitated admission has been attended to. It is not clear, however, what form this mechanism needs to take. Further research is suggested to identify and investigate the organisational barriers to practice and service delivery change in order to provide structure and detail to this mechanism.

- A study that incorporates the lived experience of carers and family members is needed to complete the picture of inpatient care. While consumers in this study spoke about the importance of family, this issue did not feature in the major interpretations when it was considered in the light of the shared experiences across the three groups. The perspective of carers and family
would provide a more comprehensive view of inpatient care from all major stakeholders.

- Whether the researcher’s position of insider is seen as a limitation or as a strength, further research from an outside position could yield different perspectives. It is therefore included here as a suggestion for future research.

**12.6 Conclusion**

Through the inclusion of consumers, workers and managers in this study an holistic view of inpatient care has been presented. This study has value added to other studies that have sourced worker experience alone or only reported the experience of consumers post discharge. This study contains the views of consumers as they lived the experience of inpatient care alongside those workers and managers responsible for the provision of care they were receiving, leading to the discovery of a shared space of lived experience that transcends the polarity of a normal/abnormal divide. Strengths and opportunities have been unearthed to enact recovery principles in a setting usually considered hostile or in opposition to such principles. However, there is some way to go to ensure these opportunities are grasped and realised. Rather than viewed as oppositional models of care, the biomedical framework and the mode of care based on recovery principles need to co-exist in a setting that requires the prioritisation of both at various times throughout the period of inpatient care. This needs to be made explicit with the development of a mechanism or strategies by which the skills of workers and associated local policies and guidelines can reflect and adapt to this fluid system of care.
Final Personal Reflection #6

Finding myself now at the end of this adventure, I can reflect on its entirety and its impact on me personally and on my learnings. I commenced this project from a position of outrage and personal indignation at the injustices I observed in the acute mental health inpatient setting but now find myself considering a more subdued and mollified state of being. Have I succumbed to the forces at play that extinguish the energy and passion for change in this setting when I should be maintaining the rage? My responses to the data kept surprising me and I found myself cranking my thinking towards a different path – I could almost hear the crunching of the gears protesting at this change of thinking and meaning-making. Why weren’t consumers in particular, giving me the stories of negativity I expected to hear? Why were the staff responding to their accounts of the workplace with declarations of love and tears to boot? Where was this leading me and where was it going to end? The iterative nature of the chosen methodology created a truly magical mystery tour. But perhaps on reflection this process has just confirmed the power of a strengths perspective. It was the positive aspects of the lived experiences that persistently appeared – not only to me but it seems, to the participants as well. All had stories of negativity to tell, all had experienced frustration and anger, however in the end it was the stories of success and healing that prevailed and were recounted in a language that was strong and definite. Like the existing literature, perhaps I too had succumbed to the discourse of negativity that surrounds accounts of acute mental health inpatient care.

Why then does this research unearth a different perspective? My intention in using hermeneutic phenomenology was to create the possibility of viewing the phenomenon of lived experience of acute mental health inpatient care in a new light. The mechanics of this methodology continually entreat the researcher to look below the surface and behind the scenes. The process of iteratively moving between the parts and the whole and moving between understanding and not-understanding became very real to me and assisted in the gear change required to be able to grasp
the phenomenon as it was taking shape. Rather than being asked for an opinion, the participants were asked to tell their story of inpatient care beginning and ending where they chose. Neither myself nor the participants knew exactly where this was going to lead. Words and phrases of those authors of phenomenological research I read before commencing analysis kept coming back to me and gaining substance. I was living the intersubjective nature of this methodology and it was indeed a “messy” one as Linda Finlay (2011) warned it would be. Karin Dahlberg (Dahlberg et al 2008) guided me in the analysis of the data by holding onto principles of scientific openness without a strict prescription of method, as unsettling as this was for me at the time. Carla Willig (2012) “told” me that the text would not only have an influence on me but also change me and that it was my role as the researcher to “create the space” to allow the phenomenon to disclose itself. It disclosed itself in a way that I was not expecting. Far from confirming my initial apprehensions of inpatient care I have had to embrace an almost contrary perspective – quite a change for me. Instead of feeling disappointment that my initial assumptions were not substantiated I rejoice at the discovered opportunities. This matches the spirit of recovery principles as the strengths of inpatient care were disclosed and with them a sense of hope and optimism that this level of care can significantly contribute to individual recovery. In saying this I do not want to give the impression that I am now viewing inpatient care in a Pollyanna way. It is still clear that there is a long way to go before recovery principles are evident in the delivery of inpatient care but the discovery of the potential waiting to be actualised was unexpected and exciting.

