Recovery-oriented mental health practice in a Community Care Unit: an exploratory study

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ABSTRACT

A recovery-oriented model of care has become the major focus of mental health service delivery in the state of Victoria, Australia. However, there is a total absence of knowledge of recovery-oriented mental health practice in Community Care Units (CCUs). Therefore, the aims of this exploratory study were to; (1) describe what aspects of the current model of care fit within the domains of recovery and (2) describe the pragmatic processes that staff use to mould their care within the domains of recovery. A total of 21 key stakeholders provided informed voluntary consent to participate in one-to-one interviews. Six content domains evolved to include; (1) a common vision: "a continuous journey", (2) promoting hope, (3) promoting autonomy and self-determination, (4) meaningful engagement, (5) holistic and personalised care, and (6) community participation and citizenship. The CCU appeared to be on a journey of transformation toward personal recovery. However, clinicians were grappling with an identified tension among personal recovery and clinical recovery. The tension among personal recovery and clinical recovery may be attributed to the psychosocial rehabilitation model of care which was previously systemic in Victorian CCUs

Key words; Recovery-orientated practice, Staff perspective, System transformation, Mental illness

BACKGROUND

A recovery-oriented model of care (recovery) has become the major focus of mental health service delivery in the state of Victoria, Australia (Department of Health, 2011a). Adoption of recovery is in accord with the recent international trend away from a biomedical and pervasive model of care and towards person-centred models of care (Hyde et al., 2014; Slade et al., 2014). Subsequently, in accord with regional and national strategies (Rabenschlag et al. 2014), the Victorian Government created a policy directed framework to assist organisations to make the transition to recovery across the entire mental health service spectrum. Nine overlapping domains of recovery in the Victorian mental health service context were identified and supported with a literature review (Department of Health, 2011b) and framework (Department of Health, 2011a). The domains are "(1) promoting a culture of hope, (2) promoting autonomy and self-determination, (3) collaborative partnerships and meaningful engagement, (4) focus on strengths, (5) holistic and personalised care, (6) family, carers, support people, and significant others, (7) community participation and citizenship, (8) responsiveness to diversity, and (9) reflection and learning" (Department of Health, 2011a, p6).

As a component of the Victorian mental health service spectrum, Community Care Units (CCUs) provide medium to long-term accommodation, rehabilitation, and clinical care for consumers in a residential community setting (Department of Human Services 2008; Hamden et al. 2011). In Victoria, CCUs were founded during the deinstitutionalisation process and subsequent closure of psychiatric asylums through the 1990's (Mullen et al. 2000). The process of deinstitutionalisation was supported as perceptions of psychiatric asylums has changed from therapeutic to iatrogenic (Schutt, 2016). Consumers of CCUs exhibit enduring and sometimes disabling symptoms of

mental illness (Wallace et al. 2004) and are cared for with 24-hour clinical support in a community environment (Department of Human Services 2008). The complexity of symptom profile and the presence of behaviours which make residing in alternative situations difficult, has meant that for some consumers, such support might be required for a number of years (Department of Human Services 2007).

The traditional model of care for CCUs focussed predominantly on psychosocial rehabilitation for a return to independent community living (Department of Human Services 2007). Such a model of care was thought to promote a consumer's 'recovery' (Lamb & Weinberger 2001), but not in the current context of a recovery-oriented model of care. The domains of recovery focus on 'personal recovery', or the unique journey of the individual towards a life worth living (Leamy et al., 2011; McKenna et al., 2014a; McKenna, et al., 2014b). Instead the traditional model of care in the CCU focused on 'clinical recovery', whereby the approach to care focused on the expertise of the mental health professional targeting symptom reduction, and restoring social functioning, as defined from a clinical perspective (Slade, 2009a).

