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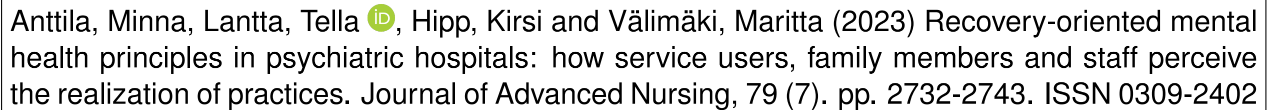

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Recovery-oriented mental health principles in psychiatric hospitals: How service users, family members and staff perceive the realization of practices

Minna Anttila[1], **Tella Lantta**[1,2], **Kirsi Hipp**[1], **Maritta Välimäki**[1,3]

[1]Department of Nursing Science, University of Turku, Turku, Finland

[2]Department of Nursing, Manchester Metropolitan University, Manchester, UK

[3]Xiangya School of Nursing, Central South University, Hunan, China

Correspondence

Maritta Välimäki, Xiangya Nursing School, Central South University, 172 Tongzipo Road, Changsha, Hunan 410013, China. Email: mava@utu.fi

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Abstract

Aims: The aim of the study was to describe and compare how recovery-oriented men-tal health principles have been realized in Finnish psychiatric hospitals from the view-point of different stakeholders (service users, family members and staff).

Design: A multimethod research design was adopted to combine both quantitative and qualitative descriptive methods.

Methods: A total of 24 focus group interviews were conducted with service users (*n* = 33), family members (*n* = 3) and staff (*n* = 53) on 12 psychiatric Finnish hospi-tal wards (October 2017). The interview topics were based on six recovery-oriented principles (WHO QualityRights Tool Kit, 2012). A quantitative deductive analysis was conducted to describe and compare the realization of the recovery-oriented prin-ciples between three stakeholder groups. A qualitative deductive content analysis was used to describe participants' perceptions of the realization of recovery-oriented principles in practice. The GRAMMS guideline was used in reporting.

Results: Out of six recovery-oriented principles, 'Dignity and respect' was found to have been realized to the greatest extent on the psychiatric wards. The most discrep-ancy between the participant groups was seen in the 'Evaluation of recovery'. Service users and family members found the realization of the practices of all principles to be poorer than the staff members did. Wide variation was also found at the ward level between perceptions among participants, and descriptions of the realization of the principles in psychiatric hospital practice.

Conclusion: Perceptions about the realization of recovery-oriented principles in prac-tice in Finnish psychiatric hospitals vary between different stakeholder groups. This variation is linked to differing ward environments.

Impact: More research is needed to understand the factors associated with variation in perceptions of recovery principles.

Patient or Public Contribution: Service users and family members participated in this study.

KEYWORDS

family, interview, mental health care, nursing, psychiatric hospitals, recovery-oriented practice, service user, WHO QualityRights Tool Kit

1 | INTRODUCTION

Recovery-oriented practice is a paradigm that aims to focus care on person orientation and involvement (Waldemar et al., 2016). It offers an ideology that can give service providers a better understanding of mental disorders so that they can offer better help to service users (Davidson et al., 2006). Indeed, a recovery-oriented treatment approach for persons with mental disorders is emphasized in treatment guidelines (e.g. National Institute for Health and Care Excellence, 2020), and research interests in recovery in mental health has increased during the last decades. However, recovery studies have focused mainly on service users' perspectives. According to Jaiswal et al. (2020), knowledge from the perspective of family members and staff is still needed. A call for further research has also been raised to understand environmental and social factors associated with the implementation of recovery-oriented interventions. Therefore, to promote recovery, it should be examined not only in direct work with service users but also in relation to social environments (van Weeghel et al., 2019). A better understanding of how to support people with mental disorders in recovery and management of their daily lives is needed.

What problem does the study address?

Evidence of recovery-oriented principles in practice in mental health inpatient care is fragmented. In this article, we describe and compare the realization of recovery-oriented mental health practices in Finnish psychiatric hospitals based on perceptions of different stakeholder groups.

What are the main findings?

Service users and family members described the realization of practices of all recovery-oriented principles more negatively than the staff members did. There was also great variation in responses between the wards.

Where and on whom will the research have impact?

This study provides usable knowledge for better understanding of what happens in mental health practice, and it offers implementation guidance for recovery-orientation at the practice level.

2 | BACKGROUND

Although recovery-oriented practices have emerged at least rhetorically, their implementation in practice has been challenging (Chester et al., 2016) and fragmented (Waldemar et al., 2016).

In Denmark, a qualitative study involving semi-structured interviews with 14 inpatients was conducted. Despite an effort to introduce recovery orientation in clinical practice, it did not reflect well in the participants' experiences during their hospital stay. Although service users felt accepted and protected in being around other people, they missed talking and engaging with health professionals. They felt that their choices and influence regarding the course of their treatment were limited, and they considered the level of information that they received about their treatment to be low. Service users also felt continuously observed and assessed from a distance by health professionals (Waldemar et al., 2019).

