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ORIGINAL ARTICLE

The experience and meaning of recovery-oriented practice for nurses working acute mental health services

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ABSTRACT: *Since the 1990s, New Zealand mental health policy has shifted from a focus on the management of symptoms and risk to the recovery of psychological, social, cultural, and physical well-being. Despite a vision for recovery-oriented services being integrated within national and regional policies, there is growing concern that barriers to recovery-oriented service provision continue to exist. Such barriers include the attitudes, skills, and knowledge of front-line staff, as well as system issues. This study explored the experience and meaning of recovery-oriented practice for 10 nurses working in an acute inpatient mental health service. A phenomenological and hermeneutic lens was used to explore the nurses' experience of working in a recovery-focused manner alongside service users. Stories of practice were collected from participants through open-ended conversational interviews. Transcribed narratives were analysed to explore taken-for-granted aspects of working in acute mental health care and to uncover the meaning of being recovery-oriented in this setting. Findings revealed that although the experience and meaning of recovery-focused care varied among nurses, there were common elements in the practice accounts. The accounts highlighted the nurses' role in creating different therapeutic spaces to promote safety, relational commitment, and healing for service users. However, the nurses faced challenges to recovery-oriented care within the team hierarchical culture and the broader service systems. The nurses were, at times, fearless in advocating for service users and recognized that this was essential for developing recovery-focused services. The findings have implications for nursing practice, as well as training and service development.*

KEY WORDS: *hermeneutic phenomenology, mental health, recovery, inpatient, therapeutic space, nursing.*

INTRODUCTION

The recovery accounts of people affected by mental health issues have been increasingly used to inform mental health practice, training, and research (Jackson-Blott *et al.*, 2019; Leamy *et al.*, 2011; Slade, 2012). Multiple definitions of 'recovery' exist within service users' narratives; however, common themes include the importance of social connectedness, hope, personal responsibility, identity, and meaning (Leamy *et al.*, 2011). Those with

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lived experience of mental health issues have described the concept of 'personal' recovery in contrast to 'clinical' recovery (Slade, 2012). Clinical recovery is focused on the reduction or elimination of symptoms through medical and psychological approaches, whereas personal recovery broadens the sense of what is possible and includes the belief that people can recover from mental illness in the presence or absence of symptoms that recovery is an active participatory event, and highlights individuals' strengths and resourcefulness (Mental Health Commission, 2011). Personal recovery is believed to be a non-linear, unique process for each individual, involving movement towards a satisfying and hopeful life, where one can contribute meaningfully as part of one's community (Deegan 1992; Slade, 2012). Increasingly, it is argued that service providers should listen to the voices of people accessing care and broaden their focus beyond clinical recovery to support personal recovery.

BACKGROUND

Recovery-oriented service delivery and practice

A vision of recovery-oriented services originated with the lived experience and self-advocacy of service users. Organized service user movements grew internationally in the 1980s and advocated for human rights, re-distribution of power, and better services for those experiencing mental health issues (Campbell, 2009). This vision has been developed and introduced into mental health policy throughout most English-speaking countries, encompassing similar goals and priorities (O'Hagan *et al.,* 2012). Employing a recovery-oriented approach involves providing a broader range of resources to support the reduction of stigma and social alienation, while increasing a sense of belonging, purpose, and meaning in life for those using services (Repper & Perkins 2003).

Recovery-oriented practice involves offering individuals with mental health issues a 'range of effective and culturally responsive interventions from which they may choose those services and supports they find useful in promoting or protecting their own recovery' (Davidson *et al.,* 2009, p. 89). The core principle of recovery-oriented practice is for nurses and other clinicians to recognize that those experiencing mental health issues are first and foremost human beings with unique strengths, interests, values, and needs (Deegan, 1996; Farkas *et al.,* 2005). Furthermore, a focus on personal recovery requires clinicians to hold hope for the individual, support and encourage the person's resourcefulness, and facilitate greater autonomy through collaborative and supported decision-making (Farkas *et al.,* 2005).

Working in a recovery-oriented manner involves a shift in power and responsibility. The concept of the nurse as 'expert' is diminished as the service user takes increasing control of their own recovery. Balancing safety with risk-taking, reflection on practice, and an awareness of the need to reduce power imbalance through promoting service user autonomy are beneficial in supporting service users through personal recovery (Slade, 2012). Influenced by the practice context and the relational dynamics between individual staff and service users, there are variations in how recovery-oriented practice is applied (Slade, 2012). Therefore, how the principles of recovery-oriented practice are enacted in various practice settings warrants further exploration, including acute inpatient services.

