

# Principles for Recovery-Oriented Inpatient Care

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## Introduction

The statements below represent two ends of a continuum describing adoption of a recovery orientation in inpatient settings:

Recovery has no place in the hospital. How can you talk to patients about recovery when they're acutely psychotic?

—Hospital Director

Recovery has enabled us to reclaim nursing.

—Psychiatric Nursing Leader

The first instance expresses fairly common views in the early days of the recovery movement, when many mental health professionals found the very notion of “recovery” foreign to their way of thinking about serious mental illnesses and their treatment. They typically viewed recovery as something that happens—if it happens at all—outside of the hospital setting, with no relevance to what and how care is provided in

inpatient and other acute care settings. As evident in this Hospital Director's statement, many professionals also saw the implications of adopting recovery as the overall aim of mental health care [as stipulated both in the U.S. Surgeon General's *Report on Mental Health* (DHHS 1999) and in *Achieving the Promise*, the final report of the U. S. President's New Freedom Commission on Mental Health (DHHS 2003)] as being limited to discussing the concept of recovery with persons experiencing serious mental illnesses. As we discuss in this chapter, this is only one of many implications of shifting to a recovery paradigm in transforming inpatient care, the vast majority of which have little to do with using the term “recovery” in our discussions with our patients.

At the other end of the continuum we find a national nursing leader declaring that adoption of a recovery vision in inpatient care empowers psychiatric nurses to reclaim their profession. As she explained further, recovery brings nurses back to the philosophical and historical roots of nursing as a profession in order to reestablish a central, caring role in what had become a highly medicalized milieu devoted to risk assessment and management, prevention of medication errors, and the proliferation of paperwork (cf., Seed and Torkelson 2012). While we agree that many principles of the recovery vision—which we describe below—are consistent with the founding principles not only of nursing, but also of medicine, psychology, social work, and occupational therapy, we caution that there also are new elements to recovery that we will not be

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able to grasp or implement if we only look backwards. There is much work to do in moving the field forward instead and, as a recent, thoughtful review on recovery and inpatient care conducted by Kidd et al. (2014b) pointed out, this remains an area of modest effort when compared to the amount of work being done to implement the recovery vision in outpatient and community settings. Briefly stated, we really do not know what recovery-oriented inpatient care will eventually look like a generation or so down the road. This book constitutes an important step in that direction, but it also reflects the fact that this work is just at the beginning stage.

Most efforts to date have focused on eliciting patients' views on what may be helpful and not so helpful in inpatient care (Jaeger et al. 2015; Repper 2000; Siu et al. 2012; Tee et al. 2007; Walsh and Boyle 2009), training inpatient staff and patients about recovery (Chen et al. 2011, 2014; Knutson et al. 2013), including with persons in recovery serving as trainers (Hillbrand et al. 2008; Kidd et al. 2014a), reducing the use of restraint and seclusion (Barton et al. 2009; Bennington-Davis and Murphy 2005; Fisher 2003; Wale et al. 2011; Wieman et al. 2014), making inpatient care more responsive to the histories of trauma so prevalent among persons with serious mental illnesses (Chandler 2008; Muskett 2014), and reconsidering issues of power and control more broadly (Tee et al. 2007; Walsh et al. 2008). Nursing, in particular, has produced two new models for acute care that emphasize relationships and the eliciting and understanding of patient narratives as key foci (Barker and Buchanan-Barker 2010, 2011; Shanley and Jubb-Shanley 2007), and there have been attempts to develop recovery-oriented forensic units, primarily in the United Kingdom (Davies et al. 2014; McKenna et al. 2014a, b). On the whole, however, hospitals have been the most reluctant to embrace transformation, for a variety of reasons, including the social control, safety, and supervision functions they serve and the common perception, described above, that recovery is only relevant to persons who are no longer acutely ill.

In this chapter, we step back from the more operational issues that might be involved in transformation to reflect, first, on the guiding principles of recovery and recovery-oriented practice and the implications they have for inpatient care. We may mention specific practices (e.g., advance directives, Wellness Recovery Action Planning, positive behavioral supports), but these will be offered primarily as examples of the kinds of interventions that would follow from and be consistent with the principles we describe. We also will address the respective roles of each of the professions typically involved in inpatient care, but again from the perspective of how these various roles embody different aspects of core recovery principles. The remainder of this volume will offer much grist for further discussion once these principles and roles have been delineated.

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## Guiding Principles for Recovery-Oriented Care

There have been numerous attempts to identify and articulate core values and guiding principles for recovery and recovery-oriented practice, including the consensus statement on behavioral health recovery issued by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in 2011. This statement, which integrated two previous, separate statements about recovery in mental health and recovery in addiction, listed the following ten shared principles: Recovery (1) emerges from hope, (2) is person-driven, (3) occurs via many pathways, (4) is holistic, (5) is supported by peers and allies, (6) is supported through relationship and social networks, (7) is culturally-based and influenced, (8) is supported by addressing trauma, (9) involves individual, family, and community strengths and responsibility, and (10) is based on respect (SAMHSA 2011). While familiar with this list of principles—some of which we will come back to below—as well as with other attempts to break down the concept of recovery into its constituent parts (Leamy et al.

2011; Le Boutillier et al. 2011), we have chosen to offer a different set of principles that we suggest are especially relevant to the inpatient setting. This list is not in any way in contradiction to the SAMHSA vision described above, or at odds with any of the attempts we have seen in the nursing literature, in particular, with nurses having produced the most literature to date on the interface of recovery and inpatient care. We hope, however, that this list will be more directly and concretely applicable to inpatient care than previous efforts.

We also feel a need to clarify one of several areas of confusion related to recovery prior to launching into the principles per se. This has to do with the difference between recovery and recovery-oriented care, which, as different as they may sound on the surface, are often confused, as in the SAMSHA list above. Some of the SAMHSA principles, such as emerging from hope, being person-driven, and being holistic, appear to be referring to the phenomenon of recovery itself. These are concepts that apply to the person who is living with a mental illness, who is a whole person (mind, body, and spirit), who needs to have hope, and who is the driver of his or her own recovery. Other principles appear to refer to recovery-oriented practice instead, which via many pathways, is supported by addressing trauma and is based on respect. One sees this kind of confusion in mental health settings when staff says things like, “We do recovery here” or “we’re doing recovery now.” This same confusion is evident in such statements as: “My client won’t cooperate with his recovery” or “The patient’s recovery goal is to reach a level 4 before discharge.”

