Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review

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Objective: Implementation of recovery-oriented practice has proven to be challenging, and little is known about the extent to which recovery-oriented principles are integrated into mental health inpatient settings. This review of the literature examined the extent to which a recovery-oriented approach is an integrated part of mental health inpatient settings.

Methods: A systematic search (2000–2014) identified quantitative and qualitative studies that made explicit reference to the concept of recovery and that were conducted in adult mental health inpatient settings or that used informants from such settings. The quality and relevance of the studies were assessed with the Critical Appraisal Skills Program, and a text-driven content analysis identified three organizing themes: definitions and understandings, current practice, and challenges.

Results: Eight studies from Canada, the United Kingdom, the United States, Australia, and Ireland were included. The results highlight the limited number of studies of recovery-oriented practice in mental health inpatient settings and the limited extent to which such an approach is integrated into these settings. Findings raise the question of whether recovery-oriented practice can or should be an approach used in these settings, which are primarily aimed at stabilization and symptom relief.

Conclusions: Research is needed to clarify the concept of recovery and how it applies to mental health inpatient settings. The challenges to recovery-oriented practice posed by the current organization of such settings should be examined.

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The concept of recovery emerged in service user movements in the 1970s and increasingly reached the attention of mental health researchers and policy makers. In 1993, Anthony (1) stated that the future guiding vision for mental health care would be to organize all mental health services under the umbrella of the recovery vision. Since then, the concept of recovery gradually permeated political agendas and has now become a central part of the organization and delivery of mental health services. Consequently, many countries, including the United States, Australia, the United Kingdom, and Denmark, have made an integration of recovery-oriented practice a central part of their mental health policy (2–5).

Recovery-oriented practice represents a paradigm shift from a one-dimensional, medical approach to treating people with mental illness. Instead of focusing merely on rapid stabilization and symptom relief as a clinical outcome, recovery-oriented practice is based on values and principles of person orientation and person involvement (6–10). In line with this philosophy, the overall aim of recovery-oriented practice is to support the individual in gaining a meaningful and satisfactory life by promoting hope, attainment of personal goals, social inclusion, and supportive relationships (2,6,7,9).

The idea of recovery-oriented practice has led to an upsurge of research on—and changes to—elements of mental health care and currently guides many educational and organizational developments in mental health services (2,11). However, even though policy makers, in conjunction with researchers and people with lived experience of mental illness, have made numerous efforts to define and create guiding principles of recovery-oriented practice, its implementation has proven to be somewhat challenging (5,12). Furthermore, most of the values and principles of recovery-oriented practice have been generated primarily in outpatient and community mental health settings (13–15). Although it is acknowledged that mental health staff in inpatient settings should also work in accordance with the principles of a recovery-oriented practice (2–5), we know little about the current state of integrating such a practice into mental health inpatient settings.

Therefore, the aim of this study was to review the literature on recovery-oriented practice in mental health inpatient settings, investigating to what extent a recovery-oriented approach is an integrated part of such settings.

METHODS

The following research question was addressed: What is the current state of recovery-oriented practice in inpatient settings? The review was conducted in accordance with the ENTREQ guidelines for reporting qualitative reviews (16). It was based on a systematic literature search (17,18) designed by the first and last authors. The search was carried out by the first author in January 2015. The following six databases were used: MEDLINE via PubMed, PsycINFO, CINAHL, the Cochrane Library, Web of Science, and EMBASE. The search strategy was based on a preliminary pilot search to determine relevant search terms on the basis of three primary subject areas: mental health, inpatient settings, and recovery. The literature search was conducted systematically as a keyword Boolean search combining keywords with OR and AND and by using truncations after each search term (19). [A table in an online supplement to this article lists the search terms.]

We included articles meeting the following criteria: qualitative and quantitative studies published from 2000 to 2014; studies carried out in adult mental health inpatient settings or using informants from adult mental health inpatient settings, such as mental health staff working in inpatient settings or patients currently or formerly admitted to inpatient wards; and studies aimed at investigating a recovery-oriented practice in the context of mental health inpatient settings defined by an explicit reference to the concept of recovery. We excluded studies that included forensic mental health care wards, alcohol and drug treatment wards, and child and adolescent wards or that were conducted with a mix of informants from inpatient settings and community services and that did not distinguish informants from inpatient settings in the results. Quality improvement studies with the exclusive aim of describing or evaluating specific interventions were also excluded.