Precise definitions of recovery vary according to organisations and jurisdictions (Leamy et al. 2011; Oades & Anderson, 2012; Slade, 2009a). In the current setting, the nine aforementioned domains of recovery provide Victorian organisations with a policy directed framework to become recovery-oriented, yet mental health clinicians working in CCUs and consumers living in CCUs should first be able to articulate how the service may already resemble a recovery-oriented model of care. In the total absence of literature documenting knowledge or use of recovery in CCUs, the aims of this study were to; (1) describe what aspects of the current model

of care fit within the nine domains of recovery in the current CCU and (2) describe the pragmatic processes that staff use to mould their care within the nine domains of recovery.

METHODS

Research Design

An exploratory research design was used to meet the research aims. Exploratory research is undertaken when a problem has not been clearly defined (Stebbins, 2001). For this study, the problem was the absence of knowledge of recovery in CCUs. This approach involved in-depth one-to-one interviews. This research was approved by the XXXX XXXX Office for Research (LNR/QA2014110).

The Setting

The CCU is a 12-unit complex comprising 20-beds in a large metropolitan mental health organisation for a catchment of 1.3 million people in Melbourne, Victorian, Australia. Each of the 12 units are equipped with a communal kitchen and lounge area, and shared bathroom and laundry facilities. There are designated spaces for gym equipment, separate male and female living areas, a sensory modulation room, and a communal recreation room with internet access that also allows a location for various group activities. The CCU also has several court yards for outdoor recreation and quiet spaces including a vegetable garden which the consumers assist to maintain. The CCU is staffed with 20 employees across the multidisciplinary spectrum.

The unit provides medium to long-term in-patient treatment and support for adult consumers who have unremitting and severe symptoms of mental illness. This illness can often be complicated by a history of the use of drugs and alcohol, non-adherence with medication, poor response to medication, lack of social supports, family disengagement, non-engagement with community services, involvement in crime, and homelessness. The service provides treatment, supervision, support, and life skills for those whose needs cannot be met adequately by other available programmes and services. The average length of stay of consumers is 16-months.

Participants

Information flyers with contact details of the research team were placed in visible vantages through the CCU inviting consumers, staff (formal carers), and (informal) carers to participate in a voluntary one-to-one confidential interview. Potential participants then chose to contact the researchers to enter into a process of voluntary informed consent. Inclusion criteria were; (1) the ability to provided written informed voluntary consent (cognitive capability and clinical presentation [NHMRC, 2007]), (2) willingness to participate in a one-to-one interview and discuss recovery, and (3) living status or employment at the CCU for at least six-months.

Data collection

Qualitative methods of data collection (45- to 60-minute one-to one interviews with current consumers, carers, and staff) were used. An experienced consumer researcher conducted the interviews with consumer participants. A consumer researcher was used to reduce potential bias or an imbalanced power dynamic among consumers that may not have had opportunities to pursue valued goals. The interview schedule consisted of questions about; (1) the consumers'

experience of participation in the CCU, (2) what it is about the service framework that is recovery-oriented, (3) how involvement in the service has affected their recovery, and (4) the relationship of the recovery-oriented service delivery with the consumer's sense of overall recovery. For example, consumers were asked by the consumer researcher "what do you understand by the word 'recovery'?' with prompts "how does it differ from rehabilitation?" and "does recovery mean freedom from symptoms?" Consumers were then asked "does the service promote a better life (hope) for you?" with prompts "how is it done?" and "what does the service do that promotes hope?"

One researcher (XX) conducted one-to-one interviews with staff (formal carers) and (informal) carers and asked what it is about the CCU that was recovery-oriented. The interview schedule was based on the domains of recovery in the Victorian context (Department of Health, 2011a) and asked how current service delivery; (1) promotes a culture of hope, autonomy, self-determination through holistic and personalised care, (2) establishes collaborative partnerships and meaningful engagement, (3) focuses on strengths, (4) includes families and carers, and (5) encourages community participation and citizenship. For example, participants were asked "does the service promote collaborative partnerships and meaningful engagement with consumers?" with prompts "how is it done?" and "what does the service do to promote collaborative partnerships and meaningful engagement?" The interview schedule was standard across all interviews for all participants. All interviews were recorded on an audio-digital recorder (Sony ICD-PX333M) and transcribed verbatim. Data were collected from October to December 2014.