We offer, therefore, the following division of labor as a way of parsing these related (but not synonymous) concepts; a distinction we suggest is particularly important for thinking through how recovery-oriented care (rather than “recovery”) can be implemented in inpatient settings.

*Recovery* is what a *person* with a mental illness does to manage his or her condition and reclaim his or her life from the distress and wreckage the illness, and the stigma and discrimination associated with having the illness,

may have caused. For some people, this process of recovery leads to a complete, enduring elimination of all symptoms and an amelioration of any deficits or dysfunctions associated with the disorder. These people are said to have achieved a “clinical recovery” or to have *recovered* from a mental illness. Other people, however, engage in and pursue the process of recovery in the face of an ongoing mental illness; a form of recovery referred to as “personal recovery” or being “in” recovery; a notion inspired in part by the self-help philosophies in addiction and chronic illness management (e.g., being in cancer recovery; Davidson and Roe 2007; Slade 2009). Early in the process, it may not be possible to tell whether someone is recovering *from* a mental illness or figuring out how to live a full and meaningful life *with* a mental illness. Over 200 years of experience tells us, though, that few if any people recovered from a serious mental illness by putting their lives on hold. Since the 1970s, accumulating new evidence suggests that many people may, however, find the illness becoming less and less disruptive as they learn how to manage it in the context of their daily lives (Davidson and Roe 2007).

*Recovery-oriented care*, on the other hand, is what *health care providers* offer in support of the person’s own efforts toward recovery and includes enhancing the person’s access to opportunities to learn how to manage his or her condition while pursuing “a meaningful life in the community” (DHHS 2003). Health care providers cannot “do” recovery for someone else, and recovery is not something they can do to people either. A similar distinction underlies educational philosophy and practice: while the teacher can teach, only the student can learn. The teacher cannot learn *for* the student, and there is little that teachers can do to students to make them learn against their wishes. Learning, like recovery, happens all the time without the person’s explicit intention, though; it is not necessarily a willful or deliberate process. But it is a process in which the person or student is engaged nonetheless. While recovery, much like learning, is the primary task of the individual, there is still much that caring others can do to facilitate this

process through both formal (i.e., health care providers) and informal (e.g., family, friends, employers) roles. It is within this arena that we see the great potential of recovery-oriented care as this approach—one based on mutual respect and a willingness to adapt based on each patient's own lived experiences and preferences—has increasingly been recognized as a powerful determinant in recovery outcomes among persons living with serious mental illnesses (Coulter et al. 2013).

With this central distinction in place, we can now begin to discuss what these principles mean for transforming inpatient care to a recovery orientation. We begin with what perhaps is the most crucial, but also most challenging principle when it comes to the inpatient milieu, as inpatient staff is under considerable pressure to do things to people in a safe, timely, efficient, and effective manner. By the time the person arrives at the hospital, he or she will have become overwhelmed by the illness, lost some degree of control over his or her life, and have had some capacities and decision-making abilities compromised. From an inpatient staff member's point of view, the effects of the illness and the wreckage it has brought may be much more obvious or prominent than the person to whom this onslaught has occurred. Under such circumstances, it may be very difficult for staff to connect with the person behind or underneath the effects of the illness. Recovery-oriented care is based on the premise that doing so is not only possible, but also a necessary foundation for almost everything else the staff might attempt to do.

### **Principle #1: It is, first and foremost, the person's recovery**

In Western democracies, like the U.S., recovery-oriented care for many adults is person-centered and respectful of the value of autonomy, while for some persons from ethnic or cultural minority communities, as well as in more collectivist societies, recovery-oriented care may be family-centered and respectful of the core values of these cultures (such as social harmony in China). Recovery-oriented care thus makes

space for individual variation based on a person's cultural identification and preferences. Resilience-oriented care for children and youth is similarly family-centered. But, as a matter of law, adults in the U.S. retain their rights to make their own decisions, both in health care and in life in general, unless, until, and then only for as long as they may pose serious, imminent risks to self or others, are gravely disabled, or have been determined not competent to take care of themselves by a judge. Why is this important, the reader may wonder, when people are typically only admitted for inpatient care when they meet one or more of these criteria? It is important to lay this legal and philosophical/ethical foundation for our insistence on autonomy and choice for at least two essential reasons.

First, regardless of the shape the person is in when he or she is admitted, the vast majority of people leaving inpatient care return to a community in which they retain their right to self-determination. No matter how restrictive the inpatient milieu may be, most people will resume making their own decisions, both about their mental health care and their lives, soon after they leave the unit. Rather than simply ignore this important fact, or become frustrated about the patients who continue to make poor choices or bad decisions after discharge, planning for how people will make key decisions for themselves once they leave the hospital could and should be a major concern of inpatient staff (Repper 2000). It is not enough to reduce symptoms or stabilize someone clinically, focusing solely on the present stay. It is equally important to identify reasons or precipitants for the admission (the past) and to ensure that the person has the inspiration, information, and tools needed to take care of him or herself once back in the community (the future). The vast majority of persons with serious mental illnesses no longer live in hospitals. Having a serious mental illness therefore is no longer an adequate reason for being hospitalized, nor is it adequate for staff to focus only on stabilizing the illness. In other words, it is not a person's mental illness alone that brings him or her to the hospital. It is how that illness was being managed or not,

and/or the life circumstances in which the person with the illness was living (e.g., a sudden loss) that brings him or her to the hospital.

Second, recognizing that most people will resume responsibility for their self-care and recovery upon discharge has substantial implications for what and how care should be delivered on the unit. Rather than primarily treating the illness, it becomes incumbent on the staff to inform, educate, and role model self-care strategies for the person, that is, to encourage and equip the patient to take care of him or herself upon discharge (Caldwell et al. 2010; Davidson 2005; Seed and Torkelson 2012); to encourage patients to make the shift, for example, from simply taking medication because the doctor told them to, to using medication as a tool in their recovery (Baker et al. 2013). In order to do so, many people in general, and many people with serious mental illnesses more specifically, require a certain amount of self-confidence in their abilities to take on this challenge. If there is nothing I can do on my own behalf to better manage my condition or improve my overall life (which is how we can talk to people about recovery without using the term “recovery”), then why should I bother trying (Corrigan 2004; Schmutte et al. 2009). In addition to providing information, education, and some encouragement, staff may need to assess the degree to which each person views him or herself as being in control and in charge of his or her life. Should the requisite degree of a sense of agency and efficacy needed for self-care be lacking, this provides an important focus for intervention.