Due to this intersubjective and reflexive process I am aware that my findings may differ from those arrived at by another researcher. My position as a social worker was made explicit. This filter through which I heard and analysed the data no doubt influenced the interpretations throughout. However, they kept me true to the research question that sought to explore the contribution of social work as a profession to answering the challenges of the change to recovery-focused practice. On this subject I still experience disbelief as to why we as social workers are not at the forefront of practice and service change in mental health. How often does it
happen that we are handed reform on a platter without having to “fight the system” to justify change in the first place?

I am also aware of the many other aspects of the data that could have been taken up and expanded, especially issues that were specific to the different groups and to groups within groups. Consumers, for example, talked about the importance of family, while nursing staff were concerned about the lack of emphasis on mental health skills in nursing education. These were parts that did not make the cut to the final whole.

The experience of research on this topic has indeed changed me. I have a new understanding of the value of inpatient-care even in its current form of service delivery. I have a new appreciation of my mental health colleagues as I see beneath their “professional” exteriors and ponder the possible depth of emotion and humanity that keeps them connected to their chosen field of work. However, I see the extent of the challenge ahead in how we might ensure this undercurrent of humanity and connection is drawn to the fore to engage with our fellow humans who at a point in their lives are rendered so vulnerable by the experience of disturbance to their mental well being. How do we ensure this is the driving force of practice and most importantly how can it be embedded in the system of care that informs the delivery of this service? These are the continuing challenges and questions that lie waiting to be addressed - future magical mystery tours.
APPENDICES

Appendix 1: Information Sheet for Participants (Consumers)

Research Project
Information Sheet for Participants (Consumers)

Title of Research: The lived experience of admission to a mental health inpatient facility – what’s recovery got to do with it?

Invitation
You are invited to participate in a research study investigating the experience of an admission to an inpatient mental health facility and its role in recovery from the perspective of consumers and mental health workers. The study is being conducted by Bronwyn Hyde Senior Social Worker at ... Hospital part of the ... Health Service. Bronwyn is enrolled in further study in the Doctor of Social Work course at Charles Sturt University at Wagga Wagga. As part of this study she is undertaking a research project about recovery in mental health. It is expected that this project will commence in July 2013.

1. What is the purpose of this study?
The purpose of the study is to understand the meanings attached to the experience of an inpatient admission to a mental health facility from the perspective of three different groups. The project will be asking for participants from current inpatients of the Acute Units at the ... Campus and from people who work in these units as health professionals and who are managers in this facility. It is hoped that the results will inform the service about how to improve support for people experiencing a mental health problem during an inpatient admission. The aims of the research are:

1. To explore the meaning of an admission to a mental health inpatient facility from the perspective of consumers, mental health workers and management.
2. To explore the meaning of recovery in mental health as it is understood by consumers, mental health workers and management in a mental health inpatient facility.
3. To compare worker perceptions of recovery with recovery principles and consumer perceptions of recovery.
4. To understand the ways in which an inpatient mental health facility can support consumer recovery.

2. Why have I been invited to participate in this study?
You are being invited to participate in this study as a consumer because understanding your experiences about recovery from a mental illness in this inpatient setting is necessary to shape the way in which this service is delivered. It is important to learn more about your experiences in order to ensure your needs as a consumer are being met.

3. What does this study involve?
If you would like to participate in this study, you will be asked to discuss this with your treating psychiatrist or medical officer. This is because we must be sure that you are able to provide consent and to ensure that participation in the study will not expose you to any experience that could affect your wellbeing. You will then be asked to participate in an individual interview with the researcher in which you will be asked a number of open-ended questions about your experience of admission and recovery. This discussion will be audiotaped and then transcribed. The interview will last for approximately one hour and will take place in a quiet location on the Unit.