The literature search resulted in 2,527 "hits," of which 678 were duplicates and removed. The first author decided whether to include each of the remaining 1,849 articles on the basis of its title. The first and last authors screened the 178 articles that remained, first screening the abstracts independently and then meeting to discuss their results. In cases of disagreement or uncertainty, the two authors discussed the case with all authors until agreement about inclusion was achieved. The first and last authors then screened the articles by full text, discussing cases of disagreement or uncertainty with all authors. The main reasons for excluding articles were as follows: did not examine mental health services, was conducted in a setting other than the mental health inpatient setting, did not examine recovery or recovery-oriented practice, and mixed informants from inpatient settings and community services without distinguishing the informants in the results. [A flowchart of this process is included in the online supplement.]

This selection process left us with a total of eight studies conducted in the United States, the United Kingdom, Canada, Australia, and Ireland from 2004 to 2014 (20–27): one quantitative study (26), five qualitative studies (20–22,25,27), and two qualitative literature reviews (23,24) (Table 1).

The first author assessed the scientific quality and relevance of the eight studies by using the Critical Appraisal Skills Program (CASP). CASP is a checklist developed for systematically assessing scientific studies in terms of whether the aim, methodology and design, data collection, participant selection, and data analysis are appropriate and comprehensive, sufficiently rigorous, and clearly stated. It also examines whether the researchers have considered ethical issues and bias and whether they explicitly report and discuss their findings. The assessment is conducted by answering yes, no, or unsure to ten questions (28).

The CASP assessment was conducted by using the appropriate checklists for the various types of studies—for example, qualitative studies, reviews, and quantitative studies. Overall, on the basis of CASP criteria, the included studies were assessed as having sufficiently high quality. Four qualitative studies had nine positive answers and one negative; and one qualitative study had eight positive answers, one negative, and one unsure. One review had eight positive answers and two unsure; and the other review had seven positive answers, one negative, and two unsure. The quantitative study had nine positive answers and one unsure. None of the eight studies were excluded on the basis of the quality assessment.

The first author then followed the steps of a text-driven content analysis (29,30) in which overall themes were identified on the basis of repeated occurrences of similar content within and across the eight studies. The studies, which were based on different research methods, were integrated through juxtaposition—that is, they were analyzed side by side instead of being arranged by method or CASP assessment results (31).

Initially, the first author read all eight articles repeatedly to become familiar with their content. All text under the headings "Results" and "Conclusions" was extracted and entered into a single Microsoft Word document. Results from quantitative studies were incorporated by extracting the part of the Results section in which the authors described the results of their measurements in words and their interpretation of the results. The extracted text was arranged in alphabetical order by the first author of each study, and condensed meaning units were created by dividing the text into small paragraphs. The meaning units were coded according to their content and meaning—for example, "an unwelcoming environment," "no time to interact with patients," and "the paradox of collaboration and coercion."

The meaning units were then rearranged in accordance with their initial codes. On the basis of the codes' similarities, they were arranged into categories, such as "physical structures," "pressure," and "contradictions." Subsequent codes were grouped into the existing categories, and new categories were created when deemed necessary. Categories were refined on the basis of their similarities and differences, resulting in three overall themes: definitions and

TABLE 1. Details of eight studies of recovery-oriented practice in mental health inpatient settings

Study	Aim	Context	Methods	Informants and data
Aston and Coffey, 2012 (20)	To explore multiple perspectives of service users and mental health nurses with regard to the concept of recovery and how it fits within mental health services	Inpatient mental health services (United Kingdom)	Focus-group interviews	11 participants (former inpatients and staff members)
Chen et al., 2013 (21)	To explore which recovery competencies are needed for providers in inpatient programs, and what providers need to change from the current practice to recovery-oriented practice	3 mental health service centers with inpatient programs (Canada)	Literature review and semistructured interviews	32 articles; 15 participants (staff members, educators, former inpatients, and relatives of former inpatients)
Cleary et al., 2013 (22)	To explore acute inpatient mental health nurses' understandings of recovery and how they are incorporating a recovery paradigm in their day-to-day nursing practice and to identify practical measures that acute care nurses can take to aid recovery and identify barriers that hinder its implementation	Acute inpatient mental health units (Australia)	Semistructured interviews	21 participants (staff members)
Gwinner and Ward, 2013 (23)	To provide a critical reading of the perceptions and descriptions understood by nurses, as the vanguard of providing intensive care to patients experiencing acute psychiatric distress	Psychiatric intensive care units (international)	Literature review and focus group interviews	40 articles; 4 focus groups (staff members)
Kidd et al., 2014 (24)	To collate and review literature on psychiatric inpatient recovery-based care	Mental health inpatient settings (international)	Literature review	27 articles
McKenna et al., 2014 (25)	To determine the extent to which elements of existing nursing practice resemble the domains of recovery-oriented care and to provide a baseline understanding of practice in preparation for transformation to recovery-oriented services reflected in policy directives	Inpatient services (Australia)	Qualitative in-depth focus group interviews	46 participants (staff members)
Tsai and Salyers, 2010 (26)	To examine the precise elements of recovery orientation that differ between state mental hospitals and community services	State hospital units and community services (United States)	Quantitative analysis of recovery-orientation scales: Life Orientation Test–Revised, Recovery Self Assessment, and Consumer Optimism Scale	729 participants from state hospitals and 181 from community services (staff members)
Walsh and Boyle, 2009 (27)	To explore psychiatric inpatients' strategies for coping with mental ill health and in what ways acute inpatient psychiatric hospital services are useful to the individual attempting recovery	Psychiatric hospitals (Ireland)	Focus group interviews	55 participants (inpatients)