But how can inpatient staff assist people in developing a sense of agency, efficacy, confidence, and control? First, by separating the person from the illness, staff play a central role in helping the person to see that he or she is not the illness itself (e.g., consistently using, and reminding the individual to use, “person-first” language rather than referring to the person as “a schizophrenic” or “a bipolar”) and that he or she can learn to battle back against and manage the illness over time (Davidson 2003). As described eloquently by Amy Johnson, a woman diagnosed with schizophrenia in her teens who is now well along in her own recovery:

If I am my illness, instead of I am a person who an illness happens to, then I can never get better. Because I can't pull the illness off of me if *I am* the illness. If the illness and I are the same thing, then there ain't nothin' I can do. I can't change me, I can't... The forest and the tree are the same thing. But if you separate the two, suddenly I find strength. I ask myself: Where? How do you find it? I find it in the separation. If we are not the same thing, if I am not the illness, then I can beat it, I can trick it, I can out maneuver it, I can go to the library and read about how to navigate around it... If I am not the illness, then the hope that I can maybe beat it springs forth... hope then, comes from splitting off the illness from the person.

Within this context, the staff might in fact find it useful to talk with the person about how recovery is possible—whether or not that exact word is used—no matter how acutely psychotic the person might be. Everyone needs hope, and people who are in desperation need hope desperately. As a result, inpatient units need to be hopeful places where people can be inspired and encouraged to be hopeful about their prospects for having a better life.

That better life can even begin on the unit itself should the staff view assisting their patients to develop a sense of agency, efficacy, confidence, and control as a central part of their role. In addition to separating the person from the illness, there are several things staff can do to elicit and promote these essential resources. Adopting a “strength-based” perspective is crucial to recovery-oriented practice and precisely for this (as well as other) reasons. Through both formal assessments and informal conversations, staff can help patients identify their existing internal and external strengths (what they have and are good at) as well as cultivate new ones by taking an active interest in them as people. These include interests, aptitudes, meaningful activities, and connections to others. Staff can elicit and honor patients’ preferences for how they would like to be addressed and what options they would like to be offered if and when they are having particular difficulties on the unit (e.g., developing a Personalized Safety Plan that may note a person’s preference to take time out in a comfort room, to sit quietly with a staff member, or to have a cup of tea). Staff can maximize the degree

to which patients can exercise their own autonomy while on the unit, respecting the fact that they are adults both by limiting restrictions to those that are necessary for safety and creating opportunities for people to have and make choices in terms of how they spend their time, who they spend their time with, and what activities, services, and supports they engage in. In this way, to the degree possible, a hospital stay for a psychiatric illness should resemble a hospital stay for a chronic medical condition (e.g., asthma, cardiovascular disease), interfering with the person's ongoing life only when necessary for monitoring and treating the person's health condition, but otherwise respecting his or her autonomy in all matters.

It is quite possible that some persons with serious mental illnesses may seem at first to have few, if any, interests, preferences, connections, or meaningful activities in their lives and, when asked, may suggest that they have no strengths or goals. Whether this presentation is due to depression, the negative symptoms of schizophrenia, or a history of demoralization and prior treatment experiences that have socialized the person into a passive and hopeless role, it becomes incumbent upon inpatient staff to work patiently and persistently with patients to assist them in rediscovering things that were important to them in the past or things that might be of interest to them in the future. Strategies for doing so include acknowledging long-term recovery goals on recovery plans, even if such goals may seem unrealistic or are not to be pursued directly within the context of the current admission; maximizing the use of peer specialists, whether individually or in groups, to inspire hope and role model the possibility of recovery; having other people's recovery narratives widely accessible in diverse multimedia formats including print and video; exposing the person to new activities or resources with which he or she may be unfamiliar; and finding opportunities for people to make valued contributions to others (a form of "giving back" that many people will take up prior to turning to their own self-care).

Once identified, it is then important to initiate referrals to community-based rehabilitation and

recovery supports that will enable the person to continue these activities so that these connections are in motion prior to the individual leaving the hospital (e.g., arranging for a ride to Sunday services at the person's church in addition to ensuring that she has a week's supply of medications and a follow-up appointment at the community mental health center).

## **Principle #2: Recovery-oriented care is person/family-centered and culturally responsive**

In addition to exploring patients' interests, strengths, and aspirations as a way of activating them for self-care, such discussions will be important in helping to frame and develop a person and/or family-centered care or recovery plan that will guide both their inpatient stay and their discharge plan. Person-centered recovery plans (Tondora et al. 2014) are not only tailored to the unique needs, preferences, values, and cultural affinities of each person, but are also oriented toward enabling that person to determine and pursue his or her own interests, meaningful activities, and life goals. It is not only a treatment plan that identifies what treatments will be provided by whom to reduce which symptoms or ameliorate which deficits or dysfunctions, but it is also a plan for how the person, his or her health care providers, and his or her natural supports (i.e., family, friends, employers, faith leaders, landlords) will work together to support the person in achieving the kind of life he or she will have reason to value (Sen 1999).

Inpatient recovery plans should include a statement about a person's hopes and dreams for the future as such long term goals can be a critical source of hope and motivation for the individual even if they are not actively addressed in the current inpatient admission. In addition, discharge plans should attend not only to the immediate clinical needs of an individual (e.g. being released with a week's worth of meds and an appointment with their outpatient therapist), but also to the types of meaningful activities which will help to sustain their recovery in the community (e.g., an intake at the Vocational Rehabilitation Center and a ride to Sunday services).



Such person-centered care plans obviously cannot be developed without substantial input from the person him or herself (which may mean the person requires up-front education and preparation regarding treatment planning and their role within it) and/or from those people whom the patient most trusts and/or who know the person best (which may mean helping people to map their network of supporters and identify who they might like to involve and then remaining flexible regarding the scheduling of treatment planning meetings to ensure their participation).

As noted in our discussion of the first principle, not every person presenting for hospitalization will want to be the primary decision-maker in his or her own care. In addition to considering his or her psychiatric condition and competence to do so when acutely ill, staff will need to explore and understand the person's cultural affinities and values in relation to decision-making. Even in Western democracies, persons from different cultural backgrounds may have different preferences for who should make what decisions about his or her care and life in general. Persons from different cultural backgrounds may also have different perceptions, and expectations of the roles of doctors, nurses, and other staff. These preferences and expectations are to be explored and understood as much as possible so that the care provided can be offered in as much of a person- and family-centered fashion as possible, not only out of respect for each person but also because the care is then more likely to be effective and its effects more enduring over the longer-term.