Research conducted from the perspective of mental health care staff has focused on attitudes towards recovery (Egeland et al., 2021), training and implementation of recovery-oriented programmes (Lorien et al., 2020) and perceptions of recovery-oriented care (Jørgensen et al., 2020; Solomon et al., 2021). Solomon et al. (2021) interviewed 10 nurses from acute inpatient services in New Zealand, and based on the interviews, the core elements of recovery-oriented practice include working collaboratively, knowing the service user looking beyond labels, focusing on strengths, finding meaning and instilling hope. Studies on mental health care staff suggest that, while recovery-oriented practice may be emphasized, it has been challenging to achieve (Egeland et al., 2021; Jørgensen et al., 2020; Solomon et al., 2021). More knowledge is still needed about staff perspectives on how different aspects of recovery-oriented practice could be realized in daily mental health practice (Solomon et al., 2021). Further, the potential for family members to promote recovery-oriented care could be utilized more (Jørgensen et al., 2020)—this group has been largely overlooked in recovery studies. To enhance a comprehensive understanding of recovery-oriented mental health care, it is essential to study it from the perspectives of different stakeholders.

Principles of recovery-oriented care include recognizing service users as unique human beings, keeping up the service user's hope focusing on their resourcefulness, and facilitating their autonomy and sense of responsibility (Solomon et al., 2021). Based on a systematic review and narrative synthesis by Leamy et al. (2011), processes of personal recovery in mental health consist of connectedness, hope and optimism about the future, identity, meaning in life and empowerment. Principles and characteristics of recovery-oriented care have been discussed in the literature, and they provide a foundation for a rigorous and structured examination (Leamy et al., 2011).

The WHO QualityRights Tool Kit (World Health Organization (WHO), 2012) has been developed to assess quality and human rights in mental health and social care facilities. It includes principles of recovery-oriented mental health practice: uniqueness of the individual, real choices, attitudes and rights, dignity and respect, partnership and communication, and evaluation of recovery (World Health Organization (WHO), 2012). As far as we are aware, this is the first time these principles of recovery-oriented mental health practice have guided focus group interviews with service users, family members and staff. This study can provide usable implementation guidance for the recovery-oriented approach at the practice level. Therefore, in this article, we describe and compare how

recovery-oriented mental health principles have been realized in practice in Finnish psychiatric hospitals from the points of view of service users, family members and staff (World Health Organization (WHO), 2012). We identify possible similarities and differences between the views of different stakeholders related to Finnish inpatient services. The data used in this study is part of a project evaluating the effectiveness of educational intervention for nurses, aiming to decrease the use of seclusion rooms in psychiatric hospitals (ClinicalTrials.gov NCT02724748).

3 | THE STUDY

3.1 | Aim

The aim of the study was to describe and compare how recovery-oriented mental health principles have been realized in practice in Finnish psychiatric hospitals from the points of view of service users, family members and staff.

3.2 | Design

A multimethod research design (Bryman, 2004) was adopted for this study. This design was deemed appropriate for meeting our study aim, as the data from different sources (service users, family members and staff) were used in semi-structured focus group interviews and combined both quantitative and qualitative descriptive methods. The GRAMMS guideline was used in reporting (Good Reporting of A Mixed Methods Study checklist Guideline, Supplement 1).

3.3 | Setting and sampling

The study is part of the VIOLIN project, which was a clinical trial aiming to reduce the occurrence of seclusion events in public, tax-funded psychiatric hospitals across Finland. Inclusion criteria for the psychiatric wards were that they were targeted for adults, were open 24/7 and had a seclusion room and/or the possibility to use mechanical restraints in their facilities. Exclusion criteria for the wards were their specialization only in forensic, psychogeriatric, or child and adolescent mental health care, or if they had a similar project planned or underway. The study wards in the VIOLIN project were randomly allocated into intervention and control wards. (Välimäki et al., 2022). The characteristics of the wards are described in more detail in an article by Lantta et al. (2021). Half of the wards were acute inpatient wards for adults, and the rest were rehabilitation and forensic psychiatric wards. There were approximately 20 beds on each ward, and the average length of treatment period was 24 days.

In this article, the focus is only on the 12 intervention wards included in the VIOLIN project.

Convenience sampling was used for service users admitted to the wards, family members visiting them and the staff members working on the wards. All adults (≥18 years old) and occupational groups, such as nurses, psychiatrists, etc., who could speak and read Finnish, and who gave informed consent, were eligible to join this study. Participants were recruited via emails sent to the study wards, leaflets and posters informing about the study and the times that the focus group interviews would be held. Researchers recruited the participants in person before the interviews.