Nursing within acute mental health services

Nursing within acute inpatient care is demanding and complex. Most inpatient services are busy, fast paced environments. Service users are typically in crisis, thus potentially may be vulnerable, highly distressed and agitated (O'Hagan *et al.,* 2008). Traditionally, a medical approach has dominated nursing practice within inpatient mental health settings, with a primary focus on medication and containment, including the use of involuntary treatment and coercive practices (McKenna *et al.,* 2014). Despite a drive to reduce the use of the involuntary treatment orders and coercive practice globally (Hu *et al.,* 2019; Ministry of Health, 2018), compulsory treatment, physical restraint, and seclusion rooms are still widely used. However, alternative practices have been developed which, in New Zealand acute care settings, includes talking therapies, advocacy, peer support, Māori support services, sensory modulation, trauma-informed care, and greater opportunities for staff to build therapeutic relationships (Slade, 2012; Sutton & Nicholson, 2011; Te Pou o Te Whakaaro Nui, 2010; Te Pou o Te Whakaaro Nui, 2013). Yet, tensions remain for nurses in maintaining aspects of the traditional medical and custodial paradigms, while expanding practice towards a broader recovery focus.

Several studies have explored nurses' understanding and application of recovery-oriented practice principles within acute inpatient services (Chen *et al.* 2013; Cleary *et al.* 2013; McKenna *et al.,* 2014). Instilling

hope was considered a central part of recovery-oriented practice, with nurses supporting service users to envisage a positive future and set a course to achieve their goals (Hobbs & Baker, 2012). Findings also indicated that using a person-centred approach, supporting service users' personal identity, and empowerment through acknowledging a person's strengths and abilities led to better recovery outcomes (Chen *et al.,* 2013; Cleary *et al.,* 2013; McKenna *et al*. 2014). However, to date, studies related to nurses' experience of recovery-oriented practice have primarily used descriptive methods such as brief surveys that fail to capture the deeper meaning of nurses' practice experience. Additionally, very few studies have specifically explored nurses' experience of supporting service users' recovery within acute inpatient settings, and no such studies have been conducted in New Zealand.

METHODS

A phenomenological approach was used to guide the study design, which allowed for a deeper exploration and understanding of taken-for-granted practice experiences (van Manen, 1997). The methodology of hermeneutic phenomenology seeks to uncover the meaning and essence of lived experience in relation to a specific phenomenon, as well as the contextual influences that shape it (Neubauer *et al.,* 2019). The phenomenon of interest in the present study was nurses' practice of recovery-oriented care in New Zealand inpatient mental health services. The introduction of a hermeneutic lens shifted the research beyond descriptions of lived experience to the interpretation of meaning within that experience, using philosophical notions (Bynum & Varpio, 2018).

Study participants

Ten registered nurses were recruited from one acute inpatient service. Initial study information was provided via team meetings and posters, with the nurses free to contact the first author if they wished to participate. The recruited participants included eight women and two men, ranging in age from late 20s-50s. Three participants identified as Māori, with the remainder of European descent. Seven participants had nursing experience of 20 plus years, with some over 30 years' experience. Three nurses had completed their new graduate nurse training in the previous year. The mix of participants provided a rich range of experience, reflections, and viewpoints regarding recovery-oriented practice.

Ethics

The nurses were employed in small inpatient service and worked in a close-knit team and community, so were at risk of privacy breaches. In addition, there was potential for emotional or sensitive experiences and information to emerge for the nurses as they reflected on their work, the impact of inpatient team culture and other pressures. Therefore, gaining informed consent, maintaining confidentiality, and avoiding coercion or deception were critical. In addition, pseudonyms were assigned for the presentation of the findings. The Auckland Regional Ethics Committee (15/66) and the Auckland University of Technology Ethics Committee (15/66) granted ethical approval. Additionally, a locality agreement was secured from the District Health Board in which the inpatient unit was located.