As just one example, a person will be much less likely to take prescribed medication after discharge if (1) the family he or she lives with does not support the use of medication, (2) the clergy or elders in his or her faith community do not accept that the person has an illness or approve of psychiatric medication, or (3) the person's daily routine has not been structured in such a way as to maximize the likelihood that he or she will either remember or be reminded to take the medication at certain times (e.g., to take it with meals, before leaving the apartment for class, and so on). Intimate knowledge of these

kinds of details of the person's life can be instrumental in ensuring the success of discharge plans. On the other hand, the most carefully crafted discharge plan may be doomed to fail should the staff not see these kinds of considerations as central to their role. We have seen discharge plans, for instance, that have required patients to take several different medications on several different schedules, resulting in one person being expected to take one or more pills every hour over the course of a single day, leaving little if any time for anything else.

Person-centered recovery plans also provide the foundation for implementing a number of specific strategies for further tailoring care to the unique needs, preferences, and challenges of each patient. Should a psychiatric advance directive or Wellness Recovery Action Plan (WRAP) have already been developed prior to admission, honoring this plan or directive enables the staff to abide by the person's preferences and wishes even when he or she has been rendered temporarily incapable of expressing them directly. Should the person not have an advance directive or WRAP when admitted, developing one prior to discharge will prepare and equip both the person and the staff to make more safe, efficient, and effective use of any future readmissions, should they become necessary. In the absence of an advance directive, staff can use preference assessments on admission to determine how to best care for patients should they become more distressed, agitated, or isolative during the admission. Simple questions about what has worked well for the person in the past when he or she has been upset, confused, or withdrawn minimize the need for guess work or staff having to make stabs in the dark in trying to maintain a safe, welcoming, and supportive milieu. For individuals who may feel overwhelmed in responding to such open-ended questions, it can also be helpful for staff to develop simple "comfort profiles" or "safety inventories" in which an individual can review a wide variety of self-soothing and staff-supported strategies and simply check off those that can be offered/encouraged when they are having a difficult time on the unit.

Finally, person-centered recovery plans provide a framework for the design and use of positive behavioral supports tailored to the needs of each person as a recovery-oriented alternative to generic, dehumanizing level or privilege systems that are inappropriate for adults. These systems, in which patients have to “earn” certain opportunities, activities, or resources by demonstrating “good behavior,” arose over 200 years ago in the British retreats developed during the era of “moral treatment” (cf., Davidson et al. 2010). The underlying premise of this approach was expressed by one of its founders, Tuke (1813) as: “There is much analogy between the judicious treatment of children and that of insane persons” (p. 150). In other words, persons with serious mental illnesses were viewed as analogous to misbehaving children and thereby needed to be resocialized within a supportive and structured family-like community. Within this community, the superintendent of the retreat functioned as a stern but judicious father, rewarding good, and punishing bad, behaviors. It was up to the superintendent to correct the patients’ “erroneous views” and teach them to control their “wayward propensities” (p. 133). This was to be accomplished through a combination of instilling fear of punishment for unwanted behaviors and incentivizing good behavior by offering rewards, such as increased freedom and access to opportunities to socialize with people who were not fellow patients (e.g., retreat staff, family, and friends).

We must simply raise the question of whether such level systems are used on any other units within general hospitals to call into question the appropriateness of their use on a recovery-oriented inpatient unit. Are privilege systems or punishments used on any other units? Does someone who has had a heart attack or an asthma attack have to work his or her way up through a level system in order to be discharged? Does someone whose diabetes has not been well controlled have to earn privileges while in the hospital in order to visit the gift shop or take a walk in the garden? While to some readers these questions may initially seem silly, they are precisely the kinds of questions we need to ask when implementing a recovery orientation.

Mental illnesses are *illnesses*; they do not represent or result from faulty parenting, ignorance, limited intelligence, or “wayward propensities.” John Nash, the Nobel Prize winning mathematician who taught at Princeton (and was the subject of the book and film *A Beautiful Mind*) had a psychotic disorder (Nasar 1998), as has Saks (2007), an Associate Dean of the Law School at the University of Southern California and winner of a MacArthur Fellowship, and Jamison (1995), a professor of psychiatry at Johns Hopkins University and noted author, among many others. The major difference between these accomplished people and other persons who have been hospitalized is not the nature of their illness; having a psychotic disorder does not render an adult child-like. Rather than perpetuating these stereotypes, recovery-oriented practices—whether on inpatient units or in community settings—need to combat discrimination and promote empowerment, self-determination, respect, and the intrinsic equality of individuals in recovery.

But if we are not to continue to use level systems, how are we to manage the unit, ensuring the safety of patients and staff and engaging patients in therapeutic activities? Through the use of individualized recovery plans that, when necessary (but *only* when necessary), include the design and use of positive behavioral support. Positive behavioral support is a strength-based method of behavioral analysis that has been shown to be effective in increasing prosocial behaviors and decreasing behaviors of concern without resorting to coercion (Carr et al. 2002). This method is congruent with recovery-oriented care as it (1) focuses on skill development based on the unique needs and strengths of each individual, and (2) promotes ecological changes on inpatient units (and in the broader community) to improve person/environment fit in order to support people in using more effective and prosocial means of communication that decrease the need for behaviors of concern.

Positive behavioral support also involves equipping staff with new skills such as de-escalation techniques and other ways of avoiding the use of coercive measures for dealing with



behaviors of concern such as seclusion and restraint (Carr et al. 2002; LeBel et al. 2004). These behavioral methods have been shown to reduce the use of seclusion and restraint and are now considered the preferred methods of intervention for behaviors that in the past would have led to such measures (Donat 2005). In addition to allowing for unit management without resorting to punishment, these methods are also recognized for producing other benefits. There is hope, for example, that should persons perceive inpatient care as less infantilizing and aversive, they may be more prone to access hospitalization earlier on when needed (e.g., in the case of an ensuing crisis) rather than as a last resort or involuntarily (Kidd et al. 2014b).

### **Principle #3: Anticipate, and welcome, trauma survivors**

Although we still have significant challenges to address, restraint and seclusion use has been reduced significantly since passage of the 1999 Dodd-Lieberman Act, which was initially developed in response to numerous deaths that occurred while patients were in restraints. Training staff in how not to provoke aggression in the first place by avoiding unnecessary power struggles, in the use of de-escalation techniques for persons who appear to be becoming agitated, and in the use of comfort rooms have all contributed to these reductions. We suggest, however, that these approaches are most effective, and most likely to be sustained, on units that undergo a more extensive transformation of their organizational culture to one that anticipates, and is welcoming and responsive to, the history of trauma the majority of persons with serious mental illnesses have experienced.