3.4 | Data collection

The data were collected using focus group interviews in October 2017. The focus group method was selected as it provides insight into participants' perceptions through participants reflecting on each other's perceptions. Six recovery-oriented principles of the WHO QualityRights Tool Kit (World Health Organization (WHO), 2012) were used as the topics for semi-structured interview questions. These principles were adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the United Kingdom, and reprinted in the WHO QualityRights Tool Kit with permission of the Australian Government.

The topics of the open-ended focus group questions for each participant group were as follows: (1) uniqueness of the individual, (2) real choices, (3) attitudes and rights, (4) dignity and respect, (5) partnership and communication and (6) evaluating recovery (World Health Organization (WHO), 2012). The participants were asked to describe how each of the topics was realized in practice on their ward. Based on the participants' answers, more detailed questions were posed (Whiting, 2008) to clarify the principles and subprinciples included in the WHO QualityRights Tool Kit. Abstract expressions such as 'uniqueness of the individual' were specified, for example, by asking the participants, 'are there opportunities for choices and 'what kind of choices can be made'.

Service users and their family members were interviewed as one group per ward and the staff members as another group per ward. If service users and family members were not able to be interviewed as one group, they were interviewed separately. The focus groups were led by female healthcare professionals with a master's and/or doctoral degree and with experience in conducting focus group interviews (MA, TL [authors] and VP). One of the facilitators acted as the main interviewer, while a moderator ensured audio recordings, took notes in case the recording failed and made sure that all interview topics were covered.

The focus groups included a total of 89 participants (33 service users, 3 family members, 53 staff members). One withdrawal in a service user group occurred, and that person's data were removed from the analysis, leaving us with 32 service user representatives. Each focus group included 2–8 participants. In total, 24 focus groups (11 groups for service users; one group for family members; one group for both service users and family members; and 11 groups for staff members) were formed. The duration of each interview ranged between 17 and 54 min.

3.5 | Ethical considerations

Approval for the study was obtained from the Ethics Committee of the Hospital District of Southwest Finland (ETMK: 9/1801/2016), and permission to conduct the study were granted by each hospital. A WHO Permission Team authorized the use of the English version of the Tool Kit (12 April 2016). An official Finnish translation was not needed as the Tool Kit was used as an interview guide by the research team competent in using materials in English.

At the beginning of the interviews, the purpose of the study was explained to the participants, they received written information about the study and their written informed consent was obtained. For privacy reasons in our small participant groups, no background information of the participants was collected. The characteristics of the study wards are described in more detail in articles by Lantta et al. (2021) and Välimäki et al. (2022). Participants were notified about the possibility to leave the interview at any time without any explanation or consequences. The interviewers had no previous relationships with the participants prior to the VIOLIN project, and the participants were informed about the interviewers' positions and backgrounds relevant to the study. The researchers' contact information was provided in case participants wanted to discuss their thoughts after the interviews.

3.6 | Data analysis

Data to be analysed produced 185 pages of transcribed interviews (single spaced, Times New Roman, font size 11). The data were analysed by two independent researchers (KH, MA). They used the six principles (World Health Organization (WHO), 2012) as a reference point in the analysis to describe the data. Each principle was further divided into three to four more specific sub-principles, which formed the content of the principle (Table 1). Realization of principles in practice was evaluated deductively through quantitative and qualitative manners by comparing the content of each interview with the content of the WHO recovery-oriented mental health principles. This allowed the researchers to identify the main similarities and differences of recovery-oriented principles in practice in Finnish psychiatric wards.

To gain an overall picture of the realization of practices of recovery-oriented principles in participating psychiatric hospitals, quantitative descriptive methods (Siedlecki, 2020) were used. Two researchers began with assessing the interviews one by one and evaluated them in line with the sub-principles. If a specific sub-principle was found to have been realized in practice on the ward, that is, the interview was in line with the WHO QualityRights Tool Kit (World Health Organization (WHO), 2012), the researcher rated it as '1' ('Yes'). A value of '0' ('No') was given if the sub-principle had not been realized in practice on the ward. Further, if the sub-principle was not able to be assessed in practice, that is, it was not clearly indicated in the interviews, it was given a value of 'N/A' (Not available). All the ratings were marked in an Excel file. As each of the six principles consisted of three to four sub-principles, the mean value for each principle was counted. For example, if there were three sub-principles describing the principle, and the sub-principles had all the possible values (1, 0, N/A), the mean value for that principle to have been realized in practice was 1 (Yes). This procedure was done for all the service user/family member and staff member interviews on all the study wards in order to receive mean ratings for all the six principles.