understandings, current practice, and challenges. Definitions and understandings describes how staff define and understand the concept of recovery and recovery-oriented practice. Current practice describes the application of a recovery-oriented practice in inpatient settings, as perceived by staff members, patients, and researchers. Challenges consists of the factors that staff members, patients, and researchers identify as challenging when applying a recovery-oriented approach in mental health inpatient settings.

The eight studies differed in type of inpatient setting and geographical setting. The settings were described as public psychiatric hospitals, psychiatric state hospitals, psychiatric hospitals, acute inpatient wards, state hospital wards, and psychiatric intensive care units. In presenting the results of the studies below, we use only the term inpatient setting. The studies were also based on interviews with different types of informants—that is, those from various professional groups working in mental health inpatient settings, primarily mental health nurses or individuals currently or previously hospitalized in inpatient settings. Below we refer to informants from professional groups as staff or staff members. We recognize that "patient" is not a term commonly used in the recovery literature to describe individuals experiencing mental health issues. However, in consideration of the fact that this review focused on inpatient settings, we refer to these individuals as patients.

RESULTS

Definitions and Understandings

The definition of recovery by mental health staff in inpatient settings comes across as vague and sometimes contradictory; studies have found that staff members describe it in different ways (20,22,24). Although the concept of recovery is seldom new to staff, many staff members had difficulty articulating what recovery is and how it applied to their practice (20–22). Across the studies, staff members defined recovery as implying an approach that focuses on promoting personal recovery and "maintaining wellness" (22,25). Others tended to situate their understanding of recovery within a purely medical model and described recovery in clinical terms as a reduction of symptoms or a stabilization of illness (20–22).

The same contradictions were noted in the way staff members described how the principles of recovery-oriented practice can be applied in everyday treatment and care. Across the studies, staff members defined such a practice in accordance with the definition of personal recovery and equated it with interpersonal, humanistic care—including positive encouragement, meaningful engagement, collaboration, and supporting hope (21,22,25). Nonetheless, an equal number of staff members described recovery-oriented practice as very similar to the traditional treatment paradigm in which medicine and clinical recovery outcomes are paramount (20–22).

Similarly, staff members in inpatient settings expressed uncertainties about their role in recovery-oriented practice, and many also noted limitations in transferring this knowledge into practice (20–22). Although many staff members believed themselves to have adequate knowledge about the concept, they expressed difficulties in applying this knowledge in everyday practice (20,21).

In several of the studies, the vast majority of staff members expressed having intentions of providing recovery-oriented care and were generally very sympathetic toward the concept (20,22,25). However, the studies revealed different understandings—such as simplistic interpretations and ambiguities in regard to the concept of recovery and how to implement recovery-oriented practice in the context of the mental health inpatient setting (20–22,24).

Current Practice

Staff members emphasized that having a positive attitude and promoting hope were their central contributions to a patient's recovery process; they stated that such contributions were often made through the collaborative planning of treatment (21,22,25). Moreover, staff members stated that they worked toward recovery-oriented practice by focusing on patients' abilities and on various aspects of daily living. Their rationale for providing these interventions was primarily to build self-esteem, promote empowerment, and gradually support patients' autonomy and self-determination (21,22,25). Finally, staff members noted that their work was recovery oriented because they considered alternative treatment options, incorporated patients' goals into treatment planning, arranged family and peer support sessions, and had flexible visitation hours to suit the individual needs of patients' families (22,25).

However, even though staff made efforts to incorporate recovery-oriented principles into the everyday practice of inpatient settings, several studies found that the claim of recovery orientation was more rhetorical than it was an integrated model of practice (20–23). Across studies, many staff members and patients reported that the principles of recovery-oriented practice were not embedded in the hospital structures and everyday work (21,22,27). Inpatient staff members scored significantly lower than staff working in the community on all scales measuring levels of recovery-oriented practice (26).