Data analysis

A thematic analysis of the qualitative content domains was undertaken using a general inductive approach. The approach enables defensible analysis of qualitative data that may initially be varied raw text and allows it to be condensed into brief summaries (Thomas, 2006). Data were transcribed and organised with the use of colour coding. The coding for both consumer and other key stakeholder data were developed through continuous independent reading and agreement among the researchers (XX and XX) and then aligned with the pre-existing domains of recovery (Department of Health, 2011a). As necessary during analysis, content and codes were either collapsed or split into pre-existing or different categories, until central relationships began to emerge (Patton, 2002). Each pattern was examined for supporting quotes from the data. Rigor was further enhanced by collective agreement among the research team on the categorical analytic framework, emergent patterns and supporting evidence (Guba & Lincoln, 2005; Mays & Pope, 1995).

RESULTS

Sample Description

A total of 21 key stakeholders provided informed voluntary written consent to participate in this research. One-on-one interviews were held with a purposive sample of seven current consumers and three carers. The consumers' had been at the CCU for between 12-months and two years. One-on-one interviews were also held with 11 staff from the following disciplines; a manager, a medical doctor, six registered nurses, and three allied health workers (a social worker, an occupational therapist, and a psychologist). The staff had been at the CCU for between six-months and 15-years.

Content Domains

The participants in this study readily discussed aspects of service delivery, which they thought integrated into the recovery domains, upon which the interview schedule was based. Six content domains were focused on in detail in the discussions; (1) a common vision: "a continuous journey", (2) promoting hope, (3) promoting autonomy and self-determination, (4) meaningful engagement, (5) holistic and personalised care, and (6) community participation and citizenship. A theme also emerged from the data regarding the tension between recovery and rehabilitation. This tension manifested in two sub themes; (1) being 'recovery ready' and (2) confronting a 'lack of motivation.'

A common vision: "a continuous journey"

Recovery for consumers residing in the CCU was described by both consumers and staff as embarking on a journey towards achieving an improved quality of life, despite the presence of mental health symptoms:

> *"I think it's about greater quality of life and more satisfaction with life."* (Nurse)

This unique journey may have unforseen challenges which required the ongoing support of others:

> *"You may be sort of thrown a few left hooks and sort of challenges that you may not have expected, but as long as you sort of stay positive, allow people to support you, allow communities to support you and sort of keep in mind those positive thoughts that you are recovering, you will recover and it'll happen ……it's a continuous journey."* (Consumer)

However, the journey was primarily seen as being consumer driven. Sustained momentum was associated with the journey being determined by the consumer. When clinicians assumed control, recovery was perceived as being short lived:

> *"Those people who drive their own recovery are the ones who are able to sustain longer after they leave, but if you're sort of holding it for them and doing it and making them do it, it doesn't work for very long."* (Nurse)

Promoting hope

The clinicians openly discussed the pivotal need to facilitate a culture of optimism through instilling hope with consumers. The development of hope appeared to be systematically planned around the establishment of short-term goals that were methodically implemented. Clinicians placed faith in the intrinsic ability of consumers to initiate their own goals:

> *"Initially we have an assessment period where they identify their goals … It's not about what I think they should be doing or where I think they should be; it's about where they see themselves in the future."* (Nurse)

However consumer goal setting was guided, with consumers' encouraged to limit the number of goals at any one time and to start small:

> *"So sort of work on little steps of 'this is your goal, this is where you want to be, where do you want to start?'"* (Nurse).