TABLE 1 Principles and sub-principles of recovery-oriented mental health practice (modified from World Health Organization (WHO), 2012)

1.	**Uniqueness of the individual**
	(i) Opportunities for choices, living a meaningful, satisfying and purposeful life, being a valued member of the community
	(ii) Outcomes are personal and unique, go beyond an exclusive health focus
	(iii) Empowers individuals to recognize that they are at the centre of care
2.	**Real choices**
	(i) Supports and empowers individuals to make own choices about how to lead lives
	(ii) Supports individuals to build on strengths and take responsibility for their own lives
	(iii) Ensures that there is a balance between duty of care and support for individuals
3.	**Attitudes and rights**
	(i) Involves listening to, learning from and acting upon communications about what is important to each individual
	(ii) Promotes and protects legal, citizenship and human rights
	(iii) Supports individuals to maintain and develop activities
	(iv) Instils hope in the future and the ability to live a meaningful life
4.	**Dignity and respect**
	(i) Consists of being courteous, respectful and honest in interactions
	(ii) Involves sensitivity and respect for each individual
	(iii) Challenges discrimination and stigma wherever it exists
5.	**Partnership and communication**
	(i) Each individual is an expert on their own life, recovery involves working in partnership with individuals and carers
	(ii) Importance of sharing relevant information to enable effective engagement
	(iii) Working in positive and realistic ways with individuals and their carers
6.	**Evaluating recovery**
	(i) Ensures and enables continuous evaluation of recovery-based practice
	(ii) Individuals and carers can track their progress
	(iii) Services use the individual's experiences of care as quality improvement activities
	(iv) The mental health system reports on key outcomes to indicate recovery

On a group level (service user/family member interviews vs staff member interviews), each of the six recovery-orientation principles was evaluated by analysing their average level in the interviews. This was done by summing up all 'Yes' scores from the interviews, principle by principle. This procedure was done separately for service user/family member interviews and staff member interviews. Differences between the service user/family member interviews and staff member interviews were counted and presented in percentages (Table 2).

On the ward level, all of the 'Yes' scores from the service user/family member interviews on each individual ward were added together to find the total number of 'Yes' ratings from service user/family member interviews per ward. The same was done for the staff member interviews. Differences between the service user/family member interviews and the staff member interviews were counted and presented in percentages for each ward (Table 3).

Qualitative deductive content analysis was conducted to gain in-depth knowledge about participant experiences of recovery-oriented principles (Elo & Kyngäs, 2008). Principles that were found to be realized in practice, as well as those that were lacking in practice, were sought deductively from the interviews and categorized into sub-categories in line with the sub-principles. Quotes for each principle were used to illustrate the participants' voices. Our analysis included perceptions of all the participant groups as well as more detailed information about perceptions of specific participant groups.

3.7 | Validity, reliability and rigour

To securing the validity of the study, the focus group interview schedule was pilot tested on one ward, with service users and with staff members separately. Pilot participants were not included in this study. To increase the validity of the analysis, the findings of the two independent assessors were compared regarding principles. In cases of discrepancy between the evaluations, the principles were rated by a third assessor (TL), and a consensus was sought among the three assessors. Reliability was considered to have been achieved in interviews when the data saturated and was sufficient to describe the principles. Overall, the rigour of the study was ensured with detailed and transparent descriptions of the procedures taken in the study, and by coherent and complete descriptions of the phenomena, through combining and comparing perceptions of different stakeholders (Mays & Pope, 1995).

4 | FINDINGS

4.1 | Presentation of the main themes

The topics were 'Uniqueness of the individual', 'Real choices', 'Attitudes and rights', 'Dignity and respect', 'Partnership and communication' and 'Evaluating recovery'. We quantitatively presented how each of the topics were realized in practice, as well as the comparison of the topics between all stakeholder groups. We also qualitatively described the participants' perceptions of the realization of the recovery-oriented principles and illustrated the sub-principles according to Table 1. The sub-principles are differentiated using the marks (i, ii, iii and iv).

4.2 | Perceptions of realization of recovery-oriented principles in Finnish psychiatric wards

Based on the focus-group interviews with service users and family members, between 46% and 85% of the recovery-oriented principles were considered to have been realized in practice. The principle of 'Dignity and respect' was found to have been realized to the greatest extent on the wards (85%), while 'Evaluating recovery' was considered to have been realized the least (46%). On the contrary, staff members perceived that all the principles had been realized in practice at a high level (range: 82%–100%). They were especially satisfied with how the principle of 'Partnership and communication' had been realized on the wards (100%). In general, service users and family members described all the principles to have been realized in practice to a lesser degree than the staff members did. Disagreement was greatest concerning the principle 'Evaluating recovery' (45% difference), while the participants agreed the most about the principle 'Dignity and respect' (6% difference) (Table 2).

When the results of the focus group interviews were considered at the ward level separately for 12 wards, the service users and family members described that they perceived the principles to have been realized in practice between 0% and 100%. There was one ward in which a staff interview was not conducted because of a lack of participants (N/A). Staff members considered the principles to have been realized in practice between 67% and 100%. There were two wards where the service users and family members described the principles to have been realized in practice to a greater extent

TABLE 2 Realization of recovery-oriented principles in practice

Focus groups	Principles[a]					
	Uniqueness of the individual	Real choices	Attitudes and rights	Dignity and respect	Partnership and communication	Evaluating recovery
Service users and family members ($f = 13$)	7/13 54%	9/13 69%	10/13 77%	11/13 85%	10/13 77%	6/13 46%
Staff members ($f = 11$)	9/11 82%	9/11 82%	10/11 91%	10/11 91%	11/11 100%	10/11 91%

aThe number of interviews out of all interviews in which principles were considered to realize in practice.