If you experience any discomfort or distress as a result of your involvement in this study you will be able to access counselling provided by the psychologists or social workers whose names appear at the end of this information sheet. None of these workers have been involved with the study and there is no charge for this service.

4. Will I benefit from the study?
This study aims to further an understanding of the experience of recovery for consumers in an inpatient facility. While there is no direct benefit to you it is hoped that your participation will contribute to improvements in this setting by ensuring the service is more responsive to both worker and consumer needs.

5. How is the study being paid for?
The study is being supported by the Mental Health and Drug & Alcohol Service … Region. The researcher will be conducting the research within her capacity as an employee of this service.

6. Will taking part in this study cost me anything, and will I be paid?
Participation in this study will not cost you anything, nor will you be paid.

7. What if I don’t want to take part in this study?
Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your stay in hospital in any way or the care you receive.

8. What if I participate and want to withdraw later?
If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason. There are NO consequences for you if you decide not to participate or if you decide to withdraw after initialling agreeing. If you wish to withdraw after participating in the interview your transcript and recording will be destroyed. However, it may not be possible to withdraw your data from the study results if these have already been incorporated into a general analysis.

9. How will my confidentiality be protected?
If you agree to participate you will be allocated a participant number and no personal details will be used. Names will be changed when the information is being transcribed or if direct quotes are used in any written form. Any identifiable information collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researcher will have access to your details which will be kept securely in a locked filing cabinet in the workplace and will be destroyed after a period of 5 years in accordance with the University’s requirements. Please note,
however, that there is certain information that must be reported if disclosed during the interview. This involves the reporting of any child protection concerns or the conducting of illegal activities.

10. What happens with the results?
If you give us your permission by signing the attached consent form, the information from the interviews will be used for the development of a thesis that will be submitted to the University. It is expected that the information will also form the basis for journal articles and for presentations at conferences however information will be presented in such a way that you cannot be identified.

11. What should I do if I want to discuss this study further before I decide?
When you have read this information, the researcher will discuss it with you and answer any queries you may have. If you would like to know more at any stage, please do not hesitate to contact the researcher on the numbers below.

12. Who should I contact if I have concerns about the conduct of this study?
This research has been approved by the Charles Sturt University Health Research Ethics Committee and the … Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Research Ethics Committee Executive Officer (CSU) and/or the Research Governance Officer (… LHDs) who are the people nominated to receive complaints from research participants. The contact details are set out below:

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<th>1. Charles Sturt University’s Human Research Ethics Committee</th>
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<td>The Executive Officer</td>
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<td>Human Research Ethics Committee</td>
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<td>Office of Academic Governance</td>
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<tr>
<td>Charles Sturt University</td>
</tr>
<tr>
<td>Panorama Avenue</td>
</tr>
<tr>
<td>Bathurst NSW 2795</td>
</tr>
<tr>
<td>Tel: (02) 6338 4628</td>
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<tr>
<td>Email: <a href="mailto:ethics@csu.edu.au">ethics@csu.edu.au</a></td>
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<th>2. Research Ethics Committee</th>
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<td>Ethics &amp; Research Governance Officer</td>
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<td>Population Health Unit</td>
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<tr>
<td>Tel: …</td>
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<td>Email: Ethics.committee@…</td>
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Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Researcher Contact Details: Bronwyn Hyde Senior Social Worker ……..
or ……..
Supervisors: Dr Wendy Bowles 02 69332695 and Professor Manohar Pawar 02 69332497 Charles Sturt University, Wagga Wagga, NSW.

Counselling Contacts: ... and ... (social workers)
... (psychologist)
Please see nursing staff to arrange referral

Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form.
This information sheet is for you to keep
Appendix 2: Participant Consent Form (Consumers)

PARTICIPANT CONSENT FORM (CONSUMERS)

The purpose of this study is to explore the experience of an admission to an inpatient mental health facility and its link to recovery from the perspective of consumers and mental health workers. Please read the following and sign if you would like to participate.