Descriptions of poor communication and lack of collaboration and patient involvement by both inpatients and staff members were found in all but one study (20–24,26,27). In some studies, staff members were described as practicing recovery-oriented care by working toward collaboration with patients and their families in determining treatment goals and options in regard to treatment and care plans (22,23,25). Conversely, these and some of the other studies reviewed also showed that patients felt excluded from planning their care and creating their treatment plans and that there was a lack of family involvement at this stage (21,23,27).

The studies also pointed toward general patient dissatisfaction with the level of information they received and the

lack of information about recovery education, alternative treatment options, and effects and side effects of medical treatment (21,24,27).

Staff members appeared to appreciate that the level of patient involvement and personalization regarding treatment and care planning was not acceptable (21,22,26). In one study, staff members explained that the low level of patient involvement was the result of not wanting to overwhelm patients in discussions of care plans (25). Instead, staff directed the collaboration in small stages, achievable within the short time frame of the patient's stay.

Across studies, several staff members reported that their primary contribution to the recovery process was through stabilizing illness, providing medication, and helping patients understand mental illness with psychoeducation (21–23,25).

Central aspects of recovery practice, such as instilling hope, collaborating with the patients to increase autonomy, and engaging in meaningful conversations, were mentioned by staff members as important elements in working in a recovery-oriented manner (20,22,25). However, medication, psychoeducation, and focus on problems and deficits became prominent when specific measures staff used to support recovery were examined (21,22,25,27).

Challenges

Most of the eight studies reviewed highlighted serious constraints in terms of resources and capacity in inpatient settings as major challenges in providing recovery-oriented care and treatment (20–23,25). Rapid patient turnover, an insufficient number of beds, and understaffing all put pressure on staff; crowded wards, increasing acuity levels, and unpredictable situations seemed to reinforce traditional medical and crisis-driven practice directed at providing rapid and accessible diagnosis and treatment (20–23,25). These factors resulted in loss of valuable time for staff to engage with patients and tended to undermine recovery-oriented principles, leaving staff unable to move beyond a medical and problem-focused way of working (20,21,23).

Physical structures in inpatient mental health settings were also often described as a challenge to adopting a recovery-oriented approach (22–24,27). According to patients and staff members, the designs of inpatient settings were not fit for the purpose and tended to create an unsafe and unwelcoming environment, with only limited space and access to privacy (23,24,27). The lack of thought behind the design of the wards often resulted in a failure to meet acceptable requirements of acute care and created tensions. Moreover, the lack of space created safety issues, adding further constraints for the staff to address (22–24). Both staff and patients stressed a need for more space and for designs grounded in recovery-oriented principles, such as family rooms for visits, gardens, and access to services, such as computers with Internet and activities that can support patients in their personal recovery process (23,24,27).

The application of a recovery-oriented approach in inpatient settings was also rendered challenging by contradictory structures in standards and procedural practices (23,25). Several studies evidenced the paradoxes between a vision of recovery-oriented practice and the current structures of the inpatient settings (20–23). Staff members in one study presented this paradox as an ethical challenge: how to collaborate with patients on treatment planning in a setting where many patients undergo compulsory treatment and coercion—that is, how to negotiate choice where none actually exists (25). Staff in another study described the paradox of being given "professional responsibility" for patients' safety and well-being, which tended to make staff risk-averse, thereby reducing opportunities for patients to take responsibility and make choices for their own lives and treatment (21).

In general, the lack of a clear and coherent ideology in everyday inpatient practice tended to make staff resort to customary habits of a problem-oriented, medical approach to supporting recovery and, in some cases, led staff members to conclude that recovery-oriented practice does not apply to inpatient settings (21,23,24).

Other factors mentioned as challenges to recovery-oriented practice in inpatient settings involved lack of multidisciplinary collaboration, a top-down and oppressive management that made patients vulnerable to the power imbalance between patients and staff, side effects of medication, and illegal drug use by patients (21,22). Finally, two studies highlighted the phenomenon of "the clinician's illusion" as a significant challenge—the fact that inpatient staff engage with patients only in the worst periods of their illness, which can cause staff to unintentionally lower their belief in patients' potential for recovery (21,26).