TABLE 3 Principles described to have been realized in practice on each ward: The number of 'Yes' scores out of six

Ward	Service user and family member interviews[c]	Staff member interviews[c]
1	2/6, 33%	6/6, 100%
2	6/6, 100%	4/6, 67%
3	0/6, 0%	6/6, 100%
4	0/6, 0%	5/6, 83%
5	4/6, 67%	5/6, 83%
6[a]	5/6, 83% (service user interviews) 6/6, 100% (family member interviews)	6/6, 100%
7	5/6, 83%	4/6, 67%
8	6/6, 100%	6/6, 100%
9	4/6, 67%	6/6, 100%
10[b]	5/6, 83%	N/A
11	5/6, 83%	5/6, 83%
12	5/6, 83%	6/6, 100%

[a]Service users and family members were interviewed separately.
[b]Staff members were not interviewed.
[c]Number of principles that were realized in practice per ward.

than the staff members did, and in three wards, the evaluations were similar between groups (Table 3).

4.3 | Perceptions of recovery-oriented principles realized in psychiatric ward practice

4.3.1 | Uniqueness of the individual

'Uniqueness of the individual' was described to have been taken into account in versatile ways: (i) Service users and family members described that service users had felt valued and had received support without delay; (ii) Service users felt that they had been treated as individuals in a holistic manner, had got individual support in follow-up treatment and in integrating into society, and service users and family members especially mentioned economic counselling and social relief, while staff mentioned multi-professionalism; (iii) Service users perceived that they had been at the centre of care, that each service user had individual goals and that the staff had followed an individual treatment plan.

> They have immediately tried to get to the core, the reason why you are here, and start to solve the situation right away. (SU19)

On the other hand: (i) Service users and family members felt that service users had not been valued as human beings but rather labelled due to their past illness periods, which had affected service user care, while staff described that individual care had been lacking because staff had had no choice but to focus solely on service users' illnessed rather than the whole person; (ii) Service users and family members also stated that service users' physical symptoms had not been considered individually, but due to turnover and a lack of communication, all service users had been treated similarly without knowing each service user's circumstances; (iii) Service users had not been at the centre of care, but had all been subject to the same rules on the wards.

> Especially in this ward, when we must restrict so much and there are these rules, we must aim for the rules to impinge on everyone. Many patients may experience that they are not considered as individuals when they are restricted. (S25)

More descriptions of the realization and lacking sub-principles in recovery-oriented mental health practice, especially descriptions of how service users, staff and family members experienced the principles being realized or not, can be found in Table 4.

4.3.2 | Real choices

Relating to the topic of service users making 'Real choices' regarding their care: (i) Some service users and family members said that service users had indeed been empowered to make real choices, and staff members highlighted that service users had been able to influence their medication, for example; (ii) Care was described as having been tailored based on the service users' strengths and wishes regarding their own care—they felt that they had been heard—and service users and family members underlined that care based on service users' strengths rather than their weaknesses can provide positive results for the service users and support their progress; (iii) Service users had been able to be in charge of their own care, although staff members stated that being in charge of one's own care is a risk that does not always end in success.

> Probably, nothing else is obligated than the most necessary things, medication and such. And if it does not impair other patients' safety or one's own safety, one can quite freely choose whether they go out or not, how they spend and schedule the day. (S15)

However, some felt that making real choices was a principle that had not been realized: (i) Service users had not always felt empowered to make choices because of restrictions on their freedoms, and service users and family members complained that no reasons had been given for these restrictions, only orders to follow; (ii) When service users had difficulty taking responsibility, their possibilities to make choices had also been limited—staff members stated that it is difficult to give responsibility to service users and trust them, as service users can impair their own care, while service users and family members said that choices had sometimes been ignored and that service user's strengths in care had not been considered; (iii) Staff members stated that

TABLE 4 Descriptions of the realization and lacking sub-principles in recovery-oriented mental health practice