Data collection

Individual in-depth interviews were conducted as a way of meaningfully examining each nurse's unique lived experience. The interviews were approximately 1.5 hours in length and were conducted in a quiet space within the hospital. van Manen's (1997) principle of '*investigating experience as we live it*' was applied to facilitate a conversation with open-ended questions and a flexible structure. Questions included: What does recovery mean to you? How do you support recovery in your practice? As you seek to practise recovery-oriented care, what helps or hinders you in achieving that goal? Phenomenological research commonly uses a 'conversational' style of interview to remain as close to the participant and their experience as possible (Grant & Giddings, 2002). This approach led to a rich quality of views and experiences (Burnard *et al.,*) and yielded deeper meaning in the data. Interviews were digitally audio-recorded and professionally transcribed.

Data analysis

The transcribed data were analysed using van Manen's (1997) framework for 'reflecting on the essential themes which characterize the phenomenon' (p. 30). The focus was on using a reflective stance and uncovering emergent themes in the participants' lived experience of recovery-oriented practice. Data analysis involved listening carefully to each nurse's story and examining the corresponding interview transcripts, reflecting upon statements, phrases, and accounts, which related to the practice and meaning of recovery-

oriented care. This included drawing out relevant quotes and extracts from each transcript, and identifying practice experiences that were deemed by each nurse to be recovery-oriented. Contextual factors influencing practice were also identified.

It was important to keep an original record of each of the nurse's transcripts as returning to the original transcript helped to ensure that elements of the stories had been understood and captured accurately – both separately and within a coherent whole (Adams & van Manen, 2017). Following analysis of each interview, the interpretation turned to the 'meanings' that were emerging across participant conversations, thus allowing the formation of broader thematic groupings to communicate the phenomenological–ontological understanding of the nurses' lived experience as a whole. Keeping with van Manen's (1997) aim of 'thematic understanding', helped to identify commonalities and variations within and across participants' transcripts. Refinement of the analysis occurred through the iterative process of writing and re-writing the final interpretations of the nurses' stories.

Trustworthiness

Koch and Harrington (1998) suggested that trustworthiness in qualitative research needs to be transparent, reflecting the quality of the methodological thinking and the researcher's decision-making. Methods to promote trustworthiness included the use of a reflective research diary to capture the lead researcher's thoughts, feelings, and observations at each step in the study process. The diary provided an audit trail of the research process, opened space and time for 'playing' with interpretations, and captured the emerging themes arising from participant responses and the researcher's insights. Reflections within the diary were discussed with research supervisors and offered opportunities for new understandings and growth during the research process (Thorpe, 2010). The reflective diary became vital when writing up the findings, assisting in the recall of details in participant interviews and feedback. Additionally, participants were offered the opportunity to check their transcript for accuracy and to ensure they felt comfortable with the content. All analyses and interpretations were discussed with research supervisors and peer reviewed by a colleague with experience in inpatient nursing and qualitative research. This further supported trustworthiness by triangulating the interpretation and avoiding potential bias.

RESULTS

At the heart of recovery-oriented care within the inpatient setting was the practice of creating *safe*, *relational*, and *healing* spaces. These therapeutic spaces were formed between the nurse and service user, and held particular significance for supporting recovery. van Manen (1997) described how 'lived' space can be difficult to capture in words as, unlike dimensional space, it is something that is felt and relational but not usually reflected on. The nurses in this study were able to describe how it felt being alongside people in distress and these descriptions highlighted the taken-for-granted core practices of creating safety, building a shared relationship, and supporting healing. The three forms of therapeutic space are depicted in Figure 1.

The three therapeutic spaces were underpinned by core elements of recovery-oriented practice including: *working collaboratively*, *knowing the person*, *looking beyond labels*, *focusing on strengths*, *finding meaning*, and *instilling hope* (see Fig. 1). The nurses also identified key contextual factors affecting their ability to maintain recovery-oriented practice, including the hierarchical team culture, hospital systems, poor staffing and resourcing issues, lack of training and education around recovery-oriented practices, and unrealistic expectations within the inpatient setting. These core elements and contextual factors influenced the creation of therapeutic spaces as outlined in the following sections.

Creating safe space

The practice of '*creating safe space*' was central to recovery-focused care in the inpatient setting. Several nurses described the need to create safe space through reaching out and 'getting in touch' with distressed or agitated service users – literally and metaphorically.