The rationale for this approach was that the success of small goals developed a sense of hope and provided a launching pad to embark on further goals. This was a cyclic process of hope

building, where the clinician affirmed each achievement. These successes helped to build the consumers' confidence:

> *"If they're inspired by what they've done and have achieved a goal on their own, they're going to set higher goals for themselves."* (Nurse**)**

In some situations, the journey needed to be progressed from a consumer perceived position of hopelessness. In such situations clinicians remained focused on their responsibility to support consumers in developing hope:

> *"Sometimes it might be holding that hope for them until they're ready to engage more with that, take in more responsibility and be more involved in their recovery. I think ultimately we're encouraging them to have a view of what their life could be in the future…"* (Allied Health)

Promoting autonomy and self-determination

It was acknowledged that a shift was required from the traditional emphasis on rehabilitation in the service, in order to foster self-determination and autonomy. A shift from the historical belief that the clinician "knows best":

> *"I think there's a bit of an embedded culture in these types of services … Some clinicians feel more rewarded or job satisfaction about being able to do stuff for people rather than allowing the client to learn and try it out for themselves."* (Allied Health)

This traditional approach was reinforced by legal coercion inherent in mental health legislation, which allowed compulsory treatment, the use of force, and restrictions on leave. However, even

within these parameters, there was an expressed intent within the present clinical context for allowing choice, albeit limited choice within the constraints of administrative and legislative frameworks:

> *"Our end goal is for people to be more engaged with those issues and take more responsibility. It's meeting people where they're at and hoping to move them towards taking more responsibility and, where possible, giving them choice. They might not have a choice as to whether they're on a community treatment order or not, or whether they have to take medication or not, but I think we try where possible to give them small choices, hopefully not in a tokenistic way."* (Nurse)

The intended eventual goal of self-determination in the community was expressed as being achieved through incremental steps whereby opportunity to develop skills was offered through structured programs which focused on the skills required to engage in independent living. Examples were; managing medication independently, improving budgeting skills, improving cooking skills, social skills training, vocational support to achieve meaningful employment either voluntary or paid, managing symptoms of illness by utilising sensory modulation techniques, mindfulness, acceptance, and commitment therapy techniques:

> *"The ultimate aim is to get people engaged and doing things so we're trying to give them choice about that. At the beginning of each term we put up programs. We ask people to circle what they would like to participate in, and then which groups run and which groups they participate in is determined by them, but there is that guideline of expectation."* (Allied Health)

Participating in structured programs was perceived as offering the opportunity for consumers to experiment, and through calculated trial and error develop the skills necessary to achieve self-determined independent community living:

> *"It's about 'how are things going to look like when you're out of here and how can we mimic that environment now?"* (Allied Health)

The evolution towards a stronger emphasis in the service on autonomous decision-making was also perceived as being supported and enhanced by the Victorian Mental Health Act (2014), which placed an emphasis on supportive decision-making through nominated persons and advanced statements. That is, consumers are enabled to make or participate in decision about their treatment despite a legal status of compulsory treatment (Victorian Government, 2014):

> *"The involvement of the nominated person and also the advanced statements will give the clients* [consumers] *the chance to actually voice what kind of treatment they might be receptive to receiving in the future … at least the client* [now] *has a voice and can actually talk about what they would like to have happen."* (Nurse)

Meaningful engagement and collaborative partnerships

Engagement, which is at the heart of recovery, occurs when clinicians actively listen to consumers. This enables the clinician to understand the consumers' needs and validates that the consumer is being listened to and their concerns taken seriously. Such meaningful engagement was described in the data:

> *"It's all about collaborative partnership and this is something I talk to clients* [consumers] *about all the time: 'there's no point in me telling you what I want you to do*

if it doesn't fit your interests and your values. I need to know what you want to do so then I can support you in identifying ways of achieving what it is that you'd like for yourself.'" (Nurse)

Meaningful engagement was framed within the context of living as part of a community with associated rules that determined its cohesiveness. Such rules were further tempered by legal restrictions concurred by involuntary status under mental health legislation. Therefore, some of these rules were inviolable such as the CCU being "an alcohol and drug free zone". Nevertheless, most rules were not inviolable and a degree of flexibility was described, which was achievable through dialogue and negotiation:

"*They* [the rules] *are also open to negotiation, so sometimes time frames of coming home can be extended if it's sort of something special, like a family get together."* (Consumer)

Clinicians described a tension in managing risk on one hand and focusing on the goals of recovery on the other. Yet there was a commitment to work with that tension in order to enhance the recovery journey in partnership with individual consumers:

"*... we need to sit with risk and that's a very uncomfortable position for a clinician to be in….. there's a lot of dignity in risk for consumers."* (Nurse)

Holistic and personalised care

Recovery-oriented practice is holistic and considers the multiple aspects of the consumers' presentation. Clinicians talked about concrete examples of a real attempt to focus on the physical

health care needs of consumers, through engagement in community activities and also by establishing a healthy living emphasis in the CCU:

> *"We've formed a partnership through the Maribyrnong Aquatic Centre so we have our swim/gym program each Thursday and that has really gone from strength to strength. …. just by going weekly and seeing people in the gym ... and having an assessment with the gym instructor, having a program written up … that's really rewarding, to see people working on their physical health."* (Allied Health)

This recognition of holistic need was also demonstrated through a commitment to an appropriate responsiveness to the culture and diversity of individual consumers residing in the CCU. A starting point for accommodating the culture and diversity of others was through a self-awareness of one's own culture and uniqueness. Staff discussed an awareness raising process in this regard facilitated through:

> "[exploring] *the literature and research and attending workshops and professional development in terms of culture responsiveness."* (Allied Health)

This then allowed a genuine process of getting to know consumers through exploring the uniqueness of their world view:

> *"Not to stereotype people to say 'oh this person is Greek so this is what they must be like' or 'this person's from Somalia, this is what they're all like' because even within an ethnic background there's diversity of culture."* (Nurse)

This focus on holism translated into a comprehensive attempt to engage families and carers in the community of the CCU. Staff talked about clinical processes that carers were encouraged to be involved in such as in-depth clinical reviews, accompanying people on family outings if such supervision was required, and the attendance of family and carers at social activities in the CCU community such as an art exhibition or a 'Trivial Pursuit' evening. The level of engagement was echoed by carers who gave individual accounts as to the extent to which their involvement was valued:

> *".. they do listen … my observations are important to them as well, because they will see her presenting a certain way. I find that very helpful because then it just tells me that they're on track as well, that they really are engaged with her, they're not just sort of seeing her from a distance."* (Carer)

Community participation and citizenship

Although integrated community involvement was an endpoint goal, staff encouraged consumers to be involved in the community they affiliated with from the onset of their involvement with the CCU. External activities are centred in the community (e.g., the local community health and learning centres) to which the consumer would return:

> *"That's what they're going to do when they leave from here, so it's important. So we try and work that from the beginning."* (Nurse)

A long lead in time was discussed of the consumer's transition back into the community from structured CCU living arrangements, as this required considerable adjustment. Consumers were encouraged to maintain their relationships through active support for peers still residing at the CCU. Even when discharge occurred, relationships with the CCU were not severed:

> *"So if you know, someone's got a flat in the community that's where they're going to get discharged to. So we try and link them in areas where they will continue to engage when they leave from here. So there's a community worker who will come in and visit them at the flat or there is a group that they go from the home, you know, trying to consolidate what they're going to do when they leave from here."* (Nurse)

The tension between 'personal recovery' and 'clinical recovery'

Irrespective of the CCU embarking on a commitment to embed a personal recovery-oriented model of care, this initiative stands in striking contrast to the historical service delivery model which focused on psychosocial rehabilitation. Traditionally, clinicians determined the life skills consumers needed to develop in order to function. Staff were well aware of the contradictory, juxtaposed positions of the two paradigms:

> *"Rehabilitation is different from recovery because the rehab, it's like when the allied health people are trying to help the client to improve in developing skills. I somehow always see rehabilitation as much more clinical … whereas recovery, I feel it's individual, it's more personal."* (Nurse)

Yet the transition to a recovery-oriented approach remained a challenge. Some participants attributed this challenge to deep-seated values within their discipline, with an emphasis on "doing to" rather than "being with." This was articulated well by one nurse but not confined just to the nursing profession:

> *"… for nurses it's been a challenge because we see our role as being a carer, a caregiver, having a duty of care. So we take a lot of responsibility. It's our job to manage risk, put contingencies in place in terms of risk rather than working together with clients on how we're going to manage risk."* (Nurse)

The challenge was also attributable to mainstream societal values, which do not easily tolerate deviation from perceived normality. For example, the normative values of cleanliness and tidiness were translated into an obligation to make sure these values were prioritised in clinical practice:

> *"... the old fashioned duty of care ... we have an obligation to work with these people and they've got to be clean and tidy and they've got to present really well, otherwise we're not doing a good job."* (Allied Health)

There was clear evidence that some clinicians were grappling with change that challenged deep-seated societal, professional and institutional values, regardless of their awareness of the competing paradigms. In the tension between 'personal recovery' and 'clinical recovery', there was indecision as to where one approach started and finished, how they combined, or if they in fact combined at all.

Preparation to be 'recovery ready'

While discussing recovery, some clinicians expressed the view that there was a clinical responsibility to prepare the consumer to be 'recovery ready' in order for consumers to eventually assume their own 'personal' recovery journey. During this preparation, the emphasis was on clinical staff "protecting" the person by determining the pathway. In essence, rehabilitation was viewed as a prerequisite for recovery:

> *"There's a bit of an embedded culture in these types of services… I think in any kind of rehab there is this level of trying to bring the person in and sort of maintain and hold them in a way that kind of allows for a bit of cotton wool. I suppose in a sense, to try and help the person get back on track. Then once everyone's a little bit sort of clear about what that recovery journey's looking like,* [staff] *are able to kind of promote the independence."* (Allied Health)

During this initial process there was a clinical expectation imposed, that the consumer would participate on a programme and of activity determined on their behalf (e.g., gym, music, mindfulness, and art groups):

> *"We have an expectation that people will participate in activities of some description, four out of five weekdays; that's a sort of baseline that we set."* (Allied health)

Confronting a 'lack of motivation'

The clinical tension and confusion regarding the distinctions between 'personal recovery' and 'clinical recovery' manifested strongly when it was perceived by clinicians that consumers' "lacked motivation" to engage in their care and treatment. At such times, there was a reversion to

approaches which did not focus on their personal journey and instead coerced consumers to be involved:

> *"One of the nurses had to force me into working out three times a week …. They see it as you lack motivation and that kind of thing so you need to push. …..I find it difficult to get motivated to do housework and things like that and they come in and they go 'clean your place' and I guess it's good."* (Consumer)

DISCUSSION

The main finding of this research was the ability of consumers, carers, and mental health staff to describe how the CCU was recovery-oriented with specific and pragmatic examples. The service appeared to embrace a commitment to a recovery-oriented focus aligned to the policy directed framework to assist organisations make the transition to recovery (Department of Health, 2011a). There was strong supporting evidence of progress in promoting a culture of hope; promoting self-determination; providing collaborative partnerships and meaningful engagement; providing holistic and personalised care, which include family and carers; and encouraging enhanced community participation.

The service itself appeared to be on a journey of transformation, which is laudable. However, such transformation is both challenging and takes considerable time (Davidson et al., 2005). This transformation involves a thorough understanding of what recovery means and systemic support involving sustained leadership; aligned institutional practices and policies; training; and cultural change reflective of collaboration and consensus building (McKenna et al., 2014c). However, the extent to which this is happening in the CCU in question was outside of the remit of this study.