- I have read and understood the Participant Information Sheet on the above named research study, and understand the purpose and process described within it.
- The purpose of this research has been explained to me and I have been given the opportunity to ask questions about the research study.
- I understand that participating in the study will include being interviewed and audio recorded.
- I understand that any information or personal details gathered in the course of this research about me remains confidential and that neither my name nor any other identifying information will be used.
- I understand that my words may be quoted in publications, reports, and other research outputs but my name will not be used.
- I freely agree to participate in this study and understand that I am free to withdraw at any time.
- I have been given adequate time to consider my decision and I agree to take part in the research study.
- I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print):

.............................................................................................................................

Signature: .............................................................. Date: ..................................

Name of treating psychiatrist.....................................................................................

Signature: .............................................................. Date: ..................................

Name of treating psychiatrist

Signature: .............................................................. Date: ..................................
Declaration by the researcher: I have given a verbal explanation of the research project, its procedures and I believe that the participant has understood the explanation.

**Name of Researcher** (please print):

…………………………………………………………………………..

**Signature:** …………………………………………………………..**Date:** ………………………………..

Contact details are on the following page

**Contact Details**

This research has been approved by the Charles Sturt University Health Research Ethics Committee and the Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Research Ethics Committee Executive Officer (CSU) and/or the Research Governance Officer (… LHDs) who are the people nominated to receive complaints from research participants. The contact details are set out below:

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Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

**Researcher Contact Details:** Bronwyn Hyde Senior Social Worker ……. or …….
Supervisors: Dr Wendy Bowles 02 69332695 and Professor Manohar Pawar 02 69332497 Charles Sturt University, Wagga Wagga, NSW.

Counselling Contacts: ... and ... (social workers)
... (psychologist)
Please see nursing staff to arrange referral
Title of Research: The lived experience of admission to a mental health inpatient facility – what’s recovery got to do with it?

Invitation
You are invited to participate in a research study investigating the experience of an admission to an inpatient mental health facility and its role in recovery from the perspective of consumers and mental health workers. The study is being conducted by Bronwyn Hyde Senior Social Worker at ... Hospital, part of the ... Health Service. Bronwyn is enrolled in further study in the Doctor of Social Work course at Charles Sturt University at Wagga Wagga. As part of this study she is undertaking a research project about recovery in mental health. It is expected that this project will commence in July 2013.

1. What is the purpose of this study?
The purpose of the study is to understand the meanings attached to the experience of an inpatient admission to a mental health facility from the perspective of three different groups. The project will be asking for participants from the current inpatient population of the Acute Units at the ... Campus and from people who work in these units as health professionals and who are managers in this facility. It is hoped that the results will inform the service about how to improve support for people experiencing a mental health problem during an inpatient admission. The aims of the research are:

1. To explore the meaning of an admission to a mental health inpatient facility from the perspective of consumers, mental health workers and management.
2. To explore the meaning of recovery in mental health as it is understood by consumers, mental health workers and management in a mental health inpatient facility.
3. To compare worker perceptions of recovery with recovery principles and consumer perceptions of recovery.
4. To understand the ways in which an inpatient mental health facility can support consumer recovery.

2. Why have I been invited to participate in this study?
You are being invited to participate in this study as a health professional (medical, nursing or allied health) because your thoughts about recovery from a mental illness shape your practice and the way in which this service is delivered. It is important to learn more about this to help with service planning and to ensure consumer needs are being met.

3. What does this study involve?
If you agree to participate in this study, you will be asked to sign the attached Consent Form.
You will then be asked to participate in an individual interview with the researcher in which you will be asked a number of open-ended questions about the inpatient setting and recovery. This discussion will be audiotaped and then transcribed. The interview will last for approximately one hour and will take place in a quiet location on the Unit. The interview will be undertaken in your work time. While it is not expected that the interview will cause any discomfort or stress, should this occur please consider contacting EAP (Employee Assistance Program).

4. Will I benefit from the study?
This study aims to further understanding of mental health practice within an inpatient facility. While there is no direct benefit to you it is hoped that your participation will contribute to improvements in this setting by ensuring the service is more responsive to both worker and consumer needs.