1.	**Uniqueness of the individual**
	Realization: The staff felt that they knew the backgrounds of their service users, and tailored care considering each service user individually
	Lacking: Service users and family members were of the opinion that ward rules had varied depending on the staff members on duty
2.	**Real choices**
	Realization: All participant groups described that service users had been able to choose their daily tasks on the ward, which had been aimed to support their rehabilitation
	Lacking: From the staff members' point of view, a service user's choices can be disregarded in care since responsibility lies with the staff, especially if a service user is hospitalized involuntarily
3.	**Attitudes and rights**
	Realization: Staff members described how service users have the right to have access to all the information that has been gathered about them, and how service users have the right have contacts and certain public services outside of the hospital
	Lacking: Service users and family members felt that restrictions had been used as punishment and that decisions had been based on resources and the societal economic situation
4.	**Dignity and respect**
	Realization: All participant groups expressed a sense of equality between service users and staff, exemplified in how a staff member touches a service user
	Lacking: Service users and family members said that sometimes staff had dictated how the service user should dress or look, and staff members admitted that negative attitudes can exist towards service users, and that multiculturalism poses its own challenges
5.	**Partnership and communication**
	Realization: Staff members said that they give information about care and ward practices to service users and family members, and service users and family members expressed that family members had received information in professional confidentiality
	Lacking: Service users and family members added that family members had been ignored and their knowhow had been underestimated
6.	**Evaluating recovery**
	Realization: Staff members said that they monitor service users' health, the service users evaluate their own progress in their treatment plan, and that there is a joint evaluation of how the service users participate and are active on the ward, or of how they succeed during home leaves
	Lacking: Staff members explained that making a prognosis when plans are uncertain is difficult

opportunities cannot be given to service users because the staff have to take the entire ward community into account, and a service user cannot, for example, choose which staff member handles their treatment because of limited resources and sparse rehabilitative care orientation during short treatment periods. Service users and family members also felt that they had had no choice in treatment options, including medication.

> I do not think that I can impact the planning of my care very much. (SU23)

4.3.3 | Attitudes and rights

Many examples were given under the topic of 'Attitudes and rights': (i) Service users felt they had been heard on the wards regarding what was important to them; (ii) Service users had the right to decide who participated in their care—service users and family members stated that they had been informed of their right to complain about treatment, and staff members described more broadly how laws are obeyed, how rights are included in all the procedures on the ward, and that service users are informed about their rights; (iii) Service users had been supported in maintaining and developing a meaningful daily life; (iv) Service users and family members brought up that the attitude towards social relationships on the wards had been encouraging and had inspired hope for the future.

> Rights are respected here, yes. All kinds of equipment have been organized for contacting authorities or others if one wants to. Or one can have a priest or an ombudsman or an attorney present, or a phone call to a policeman and so on. A phone is given if someone does not have a phone of their own. (S28)

Additionally: (i) Service users and family members expressed that, even though the attitude on the ward might have been that service users were being heard, information about them had not been transmitted and had not led anywhere; (ii) Service users and family members complained that they had not been informed about certain rights, possibilities for legal aid or ways to complain, while staff members described that some rights on the ward without responsibilities may hinder recovery, for example, if personal belongings are not investigated; (iii) Service users and family members said that service users had not been allowed to do what they wanted and what was meaningful to them, while staff members described that a service user's individual behaviour can violate other people's rights, especially in situations when other service users and staff members are exposed to one service user's acts of misbehaving; (iv) Service users and family members expressed that they felt service users often have no hope, they just carry on from day to day.

> You are punished for everything you do. A mobile phone was taken away for one weekend. (SU9)

4.3.4 | Dignity and respect

For 'Dignity and respect': (i) All felt that both dignity and respect had been shown in the service user care, that they had been truly cared for on the ward and that there had been a sense of honesty; (ii) Staff members stated that human dignity and respect are a priority on the ward, and service users and family members described an atmosphere in which service users had been allowed be themselves; (iii) Inappropriate behaviour was seen to have been dealt with on the ward, and interactions were perceived as appropriate and professional.

> Interaction between a patient and a nurse is not simply interaction between a nurse and a patient but an interaction between two people. (SU6)

Still, there were examples of dignity and respect not having been realized in ward practice: (i) Indiscreet interactions on the wards were mentioned—service users and family members said that service users had sometimes been treated in a degrading and unempathetic way and they considered psychiatric care to be demanding work that had affected the capability of the staff to emotionally treat service users on the ward; (ii) Service users and family members complained that especially religiousness had not been respected and had been ignored on the wards, as if it had been thought to be some kind of symptom of mental illness, even though service users' religious choices were respected on the ward, at least in some ways; (iii) Staff members said that they tended to consider who deserved to be treated, and service users and family members felt that stigma exists, especially towards drug users.

> We have a certain attitude towards patients with substance abuse…some staff have, sort of, a negative attitude. It may impact care, for sure. Frankly speaking. (S53)

4.3.5 | Partnership and communication

For the topic 'Partnership and communication': (i) Service users had been encouraged in discussions to be active experts in their care, and family members had also been included in the service user care; (ii) Information had been shared on the wards, and communication had been simplified, understandable, repetitive and based on the needs of the recipient; (iii) Staff members said that family members are heard and perceived as a resource because they know the service user, while at the same time, family members expect support from the staff.