Research suggests that up to 80 % of such persons will have experienced some trauma prior to the onset of their psychotic symptoms (Cusack et al. 2004; Mueser et al. 2002). It only seems reasonable to assume that for the remaining 20 %, the process of being hospitalized on a psychiatric unit will represent a traumatic experience in and of itself (Priebe et al. 1998; Robins et al. 2005). As a result, it is important for staff to understand that people entering the unit will most likely be bearing the burden, and effects, of

trauma; they will, in effect, be seeking respite from some battle that has been raging in their mind, in their home, and/or in their community. To begin the process of implementing a trauma-responsive unit culture, staff needs to shift their view of patients from being the embodiments of illness (e.g., bipolars and borderlines) to being wounded warriors, fresh from the battlefield and suffering the effects of what has been done to them and/or what they have witnessed. Trauma-informed care proponents capture this shift in their suggestion that staff stop asking patients (implicitly) the question: “What is wrong with you?” and start asking them explicitly instead: “What has happened to you?” to be followed by the question: “And how can I be of most help?” (Fallot and Harris 2008).

This shift in perspective, and the extensive staff training required to accomplish it, has not only led to reductions or the total elimination of the use of restraints and seclusion (Azeem et al. 2011; Barton et al. 2009; Bennington-Davis and Murphy 2005; Bowers et al. 2006; Gaskin et al. 2007; Greene et al. 2006; LeBel et al. 2004; Master et al. 2002; Schreiner et al. 2004; Smith et al. 2005; Sullivan et al. 2004; Wale et al. 2011; Wieman et al. 2014), but to reductions in the use of so-called chemical restraints as well (the use of PRN or “as needed” sedating medications; Barton et al. 2009; Donat 2005). Patients are encouraged to take on active roles in their own care, are empowered and activated to take care of themselves, and to work collaboratively with staff to understand the effects of the trauma, and to plan and work accordingly toward preventing any abuses or retraumatization that might occur unintentionally (Chandler 2008; Huckshorn 2004; Muskett 2014; Robins et al. 2005). Equipping staff for these roles requires education on the neurobehavioral effects of trauma, including Posttraumatic Stress Disorder, in the lives of adults, including the previously overlooked but potentially disabling effects they may have on self-care and functioning in social, familial, educational, and occupational domains.

Other key features of trauma-informed care include increasing feelings of safety for both patients and staff through the cultivation of

respectful, collaborative, and genuinely caring relationships (Polacek et al. 2015) and the use of personal safety plans; transforming the unit's physical environment to be less institutional and more home-like, including the use of comfort rooms, increasing patient choices in relation to food, activities, and treatment options, and reframing symptoms as possibly representing meaningful attempts to cope with awful and overwhelming experiences (Chandler 2008; Huckshorn 2004; Muskett 2014). One example of what this looks like in practice is the woman who specified in her Personal Safety Plan that staff should avoid telling her to "be quiet" or obscuring her vision during periods when restraint might become necessary as she had been exposed to years of sexual abuse as a child, during which she had been blindfolded and instructed to "be quiet." As a result, if staff triggered her traumatic memories inadvertently by recreating either of these experiences, her situation would further deteriorate rather than improve.

As trauma always occurs within the context of a person's life, shifting to trauma-informed care also requires more of an incorporation of the person's cultural identity and background, in terms of understanding both the context for the traumatic events and the person's culturally-based ways of responding to and trying to manage the trauma and its effects. Faith and other community leaders may be extremely valuable guides in helping staff explore these issues in a manner that demonstrates respect and appreciation for the key role spirituality plays in the lives of many persons with serious mental illnesses.

#### **Principle #4: Expand the interdisciplinary team**

Whether on an inpatient unit or in community settings, recovery-oriented care is provided through an interdisciplinary team that includes at least the person in recovery, one or more mental health practitioners, and those people in the person's life outside of formal mental health services who significantly support the person's

self-care efforts (otherwise referred to as natural supports; Tondora and Davidson 2006). Although, within the hospital setting, the term interdisciplinary team has historically referred to inpatient staff from various professional disciplines (e.g., psychiatry, nursing, social work), a final principle for recovery-oriented practice within this setting is that this notion of a team needs to be expanded to include both the parties described above and the outpatient and community-based staff who worked with the person prior to admission and/or will be working with the person following discharge. In addition to adding the person in recovery, his or her natural supports, and community providers, it is important that the power that has traditionally resided with the physician be distributed across this team to create a more collaborative and person/family-centered process.

An increasing number of tools are becoming available to assist practitioners in operationalizing this principle in terms of how such teams are convened and managed in developing recovery plans (e.g., Tondora et al. 2014) and utilizing shared decision-making tools (e.g., SAMHSA 2014), and will not be described here. What we will do is to describe briefly the role of each member of this team so as to offer a map of the territory to be covered. As roles invariably overlap, we limit our discussion to those aspects of each role that are more specific to that practitioner or stakeholder group.

*The role of the person in recovery.* Each path to recovery is as unique as is each individual, and only the person who is experiencing the illness first-hand will know all of the ins and outs of what has and has not worked along his or her journey. In appreciation of this lived experience, the person in recovery should be seen as possessing valuable expertise and his or her active participation and empowerment should be encouraged across all aspects of inpatient care. Supporting self-determination, wherein an individual has as much control as possible over his or her own treatment and life-defining decisions, is both expected within a recovery-oriented system

and endorsed by our country's laws. This is not to discredit or disregard the knowledge and experience clinicians and other professionals on the team may bring, but rather to encourage the team to listen and learn from the person in terms of how they can best assist and support each unique individual's recovery.

We recognize that this role may not come naturally to many service users who have prior experiences with mental health services in which being "treatment compliant" has often been valued above all else. In contrast, person-centered recovery planning is most effective when the person fully understands and participates in all steps of the plan development, documentation, and implementation. Some individuals will naturally take the reins and engage in this process immediately. Others will find person-centered planning to be a new and even uncomfortable experience. In such cases, formal and informal group or individual educational interventions (frequently delivered by peer staff or members of the rehabilitation department) can help a person to develop concrete skills which allow him or her to more actively partner in the development of his or her own recovery plan. It may take time to empower people to learn from and trust their experiences, but this will prove to be an invaluable and worthwhile endeavor.