DISCUSSION

This literature review examined recovery-oriented practice in mental health inpatient settings and to what extent a recovery-oriented approach is an integrated part of such settings. Our findings highlight two particularly salient aspects of recovery-oriented practice in these settings. First, the literature explicitly describing recovery-oriented practice in inpatient mental health settings is very limited. Second, the extent to which recovery-oriented practice is integrated into inpatient mental health settings is also limited. We recognize that inclusion criteria for this review were very strict in that only research studies that explicitly aimed to explore recovery-oriented practice were included, thereby excluding literature on specific recovery-oriented interventions in inpatient mental health care, such as shared decision making, peer support programs, and various psychosocial rehabilitation strategies (32–34). Nonetheless, it must be concluded that recovery-oriented practice in mental health inpatient settings is as yet not very well described in the literature and that the existing literature reveals several challenges to be met.

Overall, the review found that staff in inpatient settings had a positive attitude toward the values and principles of recovery-oriented practice. However, the review revealed differing understandings of the concept of recovery and difficulties in translating this concept into everyday practice. Many staff members across the studies tended to equate recovery-oriented practice with a traditional medical approach revolving around medical stabilization and symptom relief.

Moreover, poor levels of engagement, communication, and collaboration between patients and staff appeared to be common in inpatient settings. The studies highlighted concerns that low capacity created competing demands for staff members, which tended to overshadow the individual needs of patients. High bed occupancy, quick patient turnover, and high acuity levels tended to reinforce traditional crisis-driven care that was primarily directed at rapid medical stabilization. This tendency seemed exacerbated by physical designs that did not support a recovery approach and contradictory structures in organizational standards and procedures.

The review highlighted several challenges. First, differing understandings of recovery and difficulty translating the concept of recovery into practice call for conceptual clarifications of the aims of recovery-oriented practice and how this approach applies to mental health inpatient settings. Second, the challenges created by low capacity and contradictory organizational procedures call for extensive consideration of the current organization of mental health inpatient settings. This challenge also raises the central question of whether mental health inpatient care can or should be based on recovery-oriented practice. The high levels of acuity that characterize these settings (35,36) underline a need for care aimed at treating people in severe and acute distress. Providing recovery-oriented care in this environment may simply not be possible under the current capacity and organizational structures of these settings. However, even though this review focused on studies of inpatient settings, similar results have been found in mental health services in the community. Research in these settings suggests that implementation of recovery-oriented practice is affected when the demands of the organizational system take precedence over an approach that supports personal recovery (37,38). Moreover, studies on outpatient and community mental health settings have noted the same differences found in this review in regard to how staff members understand the concepts of recovery and of recovery-oriented practice (37–39). Thus the challenges of adopting recovery-oriented practice are not solely related to mental health inpatient settings but to mental health service systems in general.

Some limitations of this review should be noted. The results are based on the secondary analysis of results and conclusions of other researchers, not on primary data. This is a potential source of bias because secondary analysis can distort the meaning of the primary data. Our literature search found a limited number of studies, suggesting that the evidence in this field is scarce. However, we acknowledge the possibility that our search strategy may have inadvertently omitted relevant studies that could have added important information to the findings. We searched for studies that included the words "recovery" and "recovery-oriented practice"; however, many additional concepts, such as user involvement, empowerment, hope, and shared decision making, are central aspects of the recovery paradigm (7,32,40). Although including these concepts in our search terms could have led us to additional relevant studies, we are confident that the narrow focus of the search strategy strengthened the review because it limited the risk of conceptual misrepresentations.

Although the eight included studies took place in inpatient settings, they varied in context because they were conducted in different countries and in various types of inpatient settings. Nevertheless, the findings were remarkably similar, indicating that the nature of mental health care in these settings has strong basic characteristics and is therefore suitable for examination and comparison across countries and inpatient contexts. The similar findings also indicate that the challenges related to implementation of recovery-oriented practice in mental health inpatient settings are fundamental and need to be addressed.

CONCLUSIONS

The results of this review showed that research explicitly focused on recovery-oriented practice in mental health inpatient settings is limited. Moreover, the existing literature suggests that the extent to which a recovery orientation is practiced in these settings is limited. The studies reviewed highlighted several challenges. Practice in inpatient settings appears to be characterized by a lack of collaboration, communication, and engagement between patients and staff. Low capacity and contradictory structures in the organization create competing demands, which take priority over the individual needs of the patient, thereby reinforcing traditional crisis-driven care that ultimately challenges the values and principles of recovery-oriented practice. This raises a central question of whether recovery-oriented practice can or should be an integrated part of inpatient mental health settings, which are primarily aimed at stabilization and symptom relief, and calls for further research aimed at clarifying the concept of recovery and how it applies to inpatient settings. The challenges to recovery-oriented practice posed by the current organization of mental health inpatient settings should also be considered.

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