> Staff may speak quite honestly but, of course, there is sort of obligation of confidentially when it's about grown-ups. (FM2)

However: (i) Service users and family members described partnership as having been difficult because nurses had been unreachable on the ward at times, while staff members stated that there is sometimes a feeling of confrontation between service users and the staff on the ward, and that there are also challenges when partnerships form between staff or between service users, but not when they form between staff and service users; (ii) Service users and family members felt that there had not been enough information provided, service users' wishes and needs for help had not been recognized, and all participant groups thought that challenges in communication had been perceived because the staff, especially doctors, use professional language; (iii) Staff members stated that not only there are institutional restrictions, a lack of available resources and difficulties in co-operation with families but also unrealistic expectations on staff to work with the family members, while service users and family members felt that plans in care had not been clearly explained to them.

> Relatives quite often have high expectations about care on the ward. They expect improvements that are beyond realistic with the resources we have. It is understandable that the expectations are high since an intervention has been made in the patient's situation they are in the hospital, so quite often the wish is for a long-term treatment period. (S43)

4.3.6 | Evaluating recovery

Recovery had been evaluated: (i) Continuously on the wards through discussions with the service users and in care meetings, and staff members described making observations in multi-professional care teams and having discussions with family members; (ii) Service users and family members said that there are variety of ways to track service user progress; (iii) All said that service user feedback system on the ward is one way of receiving individual perceptions of the quality of improvement; (iv) Staff members stated that recovery evaluation is based on treatment goals, examination and outcome measures, such as BECK Depression Inventory (BDI), Resident Assessment Instrument (RAI), Goal Attainment Scaling (GAS), Mood Disorder Questionnaire (MDQ) and Beck Anxiety Inventory (BAI).

> We have a multi-professional team. We consider functional capacity and such in it, that should there even be evaluation of the capacity. We really use the scales to know the current situation and then to compare. (S3)

Besides well-realized practices in recovery evaluation: (i) Service users and family members described that prognoses had not been discussed, and feedback about recovery had not been provided continuously; (ii) Service users and family members felt that service users had not been involved in tracking their own progress, and that recovery evaluation had been inconsistent; (iii) Staff members said that feedback about perceptions of care is difficult to utilize and put to good use. (iv) They also stated that there are challenges in using specific

evaluation instruments because not all service users' want to be involved in evaluations.

> At least I did not receive any kind of interim information for how I cope. (SU9)

5 | DISCUSSION

In this study, we describe and compare the realization of recovery-oriented mental health practices in Finnish psychiatric hospitals from the points of view of service users, family members and staff, in line with the World Health Organization (WHO) (2012) QualityRights principles. We identify differences in perceptions between staff, service users and family members of how recovery-oriented principles have been realized in practice. One way to interpret our findings could be that staff more often described ideal practice and aimed to give socially desirable responses, and service users and family members reflected more on the reality on the wards. These findings are similar to those of a study conducted in the UK (Coffey et al., 2019), which compared perceptions of staff, service users and carers regarding recovery-oriented mental health care planning and co-ordination. They found that staff rated all realized practices as more recovery-oriented than service users did. However, as in this study, qualitative findings revealed more mixed results. Staff described struggling to put principles of recovery-orientation into practice, and they found many obstacles in their realization, such as lack of insight on the part of the service users (Coffey et al., 2019).

We also found deviations between individual recovery-oriented principles. Service users, family members and the staff shared a common opinion that 'Dignity and respect' had been realized well in practice on the wards, while they had opposing views regarding the principle concerning 'Evaluating recovery'. Coffey et al. (2019) also reported that, overall, service users and carers had a positive view towards treatment and being treated with dignity, respect and compassion. Contrary to our study, however, service users reported high satisfaction with regular monitoring of progress towards their recovery goals. Our results are confirmed by the results of Waldemar et al. (2019), who found out that service users felt accepted and protected, but that they had limited choices in and influence on the course of their treatment, low information levels regarding their treatment, and ambivalent experiences of support from health professionals. In this study, service users and families also stated that they had limited opportunities to participate in planning their care. In turn, staff members admitted that it is difficult to give responsibility to service users and believe in them. This might be because, especially in acute inpatient care, professionals tend to use much of their daily time on safety aspects of care and minimizing risks (Higgins et al., 2016). For example, Bee et al. (2015) reported that the biggest barriers to service users and family involvement in care planning are time pressures and high workloads. In addition, professionals may lack the confidence to include positive risk-taking opportunities in care planning and allow service users to make their own choices and pursue their own recovery goals (Bee et al., 2015; Higgins et al., 2016). These positive risk-taking opportunities could, however, serve as an important part of recovery and personal growth, and inpatient care is a safe environment in which to practice these decisions (Higgins et al., 2016).

The differences in our results might have been caused by the fact that in general, a common understanding of the concept 'recovery' is missing (see also Coffey et al., 2019). This may limit shared goals in monitoring, as a study conducted in the UK found (Simpson et al., 2016). Moreover, recovery as a concept, has been adopted to Finnish psychiatric care only in the most recent years.