*The role of the family and other natural supports.* Family, friends, and other community members considered a part of the person's circle of support outside of the traditional medical/mental health system are known as "natural supporters" and can arguably prove to be some of the most influential and supportive individuals in a person's recovery (Tondora et al. 2014). These people are often part of a person's family and may also include, but are not limited to, friends, religious community leaders and members, neighbors, and coworkers. Each of us has natural supporters in our lives and our relationships with each of them are different. While a recovery-oriented system strives to build a supportive network of people beyond the mental health system, the final decision to include such people in one's care while in the hospital lies in the

hands of the person receiving services (Tondora et al. 2014).

When a person decides to actively involve natural supporters in the planning process, these people need orientation to what role they've been invited to play and information about what to expect from the process. A friend or family member may have learned much in supporting his or her loved one through years of illness and recovery and this experience should be respected and welcomed in the dialogue. However, it should be clear to natural supporters that the person holds the ultimate decision-making power and the intention of the meeting is not to give the team an opportunity to collectively coerce or convince the person to do something against his or her will. First and foremost, natural supporters are encouraged to be positive, respectful, and supportive of the person in recovery and his or her identified needs, values, and preferences. Specific activities may include helping the person to think about priorities and goals ahead of time, asking him or her what kinds of support would be helpful, assisting the person in advocating for him or herself, or following through on specific action steps on the plan to help the person in recovery to achieve identified life goals (Tondora et al. 2014). Having supports, above and beyond the traditional paid roles of mental health staff, especially when a person is transitioning from an inpatient unit back to the community, can prove a valuable resource.

*The role of community-based practitioners.* People served in inpatient settings frequently work with a variety of community-based providers both prior to admission and are anticipated to on discharge. For instance, a person engaged in services at a local community mental health center might have both a primary clinician as well as a care coordinator. If taking medication, he or she would also have routine contact with a psychiatrist or nurse practitioner. If also meeting with a peer specialist, or working with a benefits coordinator, the team of providers within the community-based network grows to include numerous people, serving a variety of functions based on their specific training and expertise.

What exactly is the role of such community-based practitioners during hospitalization? And how does thinking through a recovery lens impact the interface between inpatient and outpatient service providers?

It is not uncommon for hospital admissions to be treated as discrete treatment episodes with limited continuity of care maintained with the primary outpatient providers. The minimal contact and collaboration that does occur tends to be restricted to the moments of admission and discharge with many missed opportunities in between. When an individual requires an inpatient level of care, it is critical to coordinate efforts with this outpatient network of providers as they may have a wealth of information both about what precipitated the individual's admission and how the team can work together in the future to avoid another episode. This requires adequate exchange of necessary information as well as a shared understanding of recovery goals that continue to be relevant across levels of care.

This type of care coordination and information exchange is sometimes achieved by a generic outpatient representative, often referred to as a local or regional "hospital liaison" whose primary function is to participate in discharge planning to promote continuity of care. While this may be a step in the right direction, it is often woefully inadequate in the eyes of service users as it fails to appreciate the importance of the human connections and real relationships they may have with their primary community providers. It is critical to ask the individual: Who knows you best from your team in the community? Who do you trust and feel most comfortable with? Who can help us plan for what you need/want—both here in the hospital and upon discharge? And upon learning the answer, do we do everything possible to ensure that individual's ongoing involvement (in person or via phone or video conference)? There is no substitute for this authentic human relationship. People do not want to be yet another "case" to be managed by a generic hospital liaison. Whether they are living in their apartment or being treated in the hospital, they want to know that they matter and the presence of a preferred outpatient provider is a

powerful reminder that someone truly cares about them and their wellbeing.

*The role of the psychiatrist.* Psychiatrists have the opportunity to play a highly influential role both in the creation of a recovery-oriented and trauma-responsive culture on the unit and in the delivery of person/family-centered, recovery-oriented care within that context. Psychiatrists are at the heart of medical decision-making and can set a collaborative and inclusive tone that values the contributions of all parties, with the aim of educating and empowering patients to exercise their responsibility for self-care. Notably, as some persons may not believe or acknowledge having a mental illness or addiction, and/or may not want to take medication, psychiatrists can also play an important role in modeling for staff how to explore respectfully the person's and family's own understanding of their situation in order to identify potential junctures or opportunities for education and intervention. A combination of motivational interviewing, inviting the person and family to consider other perspectives, and offering education regarding medication benefits and costs/side effects should be incorporated to respect the individual's or family's autonomy while enhancing their capabilities for decision-making.

Psychiatrists elicit patient preferences, honor advance directives, and assume that people are capable of making their own decisions unless there is persuasive evidence to the contrary. In the case that a person's decisional capacity is being compromised by illness, psychiatrists seek the input of substitutive decision-makers, whether they have accepted this role formally by law or are identified by the patient as someone who knows the patient well and has his or her trust. Psychiatrists assess for risk, with a focus on safety planning both on the unit and in preparing for discharge, involving family and natural supports to the degree that is possible based on the patient's consent. If chairing the recovery planning team meetings, psychiatrists ensure the meaningful participation of all parties, seek out and consider alternative perspectives, and maintain a collaborative stance throughout the process. They are informed by the practitioners who

were working with the person prior to his or her admission and plan for discharge in collaboration with those practitioners who will be working with him or her upon returning to the community. Finally, psychiatrists consider acute admissions to represent crises that offer opportunities for enhancing the person's senses of autonomy, responsibility, and self-efficacy through learning new lessons about processes and pathways of recovery.

*The role of the psychiatric nurse.* Inpatient psychiatric nurses have responsibility for the overall, twenty-four hour monitoring of physical safety, and planning and implementation of nursing focused recovery-oriented care for patients in the hospital setting. Nurses are key in setting the standards of recovery-oriented care, including through demonstrating respect and maintaining a collaborative stance within all patient and staff interactions and relationships. In particular, nurses are role models for all other staff in how to avoid getting into power struggles with patients and how to implement de-escalation techniques when patients begin to become distressed.

In conventional inpatient environments, nursing plans of care are often predesigned based on institution safety requirements, patients' documented medical needs, symptoms, and behaviors of concern. These plans of care have typically assumed that the nurse is in the best position to plan care based on his or her expertise and experience. Patients, on the other hand, may have "received" care with little input into its design, implementation, or outcome. In contrast, recovery-driven nursing care supports the belief that patients are also experts, especially with respect to their own strengths, preferences, and needs and are most intimately familiar with the ins and outs of the illness(es) they have. They, therefore, should also participate, to the best of their ability, in designing the plan of care. In addition to working in collaboration with their patients in developing, implementing, and evaluating plans of care, nurses are role models and educators related to other components of person-centered care. Given their historical role in managing the unit milieu, nursing influence is

especially important in advancing the recovery orientation of the structure and functioning of the milieu and the overall unit culture. Nurses must be involved in designing and supporting policies that increase patient independence and eliminate punitive, negative policies based on fear rather than on evidenced-based practice. Inpatient policies such as denial of computer and phone access, staff-selected or screened visitors lists, denial of personal clothing, and limitation of access to foods and beverages, are but a few of the policies nursing can directly impact to bring care into the recovery era.