> I actually use touch a lot, but… I'm careful in what I do. So if I think someone is really unwell and or I think it might escalate them or they're quite disinhibited or maybe if they're quite psychotic or, and agitated I might start by perhaps just touching them on the arm once. I actually use that as a bit of a litmus test, or I'll just touch their back, just briefly and see how they respond. (Rae)

Rae reaches into the service user's lived space to support them in their distressed state. She demonstrates a 'tactful' approach (van Manen 1991), using touch in neither an aggressive nor an intrusive manner.

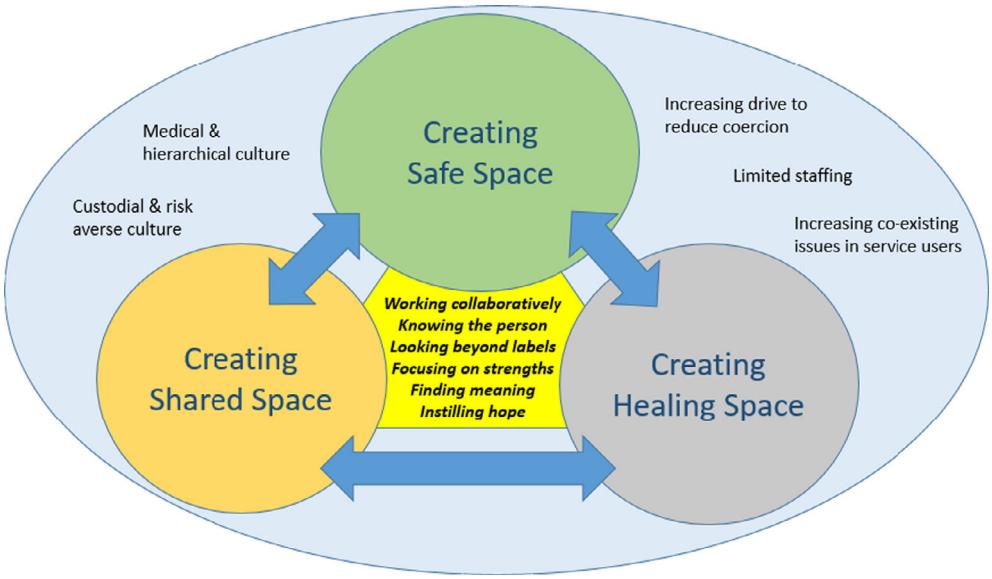

FIG. 1 Themes emerging from nurses' accounts of recovery-oriented practice.

Rae uses touch as a 'litmus test' to gauge where the service user 'is', psychologically, in their world, at that moment in time. She is self-aware and her orientation and tact towards the service user shows how important it is to know oneself and recognize that the other is a separate 'self' (Smythe & Norton 2007) with concerns, feelings, and needs that are as yet unknown. Rae provides a safe space, waiting patiently and intuitively for them to open up and reveal their world.

Matt describes his engagement with a young man who was picked up by the police after an urgent call from the public. Described as 'disorientated and psychotic', the crisis team felt the young man needed to be formally assessed:

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

Recognizing the young man's hyper-vigilance and potential vulnerability, Matt works to facilitate a sense of safety and trust by shifting from a custodial orientation (requesting the removal of handcuffs) to offering a warm drink. 'Being-with' (Heidegger, 1962) the distressed service user in a calm and relaxed manner creates a safe space.

The acute mental health setting is demanding and the nurses in the study related how they frequently needed to use their ability to connect, and manage crisis and distress. For these nurse participants, it was essential to work alongside service users and create a sense of physical and emotional safety as a foundation for recovery-oriented practice. Working alongside meant 'looking beyond labels' or diagnoses and moving away from medical ways of working, that is shifting focus from the service users' deficits towards focusing on strengths. The broader health care system and dominant medical culture within the acute setting require observation of signs and symptoms. However, widening their perspective, to see the human being beyond the diagnostic label, enabled the nurses to counter the focus on vulnerability with recognition of positive personal attributes and capacities. In doing so, the nurses aimed to move service users from passive onlookers in their treatment into active partners in their own recovery.