The need for staff education and support was signalled by the clear indication that staff were grappling with the distinction between ‘clinical recovery’ and ‘personal recovery’. The finding in the current study can relate to the known juxtaposition among person-centred care and traditional biomedical psychiatry (Muir-Cochrane & Gerace, 2016). Some staff perceived that if a consumer’s ‘personal recovery’ journey was not evident, then their response was to set clinician determined goals with interventions to which the consumer was expected to adhere. Rather, a personal recovery-oriented approach would be to maintain therapeutic optimism and collaborative engagement by encouraging the consumer to explore their reality and through this evolve an awareness which prepares for a journey of recovery (Slade, 2009b). Psychiatric settings in which coercions persists are known to be antithetical to recovery-based, person-centred care (Muir-Cochrane & Gerace, 2016)

The clinical challenge is that the recovery journey is unique and approaches used with one consumer may not be appropriate with another. This may lead to clinicians experiencing feelings of failure if they perceive a consumer is not ‘recovering’ (Slade, 2009b). The motivation required to commence or continue personal recovery identified in the current CCU may be an antecedent to feelings of failure. As such, the requirement of supervision, reflective practice, or mentoring to ease tensions becomes salient for mental health staff as they grapple with the transition away from a clinically determined process to ‘personal recovery’. In such situations, reflective learning opportunities such as Action Learning Sets (Revans, 1982) can be modified to allow clinical situations to be discussed in small groups of clinical staff to assist with problem solving, critical thinking, and reflective inquiry (Lamont et al., 2010).

Implications for clinical forensic nursing

Although the data collected in the current study were not located in a forensic setting, it is known that crimes committed by people with serious mental illness are attributed to antisocial traits (Peterson et al., 2014) and co-occurring substance misuse (Wallace et al., 2004) rather than just symptoms of mental illness. Furthermore, for clinicians working in forensic mental health services, recovery from mental illness can depend on how consumers with co-occurring substance use disorders are cared for (Ogloff et al., 2015). As future research may look to pragmatically describe recovery in forensic mental health settings, the results of the current study add to the limited knowledge about consumers who exhibit enduring and sometimes disabling symptoms of mental illness. Now that all mental health services in Victoria should be transitioning to a recovery-oriented model of care, the results from the current CCU add to the evidence that recovery is embedding into acute inpatient units (McKenna et al., 2014b), secure services (McKenna et al., 2014c; McKenna et al., 2014d), and aged persons mental health services (McKenna et al., 2014a), albeit at a pace that is inconsistent. Clinicians working in secure or forensic settings may recognise tensions among past models of care and practical applications of clinical and personal recovery. The methods and findings of this study may be used by clinicians to describe and pragmatically define how their own care with consumers assists with personal recovery or to broadly describe how the service in which the consumer resides can facilitate personal recovery for each consumer. Future research to support nurses working in forensic settings may look to address how the domains of recovery may be quantified and qualified during and after admission to secure extended care and forensic settings.

Limitations

This study does not claim to establish the effectiveness of the recovery–oriented model of care in the CCU, as it is difficult to determine this based on the reflections of stakeholders. The study is limited to a pragmatic description of a CCU through the perceptions of a small number of purposively selected key stakeholders who interface with the service. As such, data may not represent recovery in other CCUs in Victoria, or other mental health jurisdictions. Furthermore, findings may be biased as an independent researcher was not involved in data analysis.

CONCLUSION

This study was an attempt to describe recovery-oriented mental health practice in a CCU in Victoria, Australia. Key stakeholders with involvement at the CCU were able to describe how functioning of the unit could fit within the domains of recovery in the Victorian context. The CCU appeared to be on a journey of transformation toward personal recovery. However, clinicians were grappling with an identified tension among personal recovery and clinical recovery. The tension may be attributed to the initial psychosocial rehabilitation model of care in Victorian CCUs.

Competing interests

The authors declare that they have no competing interests.

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