*The role of the social worker.* Social workers as a profession are guided by values, which are fundamental to a recovery orientation, such as recognizing "the dignity and worth of a person" and "the importance of human relationships" (National Association of Social Workers 2014). Training and education is strength-based and work involves exploring individuals' needs and wants while keeping in context the individuals' relationships with families and communities. Social workers bring this skill set of working with the "whole person" to interdisciplinary inpatient care teams. Too often social workers have been misunderstood in teams as simply discharge planners, without other professionals fully understanding what that means and the level of skill that is inherent in this work. Effective discharge planning by a social worker involves recovery-oriented care, having a skill to connect with patients and get to know them upon admission, to listen to and find out their needs and preferences, to explore their circumstances within the family and community system, and to plan for how each person can live successfully once he or she returns home to family and community.

In many cases, social workers find themselves advocating for patients when on inpatient units where patients' dignity and self-worth appears not to be recognized or valued. This can easily and unintentionally occur within a quick-paced system of care in which there are constantly moving parts. As a result of their philosophical grounding in a social justice framework, social workers may thus find themselves at times called

to serve as the conscience or watchdog for their colleagues from other professions.

Social workers provide a connection to community and community resources for patients as well as for the other professionals on interdisciplinary teams. They have knowledge of services and supports available to individuals, families, and communities and serve as advocates and brokers so patients and families obtain the supports they need and prefer. Educating others on the values and ethics of social work and discussing how these values are consistent with recovery-oriented principles is important for new and well-seasoned social workers and also for other professionals.

*The role of the psychologist.* The role of the psychologist in recovery-oriented inpatient care may be multifaceted. Psychologists who are in leadership positions may play a major role in creating a culture of recovery that is responsive to trauma, for example. They can use their understanding of organizational and system dynamics to help foster a recovery mission for staff that views patients as people first, fosters hope, builds on strengths, and partners with patients in building autonomy, self-determination, and lives of meaning and purpose. Creating such a culture involves providing training and education on trauma and its effects, on person/ family- centered care planning and the involvement of the person and his or her natural supports as part of the interdisciplinary team, and on discharge planning within a social inclusion framework (Repper 2000). In terms of direct care, psychologists can offer group and individual psychological and social interventions including strength-based assessments, evidence-based psychotherapies, and skills training approaches that can best meet patient needs, and are responsive to patient preferences, goals, and choices. Psychologists are best positioned to provide such interventions as they typically have advanced clinical training, are highly skilled in the provision of psychotherapy, and are well versed in the provision of evidence-based approaches.

Psychologists also are most qualified to contribute their expertise in two focal areas. First is

in relation to the importance of a sense of agency, efficacy, and self-confidence in promoting self-care among persons receiving care on inpatient units. As these are psychological concepts, psychologists are in the best position to assess for and promote these often-diminished capacities in persons with serious mental illnesses. They can suggest ways to promote the development of these capacities on the unit, as well as identify ways to support their development while accommodating their absence in community settings following discharge. For example, one woman who had been maintained for weeks on 1:1 observation due to severe self-injury finally came to be able to participate safely in her own care once the unit psychologist discovered that she was an avid reader who used getting caught up in books as a temporary escape from her trauma. Not only did she find reading books on the unit to be self-soothing, but she also was coaxed by the psychologist to volunteer to sort and reshelv books in the hospital library—an activity which was then incorporated into her discharge plan and continued in the community.

Secondly, many psychologists also will have received specialized training in behavioral analysis and the provision of positive behavioral supports. When indicated, they can bring this expertise to the interdisciplinary team, developing and implementing this aspect of a person's recovery plan in promoting strengths, increasing skills, and improving person/environment fit while mitigating the likelihood of the need for coercive measures. Integrating positive behavioral supports will likely have ongoing impact on fostering a culture of a recovery as well, with units becoming more hopeful and supportive, and less traumatizing and punitive, places as patients become hopeful, build on their own strengths, enhance their self-care, work towards achieving personal goals, and ultimately build a life of meaning and purpose.

*The role of the occupational therapist.* The major focus of occupational therapy is directed toward creating opportunities for participation; enabling skill development; collaborative problem-solving and use of strategies to make environmental adjustments, with the intended



outcome of enabling participation in activity patterns that support recovery, health, well-being, and social connectedness (Kielhofner 2009; Krupa et al. 2010). As referred to here, occupation is inclusive of the range of paid and unpaid ways in which we may look ourselves, connect with others, find enjoyment, learn, and contribute in communities socially and economically (Townsend and Polatajko 2007). It also involves everyday tasks that may sometimes be taken for granted, but bring rhythm to daily life, allow assumption of valued roles, develop abilities and capacities, and define who we are in the social world (Hammell 2004; Kielhofner 2009). Occupational therapists undertake varied roles to implement recovery principles in acute care settings, using their knowledge of occupation and how to enable participation. Broadly, these roles are likely to include directly working with individuals to understand their occupational experiences and challenges, enabling individual and group participation in occupations, and environment-level practices with a focus on altering acute care environments to promote recovery.

At an individual level, occupational therapists work directly alongside people to assist and support their recovery through attending to the varied ways in which daily life may have been disrupted by experiencing mental health issues and being in a hospital environment. Perhaps the most obvious is that not being in one's usual surroundings that support familiar activities and routines can add to or exacerbate the person's distress. In such a case, tools and opportunities for involvement in ordinary activities can provide important grounding experiences amid the turmoil that a person may be experiencing whilst in acute care. Occupational therapists also have available to them frameworks and tools to support listening and learning about person's lived experiences of occupations, patterns of activity engagement, interests and choices, how disruptions or difficulties in occupation might be experienced, what factors might be contributing, and how these might be addressed. In turn, this means occupational therapists can contribute to the team's understanding of individuals as

persons with everyday life contexts (including occupations, community involvement, relationships, aspirations, and so forth). In addition, through the analysis of actions and skills underlying performance, occupational therapists may also contribute to understanding individuals' strengths and difficulties in doing, and how their strengths, skills, and environments can best be utilized to support them in pursuing those occupations in which they seek to participate (Krupa et al. 2010).