Creating shared space

Participants described the practice of '*opening shared space*', to create connection and shared commitment over time, a practice that took different forms. Several of the nurses challenged traditional relational boundaries in their efforts to develop trusting bonds. Both humour and play featured within participants' stories

as such moments opened space for different kinds of connection and alternative ways of approaching a situation, as Marianne described:

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

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

Māori nurses focused on meeting cultural and spiritual needs, alongside achieving clinical tasks. Their experience of creating shared relational space became significant when working alongside service users:

> This particular patient was on the ward for quite a long time, [she had a diagnosis of] …paranoid schizophrenia, an older Māori lady….she was listening to the Māori [radio] station one night. She said, 'sing me a song, sing me a song, sing me a waiata [song]'… I quickly pulled out my phone and had a quick look and…I started singing this waiata, and she started joining in and we sang a few little waiata together. It just helped her sort of calm and build that relationship. (Tui)

Pat shared,

> Sometimes we have to build some rapport with service users in a really short time, like 10 minutes…I use as much Māori as I can when I am speaking, little things. Using te reo [Māori language] makes the whānau [family] comfortable and makes me comfortable and then you can share with, and bring your joking side into it…

The calming influence that both nurses provide through waiata and language illustrates how the use of shared language and song can create strong threads of connection, cultural meaning, and sense of safety. The accounts underline the significance of cultural support and connection in recovery-oriented practice. The nurses showed their commitment to the relationship and service users' cultural needs by singing and having a 'kōrero' (conversation in Māori language). While singing to service users is not a typical intervention in clinical practice, it seems particularly powerful in opening shared space.

The nurses' stories highlighted the value of 'working collaboratively' and getting to 'know the person' through engagement in genuine relationships. It was within the context of relationship and spending time 'being-with' (Heidegger 1927/1962) that nurses were able to come to understand the service user. The nurses reported that 'being-with' and supporting service users promoted hope and trust, which opened up space for healing.

Creating healing space

The nurses' accounts indicate that the formation of both safe space and a shared relational commitment are important foundations for opening up healing space, where meaning making and processing grief and loss can occur. While sharing elements such as interests, humour, and life experiences opened up relational space, the participants recognized that recovery-oriented practice often involved service users addressing loss, trauma, and trying to find meaning in personal experience. Carole's excerpt illustrates the importance of recognizing how loss and trauma can affect individuals' experience of distress:

> I am in a wheelchair, and this often opens doors into discussing how it is coping with a trauma and breaks down barriers because they think I understand where they're coming from. One guy had previous physical traumas where he had lost a leg as a teenager and had other grief issues, he had lost his son. He really opened up quite quickly to me about his trauma and how difficult it was for him to adjust and come to terms with the loss of his son.

Carole demonstrates her ability to understand the service user's experience. She identifies that they have struggled to process their grief, which has transferred into feelings of loss, fear, and a deep depression. Carole's own experience of physical trauma and loss affords a connection and she is able to create a healing space where the service user can safely talk about their trauma.

One participant suggested that helping people to make sense of experiences required nurses to just *'be-*

with' and to '*stop, validate and listen*' when service users shared their stories, as illustrated in two excerpts from Anna:

> [I'm working with a] lovely Māori lady, who is very unwell at the moment... So I, I go along with her stories and say 'how does it make you feel?' and she talks of 'the Lord and Dad's right there, Papa's right there'... So, we talk about her journey.
> It was just about spending time listening to him. Then one day we were just sitting there, he was having a low moment, and he suddenly started talking about his thoughts, about his family and wanting to die. It seemed that he was desperate to talk to somebody; it was like opening his soul to the devil...

Despite high levels of service user distress upon admission, the nurses' accounts highlighted that a healing process could begin in the inpatient setting through creating space for sharing stories, meaning making, as well as the processing of grief and loss. The underlying aspects of 'instilling hope' and 'finding meaning' were central to this process. Instilling hope involved creating a feeling of safety and simply being alongside service users. It also involved using hopeful language and supporting service users to be future-focused – projecting their narrative towards new possibilities.

Challenges to creating recovery-oriented practice

Creating safe, shared, and healing interpersonal space was not always easy. The nurses identified various challenges to enacting recovery-oriented practice. These challenges for nurses were told in their stories of fatigue and frustration caused by expectations to work in new ways and meet targets such as eliminating seclusion practices, without adequate resourcing. It was difficult to maintain a broader recovery focus with increasing caseloads and the complex needs of service users with co-existing issues such as substance use or intellectual impairment. System issues such as the pressure to discharge people quickly, or delays in discharge due to lack of suitable housing also affected core elements of recovery, including personal choice and hope (McKenna *et al.,* 2014). However, the participants also spoke about developing recovery-oriented change in their practice by creating space for reflection and making the principles of recovery-oriented care more explicit in their team discussions. Despite the contextual challenges, it was still possible to find ways to work collaboratively, challenge stigma and coercion and maximize choice and autonomy. Involving service users and their whānau created a positive change – a space for belonging – and enabled nurses to be more reflective and inclusive in their practice (Cleary *et al.,* 2013; Mc Kenna *et al.,* 2014).