5. How is the study being paid for?
The study is being supported by the Mental Health and Drug & Alcohol Service, … Region. The researcher will be conducting the research within her capacity as an employee of this service.

6. Will taking part in this study cost me anything, and will I be paid?
Participation in this study will not cost you anything, nor will you be paid. However, you will be able to participate as part of your work duties.

7. What if I don’t want to take part in this study?
Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your employment in any way.

8. What if I participate and want to withdraw later?
If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason. If you decide to withdraw, it will not affect your employment in any way. There are NO consequences for you if you decide not to participate or if you decide to withdraw after initialising agreeing. If you wish to withdraw after participating in the interview your transcript and recording will be destroyed. However, it may not be possible to withdraw your data from the study results if these have already been incorporated into a general analysis.

9. How will my confidentiality be protected?
If you agree to participate you will be allocated a participant number and no personal details will be used. Names will be changed when the information is being transcribed or if direct quotes are used in any written form. Any identifiable information collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researcher will have access to your details which will be kept securely in a locked filing cabinet in the workplace and will be destroyed after a period of 5 years in accordance with the University’s requirements. Please note, however, that there is certain information that must be reported if disclosed during the interview. This involves the reporting of any child protection concerns or the conducting of illegal activities.
10. What happens with the results?
If you give us your permission by signing the attached consent form, the information from the interviews will be used for the development of a thesis that will be submitted to the University. It is expected that the information will also form the basis for journal articles and for presentations at conferences however information will be presented in such a way that you cannot be identified.

11. What should I do if I want to discuss this study further before I decide?
When you have read this information, the researcher will discuss it with you and answer any queries you may have. If you would like to know more at any stage, please do not hesitate to contact the researcher on the numbers below.

12. Who should I contact if I have concerns about the conduct of this study?
This research has been approved by the Charles Sturt University Health Research Ethics Committee and the … Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Research Ethics Committee Executive Officer (CSU) and/or the Research Governance Officer (… LHDs) who are the people nominated to receive complaints from research participants. The contact details are set out below:

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Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Researcher Contact Details: Bronwyn Hyde Senior Social Worker …….. or ……..
Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.
Appendix 4: Participant Consent Form (Workers and Managers)

PARTICIPANT CONSENT FORM (HEALTH WORKERS AND MANAGERS)

The purpose of this study is to explore the experience of an admission to an inpatient mental health facility and its link to recovery from the perspective of consumers and mental health workers. Please read the following and sign if you would like to participate.

- I have read and understood the Participant Information Sheet on the above named research study, and understand the purpose and process described within it.

- The purpose of this research has been explained to me and I have been given the opportunity to ask questions about the research study

- I understand that participating in the study will include being interviewed and audio recorded

- I understand that any information or personal details gathered in the course of this research about me remains confidential and that neither my name nor any other identifying information will be used

- I understand that my words may be quoted in publications, reports, and other research outputs but my name will not be used

- I freely agree to participate in this study and understand that I am free to withdraw at any time

- I have been given adequate time to consider my decision and I agree to take part in the research study

- I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print):
........................................................................................................................................

Signature:............................................................................................................ Date:
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Declaration by the researcher: I have given a verbal explanation of the research project, its procedures and I believe that the participant has understood the explanation.
Name of Researcher (please print):
........................................................................................................
Signature: ........................................................................Date: 
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Contact details are on the following page

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   Population Health Unit
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Researcher Contact Details: Bronwyn Hyde Senior Social Worker ........ or ........
Supervisors: Dr Wendy Bowles 02 69332695 and Professor Manohar Pawar 02 69332497 Charles Sturt University, Wagga Wagga, NSW.

EAP Contact:
REFERENCE LIST


Copeland, M.E. (2002). Wellness recovery action plan. A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings. Occupational Therapy in Mental Health, 17(3-2), 127-150.


Nolting, J. (2010). *Serious Mental Illness: Characteristics of state hospital organisational structures supportive of rehabilitation and recovery*. Dissertation presented to the Faculty of The Graduate College University of Nebraska.