In this study, there were study wards in which none of the principles had been realized in practice, based on the perceptions of service users and family members. On the contrary, some wards represented 'a golden standard' where all principles were seen to have been in place. We can only speculate on the reasons for this variation. One reason might be that our results represent different types of wards, which varied in size, average treatment times, staff resources and treatment offered (Lantta et al., 2021). Another reason might have been that nurses cannot prioritize the service user recovery approach in their daily practice. Coffey et al. (2019) reported that staff were ambivalent about whether recovery ideas were relevant at all in busy inpatient acute wards; treatment periods are short and only limited support for service users and family members can be offered. Previous researchers have questioned whether recovery-oriented practice can or should be an approach used in inpatient care, which is primarily aimed at stabilization and symptom relief (Waldemar et al., 2016) because of the short treatment periods. Based on the staff's homogenous opinions in our findings, we can make a positive assumption that the recovery-oriented approach is well accepted among staff. However, there is still room for improvement regarding turning the recovery-oriented approach into actions.

World Health Organization (WHO) (2012) QualityRights principles were a systematic framework for evaluating the level of the realization of recovery-orientation practices. To achieve the true value of this orientation, several recommendations can be delivered based on our findings. First, realization of recovery-oriented practices requires strong nursing leadership, so that these ideals becomes reality (Stickley et al., 2016). Second, it was seen in this study that good intentions are not visible to service users and their family members, and they should be the ones who really feel that the care is directed towards recovery. It would be beneficial for staff as well as service users and their family members to have commonly shared descriptions of what recovery-orientation could mean in different types of services. For example, re-hospitalization may have been seen as a treatment failure, or as a natural part of recovery (Ådnanes et al., 2018). Therefore, acute inpatient care could be seen as an integral atmosphere for recovery-oriented care, contrary to what has been stated before (Waldemar et al., 2016). Third, as it was seen in this study that realization of practices differ between wards, it

would be important to harmonize education in different professional groups regarding recovery-orientation. This should be done in both basic and continuing education. Involving persons with lived experience in professionals' education could be one successful method of increasing preparedness to provide recovery-oriented care (Happell et al., 2019). This could reduce the stigma towards service users (Happell et al., 2014), as revealed in our findings.

5.1 | Strengths and limitations

As a strength of the study, our total sample size of the participants was 89, and the data were collected in 24 focus groups. The numbers are higher than are usually suggested for focus group interview studies, and this enriches our data. Saturation was achieved as there was repetition in categories among the focus group interviews. Moreover, as we conducted the deductive analysis and deductively sought expressions from the interviews in line with the sub-principles, we did not analyse the leftover data that did not fit the existing sub-principles. As a whole, in the quantitative findings, staff members perceived that all the principles had been realized in practice to a high degree, and there were more wards where the staff members described the principles to have been realized in practice to a higher degree than the service users and family members described. At the same time, in the qualitative findings, service users and family members broadly described shortages in practices. This corroborates the strength of the chosen study method, in which a multimethod research design was adopted combining both quantitative and qualitative descriptive methods. However, to note one limitation, due to a short admission period of service users, we used convenience sampling among those participants who happened to be on the wards during interviews. Therefore, we were not able to return the transcripts and data categorization to the participants. As another limitation, we were not able to reach as many family members in our interviews as we had hoped for. Our study was only able to recruit three family members. We can only speculate on the reasons behind this difficulty. Sin et al. (2017) have reported, for example, that reasons for family member recruitment difficulties may include concerns about service user's opinions, failure in recruitment strategies and lack of interest/time in participating in research. This recruitment issue may have hindered the strength of the study, as statements made by family members cannot be triangulated sufficiently with findings from service users and staff members. There was also one ward in which staff member interview was not realized at all, and we may question why they were not willing to share their perceptions regarding the realization of practices on their ward. We cannot know for certain if only the most critical service users and staff members participated in the interviews; on the other hand, the staff members in the interviews could have only been willing to share the optimally realized practices in their care. All of these unknowns may have biased the results of this study. A further limitation related to our analysis was that there were some difficulties in the categorization process as some sub-principles and even principles were closely related to each other. Therefore, there were only slight nuances between some contents of the different categories, which might have also caused bias in our results.

6 | CONCLUSIONS

Based on our study findings, we can conclude that experiences of practising recovery-oriented care in Finnish psychiatric hospitals vary, and the perception of care depends heavily on the stakeholder group in question. World Health Organization (WHO) (2012) QualityRights principles provided a useful framework for evaluating realized ward practices. Based on our findings, we recommend strong leadership to guide recovery-oriented practices and establishing common descriptions of what specific recovery-oriented practices mean at different levels of service. To harmonize realized practices between wards, we recommend investing in professionals' education on this topic.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*):

1. substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
2. drafting the article or revising it critically for important intellectual content.

* http://www.icmje.org/recommendations/

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CONFLICT OF INTEREST

The authors have no conflict of interest to disclose.

DATA AVAILABILITY STATEMENT

Research data are not shared due to ethical reasons.

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