DISCUSSION

Using a phenomenological and hermeneutic lens, this study set out to explore the experience and meaning of recovery-oriented practice for 10 nurses working in an acute inpatient mental health service. While phenomenological studies can indicate the essence of a phenomenon, any one study will never capture 'the' single essence. Understanding about recovery-oriented practice in acute mental health nursing will continue to develop – never arriving at a single 'truth'. Therefore, the findings reinforce some of what is already discussed in the literature regarding recovery-oriented practice, including the need to look beyond symptoms and diagnoses to work in partnership with people, instilling hope and supporting the strengths and goals of the individual (Slade, 2012).

However, the study does contribute new insights into the acute inpatient nurses' experiences of recovery-oriented practice which are encapsulated in three core elements of relational space: (1) creating safety, (2) building connectedness and shared commitment, and (3) supporting healing. These core elements of practice may be taken for granted and over looked when staff are under pressure to complete tasks, such as observing signs and symptoms, managing risk, administering medication, completing notes, managing intake and discharge processes, and clearing beds (Waldemar *et al.,* 2016). Thus, at face value, the three elements of relational space appear simple and easy to communicate to nurses and other clinicians. The reality is complex, particularly when the physical, social, and institutional environment is not conducive to recovery-oriented practice.

Element 1: safe space

Creating safety for service users has been explored by Slade (2012) who advocated that a recovery-focused service should be geared towards preventing crisis, and then knowing how to respond well when crisis does occur. Slade outlined four principles: (1) prevent unnecessary crisis, (2) reduce the loss of personal responsibility, (3) maintain hope during crisis, and (4) support identity during and after the crisis. In the

present study, nurses used a range of different skills and actions to creatively implement these principles. However, the key to creating safe space was getting 'in touch' – literally and metaphorically – with the service user to understand their safety needs. This finding goes beyond the narrow focus on risk of physical harm and viewing the service user as an 'object' for clinical observation (Bowers *et al.,* 2000; Horsfall & Cleary, 2000). Research has highlighted that service users report feeling continuously observed and assessed from a distance by health professionals (Waldemar *et al.,* 2018). Getting in touch requires close proximity and reaching into the other's lived space to support co-regulation of distress (Sweeney *et al.,* 2018). The findings of the present study reveal the importance of implementing 'touch' as part of recovery-oriented practice.

Literature addressing service users' perspectives of what helps them when distressed (Borg & Kristiansen, 2004; Leamy *et al.,* 2011), includes support and acceptance from nurses (Kidd *et al.,* 2014). The findings of the present study provide more detail as to the type of support and acceptance that is required. The nurse participants revealed the need to attune to service users, recognizing potential vulnerability through genuinely 'being-with' the individual before and during their distress. Thus, it is critically important for nurses to have the ability to create a safe space through an intuitive or attuned awareness. For example, noticing small changes in body language when service users were starting to become distressed. Without attuned awareness, nurses may miss the opportunity to offer support and acceptance. Such embodied knowledge has been described as 'savoir de familiarite' or the knowledge bred of familiarity (Merleau-Ponty, 1962). Through their accumulated experience of being with people in distress, the nurses noticed subtle changes in both the service users' embodiment as well as their own.