Occupational therapists' approaches to working alongside persons in recovery tend to be participatory and action-oriented, frequently using processes such as guiding, coaching, information-sharing, prompting, consulting, and reflecting to support individuals to try out and discover interests; to learn, use, and practice skills; to find practical solutions to problems of everyday living; to clarify occupational choices; and to develop strategies for participating congruent with their values, preferences, aspirations, and circumstances (McDermott et al. 2012). Similarly, occupational therapy group work in inpatient settings typically has goals more focused on *doing* than those of verbal groups. These usually include opportunities for direct experiences of doing and collaborating with others; supporting information exchange, storytelling, giving and receiving feedback and assistance; and aiming to positively influence participants' experiences of engagement, social connection, peer support, and satisfaction (Kielhofner 2009). Choices about whether and how to be involved are important for enabling participation and supporting recovery. Recognizing that group participation can seem difficult or even overwhelming initially, occupational therapists who facilitate groups in acute care may encourage simply being in a group as a first step towards joining in as and when a person chooses, rather than requiring participation.

At an environmental level, occupational therapists also use their knowledge of factors external to individuals that influence participation (e.g., social, physical, cultural, and institutional factors) to attend to the extent to which inpatient and other acute care programs focus on, create, and

develop opportunities to engage in meaningful and satisfying occupations (Krupa et al. 2010). One example of this environment-level practice is that occupational therapists often play a lead role in advocating for and organizing activity programming in inpatient settings. The primary purpose of activity programming has sometimes been understood within services as to relieve boredom, or fill in time on inpatient units while treatment is taking place. Yet, in recovery-oriented inpatient care, opportunities to engage in ordinary activities and experiences can be catalysts for several key recovery processes. For instance, they create opportunities to exercise choice and control; to stay connected or reconnect with activities, interests, and a sense of self beyond being defined by illness; to use existing strengths or discover new strengths; to explore different ways of dealing with symptoms, distress, and effects of trauma; and to explore possibilities for rebuilding a meaningful and satisfying life in the world beyond hospital. However, to maximize the recovery-promoting potential of acute care environments requires more than opportunities for activity engagement; it also requires attention to how these environments are experienced. Here, using their skills and tools for analyzing environments, occupational therapists may work collaboratively with peer providers and other team members to consider “what is it like to be and spend time here”, and to identify ways in which acute care environments may be altered to create more welcoming spaces, as well as spaces that address other needs such as those for privacy, calm and quietude, socializing with others, and activity engagement.

*The role of the peer support staff.* Peer support staffs are individuals that identify as people in recovery from mental illness and/or substance use, trained and hired to provide supports to others with similar lived experiences. Peers hired on inpatient units provide hope to patients in these settings, particularly when they have a shared story of hospitalization or institutionalization. Peers are trained in the foundations of recovery-oriented care, thus guided by “meeting an individual where they are at” and assisting an

individual, instead of “doing for” as he or she walks their own individuated recovery journeys. While there are many skills that peers bring to their work on inpatient units, two will be briefly discussed: sharing of their own lived experiences to model one path of recovery and learning to work within a behavioral health system in where they are open about their own mental health history.

The first skill of sharing and modeling recovery is a skill that can be developed over time by peers. Learning to share in a way that promotes the growth and dignity of others is key. Sharing indiscriminately is not appropriate. Instead, stories are used as examples of how challenges were faced in their own recovery journeys. In some cases, the peer may not have similar or shared lived experiences, the “we” story becomes important so that the stories are about collective ways in which individuals recover not focused solely on the peer’s own experiences. Developing the skill of disclosure is not a simple task, though there are some peer staff who appear to do it naturally. Supervisors, ideally persons with lived experience themselves, should provide supervision that incorporates the learning and development of disclosure.

The second skill involves learning to work in an environment in which they were once served. It has only been recently that we have seen the expansion of peers working within the traditional behavioral health workforce. Unfortunately, it is a system that only too recently believed that people were not capable of “recovery” (unfortunately some staff may continue to believe this because of societal stigmas of mental illness and addictions). Peers working in these settings often find themselves advocating for themselves on teams as well as for those they serve. Supervisors and other staff in inpatient settings should serve as allies to promote a culture that values the work of the peers.

In some inpatient settings, peers are assigned to be on interdisciplinary teams and do not have a recognized department. In fact, some find themselves as the only peer on the unit or in the psychiatric hospital. It is highly advisable, though, for peers to be able to learn from other

peers and have the opportunity to reflect on the work they are doing with others that do it. Hiring more than one peer therefore is recommended. Other inpatient settings have developed a peer department that is free standing and provides services to individuals or providers requesting peer support. There are pros and cons to each model; however, developing a culture that believes in the evidence of peer services and values the principles and ethics of peer support is necessary in promoting recovery-oriented care.

Finally, peers are also trained in providing assistance with individuals to connect them back to their communities. Again, “having been there” is important; however, learning ways that have worked for others as well as learning about peer modalities will be useful to doing this work successfully (i.e., Wellness Recovery Action Planning, person-centered care planning). Being in an inpatient psychiatric unit can be scary and challenging as well as awfully lonely. Even more difficult is transitioning back to community, to work, to family, to school. Peers can prepare and serve as a bridge from the time people walk into the hospital until they are discharged. They can provide linkages to peers working in outpatient settings and/or to other self-help and/or community programs. Peers working in inpatient settings signify that people do recover, people do return to work, and that people should be involved in their own care. This in and of itself may help patients/individuals alleviate internalized stigma of mental illness, to see beyond the engulfment of their mental illness, and to visualize that recovery can and does work.

## Conclusion

This chapter has presented guiding principles for the implementation of recovery-oriented practices in inpatient settings and described the respective roles of staff from the various disciplines as well as the patient him or herself, his or her natural supports, and community-based practitioners in developing and implementing person/family-

centered recovery plans. We offer these principles and roles as a useful framework for rethinking many of the more operational and practical issues faced in delivering inpatient care to persons in acute distress, who are significantly disabled by a mental illness, and/or who pose risks to themselves or others. Preliminary results of implementing some recovery-oriented and trauma-informed practices—such as de-escalation techniques, preference assessments, positive behavioral support, and advance directives—have been promising, but much work remains to be done in creating welcoming, supportive, strength-based, and person/family-centered milieu that are truly respectful of and responsive to the dignity, autonomy, and tremendous suffering of the people they are intended to serve.

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