Element 2: shared space

Creating shared space through engagement and commitment to an ongoing relationship emerged as another key element of recovery-oriented practice. Participants recognized how their relationships developed when both they and the service user shared aspects of themselves and worked towards common goals. Here, nurses met the challenge of shifting from the role of the empowered nurse (in control and with no problems) to the mindset of two individuals both struggling to work out how best to support the service user's recovery (Slade, 2012). To achieve shared space, the nurses in this study looked 'beyond labels' or diagnoses and deliberately sought to build relationships different to those described in medical and custodial paradigms (Kopacz, 2014). Service users often experience feeling on the 'outside', alienated from professionals (Chevalier *et al.,* 2018) and from being fully involved in their care planning within inpatient mental health settings (Grundy *et al.,* 2016). To combat this sense of alienation, the findings of the current study indicate the need for nurses to be more engaged through sharing common interests, humour, music, touch, and experiences. Doing so creates a relational space where there is mutual contribution and valuing of each other. For example, humour can be a fundamental component when connecting with service users (Gelkopf, 2011), breaking tensions, sometimes in the midst of crises, and opening up the relational space to build trust in a playful manner. The nurses stressed the need to use humour and other means (e.g. music or touch) respectfully and sensitively to avoid it being misconstrued or seen as demeaning by the service user. Used in this manner, nurses and service users shift into a more humanistic way of working together that creates a sense of possibility and hope (Kopacz, 2014).

In addition, this study highlighted the significance of creating shared space through ethnic culturally meaningful practices. This study captured the specific experiences of Māori inpatient nurses and how they use recovery-oriented practices. The Māori nurses drew on culturally embedded knowledge and practices in addition to clinical knowledge – sometimes stretching traditional boundaries to provide cultural and spiritual safety. As outlined in other literature (Te Pou, 2014), the nurses stressed the need to provide manākitanga (hospitality) and build connections through welcoming processes, involving whānau (family), providing hugs, and singing soothing waiata (song). This was further enhanced through the use of Māori language (Ministry of Health, 2020), which added depth to the shared experiences and strengthened connections with Māori service users.

Element 3: healing space

This study further indicated the importance of nurses providing a healing space for service users to process and find meaning in their distress, loss and trauma. Grief and trauma may present in various guises; feelings of loss and vulnerability translated into withdrawal and shutting down and, at times, into anger and rage

(Resick *et al.,* 2012). Herman (2002) identified the initial stages of trauma recovery as securing safety and then processing the traumatic experience. While the current study reinforces the importance of creating a safe space for talking about trauma and grief, the findings clearly reveal that this space cannot be maintained through controlling distressed or aggressive behaviours by force. Rather, the nurse participants indicated that it was important to spend time calmly validating the service user's experiences. This finding has implications beyond the nurses' practice. Inpatient services must be structured in such a way that allows nurses to spend time with service users which has implication for staffing levels on the ward. Doing so opened the space for trust and connection to slowly grow, a space where verbal and non-verbal dialogue between nurse and service user facilitated meaning making. When service users were able to make sense of their experiences and see new possibilities, healing could begin. Recognizing that all individuals are simply trying to get through their grief, loss and trauma in their own way helped nurses to practise in a recovery-oriented manner. The current study supports the need to supplement acute inpatient nurses' training in recovery-oriented practices with trauma-informed approaches (Muskett, 2014).

To date, no previous studies of recovery-oriented nursing practice have been conducted in Aotearoa New Zealand services; hence, the findings provide useful insights to this unique context, particularly the experience of Māori nurses. However, the findings are applicable beyond the local context as the reported experiences offer a starting point for nurses in other inpatient services and countries to reflect on how they relate to people in distress. The relational spaces offer a point of reference for all nurses to consider how they focus on creating safety, shared commitment, and healing despite the varying demands of the system within which they work.

The nurses in this study tended to minimize their role in creating space for recovery-oriented practice – they often said '*it's just what we do*'. Thus, creating space was not consciously or deliberately thought about during their daily interactions with service users or in team meetings. The routine of supporting daily living and the practicalities of dealing with admission and discharges at times overtook the consciousness of how recovery-oriented care was actually practised. These findings align with Benner's (1994) research regarding how nurses will relate experiences of care in ways they have not consciously thought about. A skilled nurse tends to be unaware of how they create a space or use their skills or taken-for-granted practices in daily engagement (Benner, 1994). Yet, it often requires this taken-for-granted practical know-how and understanding, along with self and team reflection, to support personal recovery as demonstrated in the current study.

Implications for research

Recent research has highlighted that clinical staff remain ambivalent about the relevance of recovery concepts within inpatient care (Coffey *et al.,* 2019) and that mental health nurses have struggled to create space for recovery-oriented practices within inpatient units (Cleary *et al.,* 2016). There is a clear need for further research into how recovery-oriented values and concepts can be applied more systematically within inpatient settings. The use of action research and co-design methods, where nurses and service users plan how best to work together towards recovery-oriented practices, would be a useful way to progress this work. Furthermore, this aspect of practice has not been well researched in relation to the unique bi-cultural context of Aotearoa New Zealand. Further research into culturally relevant responses and involvement of Māori researchers within acute mental health services could add depth to the insights gleaned in this study.

Implications for education

The nurse participants articulated the characteristics of recovery-focused practice; however, at times, struggled to identify how best to embed recovery-oriented care within the acute setting. More education for nurses regarding personal recovery and how to recognize and apply recovery concepts within acute mental health settings is required. Only 4 participants had any formal recovery training; an easily rectifiable situation given the availability of structured training specifically focused on recovery-oriented practice (Jackson-Blott *et al.,* 2019). Dialogue between nurses in postgraduate training forums would enable role modelling to novice nurses and colleagues, and create a formal space in which to strategize effectively on how to manage working in a recovery-oriented manner (Slade, 2012).

Relevance for clinical practice

The findings reveal that recovery-oriented practices in an acute inpatient mental health unit have the power to impact and enhance the journeys of both service users and nurses. In this study, the nurses' confidence

in expressing their voice grew as they engaged in and reflected on recovery-oriented practices. Subsequently, they were able to improve the relational space and care; and help prevent coercive cultures and practices. Thus, empowering and instilling hope in nurses to make changes in their practice is necessary to create relational space that, in a parallel process, empowers and instils hope in people using services (Bloom, 2011). Engaging in creative practices when working alongside both service users and colleagues, within the confines of the ward culture is, therefore, imperative for nurses as a means of 'letting go' of traditional and often coercive cultures. Moving away from custodial practices opens up space to connect with others, speak out, and heal divisive team cultures. Thus, nurses and the entire healthcare team need to openly discuss how to effectively create therapeutic space and support recovery for people who are acutely distressed.

If nursing is to fully embrace recovery-oriented practice, then questions must be asked of whether nurses should continue to use coercive practices such as restraint or enforced medication use. Such questions may contradict or challenge the values of mental health nurses and their profession (Barker & Buchanan-Baker, 2011). The shift away from coercive practices requires effective recovery-oriented strategies within acute units, such as shared decision-making (Drake *et al.,* 2010) and the routine co-development of plans including advance directives (Atkinson *et al.,* 2004), along with collaborative note writing (Grantham, 2010). Nurses also need to be able to advocate alongside service users and families (Funk *et al.,* 2006) and offer a range of options for management of distress, such as sensory modulation (Hirsch & Steinert, 2019).

Māori nurses are underrepresented in mental health services, despite evidence that Māori access services to a significant degree (New Zealand Nursing Organisation, 2017). Despite the challenges of under resourcing, the current study positively highlighted Māori nurses' contributions to recovery-oriented practice. This was particularly highlighted in their focus on relationship building, involvement of service users' family, and flexibility in ways of relating. Supporting Māori nurses to continue such practice must be allowed, and not dismissed due to Western notions of professional boundaries (Wyder *et al.,* 2017).

Importantly, if nurses are to be supported to implement recovery-oriented practice, then the environment in which they work needs to welcome difference and be 'morally habitable' (Wyder *et al.,* 2017). Enabling systems are paramount to facilitate morally robust work practices, which enable mental health nurses to deliver truly recovery-focused care without experiencing burnout and exhaustion (Chen *et al.,* 2013). There is a need for adequate staffing levels to support the ever-increasing and changing presentation of people being admitted to acute mental health units (Hirsch & Steinert, 2019). Priorities must shift from a task focus to nurses having time 'on the floor'; being-with service users and creating safe therapeutic spaces for healing.

Conclusion

Recovery-oriented practice has been extensively discussed within the literature. However, this study indicates there remains ambiguity around how to apply recovery concepts in acute mental health settings. Findings demonstrate that nurses working in acute mental health services face challenges and tensions, inclusive of trying to make space to support recovery in the most humanistic way possible, while balancing the contextual structures and systems in which they work on a daily basis. Despite most participants having little formal training in recovery-oriented practice, the nurses recognized the importance of creating safe and healing spaces, holding hope, being mindful of language and pace, and recognizing service users as unique and self-determining in their own recovery process. This study shows the importance of nurses working to support service users to not only cope in a crisis, but also process their experiences and move towards broader well-being and full participation in life beyond services.

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