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ORIGINAL ARTICLE

Conceptualisation of personal recovery in a private hospital mental health service

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Abstract
There has been limited research on personal recovery during a hospital admission. However, studies in this setting indicate that consumers' experiences of personal recovery, during an inpatient admission, may not mirror the experiences of consumers living in the community, which has been conceptualised by the CHIME processes of Connectedness, Hope, Identity, Meaning and Empowerment. Findings to date posit that inpatients may be more likely to experience disconnection and hopelessness. To investigate this further, staff working in a private hospital mental health service designed and implemented a research project to understand personal recovery from patients' perspectives. The method comprised four consumer focus groups ($n=16$ participants). Researchers analysed the data using inductive thematic analysis, identifying three themes: different pathways reflecting each patient's individual journey to personal recovery; challenges including experiencing hopelessness and distress, ups and downs, it not being easy, isolation and lack of support; and living well including wanting to return to everyday living, hope and acceptance, and feeling empowered. The findings suggest that the CHIME conceptualisation of recovery may need to be revised to include the experiences of hospital patients. The conceptualisation of recovery as a dynamic spectrum, with recovery moving up and down between challenges and living well may better represent hospital patient experiences. Patients also talked about a process not included in CHIME, of returning to 'everyday living' which was about getting back to doing everyday activities that most of us take for granted.

KEYWORDS
day-patients, hospitals, inpatients, mental health recovery

INTRODUCTION

Traditional approaches to recovery that focus on clinical recovery (i.e., remission of symptoms) alone are not sufficient to support people living with mental illness (Leamy et al., 2023). For recovery to be more holistic, it must include personal recovery, a concept arising from the consumer movement that encompasses the humanistic values of citizenship and being able to participate in the community, with or without symptoms of mental illness (Pelletier et al., 2015). The concept of personal recovery is complex to define, with many definitions identified in the literature (Jacob, 2015). One of the most robust conceptualisations of personal recovery, incorporating the processes of connectedness, hope, identity, meaning and empowerment (CHIME;

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Leamy et al., 2011), has been validated in multiple studies (Slade, 2012; Stuart, 2017; Vandewalle et al., 2019). Having a framework, such as CHIME, can facilitate the implementation of recovery-oriented practice to support people to live well with mental illness (Bird et al., 2014).

BACKGROUND

In addition to Leamy et al. (2011), several systematic literature reviews and validation studies have provided conceptualisations of personal recovery that highlight the complex and multifaceted nature of this concept. Ellison et al. (2018) identified four components of personal recovery frequently cited across studies: individualised and person-centred, empowerment, purpose and hope. Stuart et al. (2017, pp. 300–301) also identified elements of recovery not covered by CHIME, including difficulties, therapeutic input, acceptance and return to normality. Van Weeghel et al.'s (2019) review supported Stuart's (2017) inclusion of difficulties as part of the recovery process, highlighting the need to balance CHIME's focus on positive processes with an acknowledgement of the challenges. Bird et al. (2014) validated CHIME in community mental health services, demonstrating that the framework developed with people further along in their journey was also applicable to people's experiences earlier in their recovery. These findings suggest that the CHIME conceptualisation may fit people accessing hospital-based mental health services too, as they may be at a similar stage of recovery. However, few studies have included people accessing hospital mental health services.

A systematic search found only four studies on the conceptualisation of recovery in hospital mental health services. Two studies were conducted in the United Kingdom where participants had experienced a previous inpatient admission (Aston & Coffey, 2012) or were inpatients in a rehabilitation ward (Bredski et al., 2015). The other two studies were in Norway and Hong Kong, respectively, with participants in inpatient mental health facilities (Eldal et al., 2019; Siu et al., 2012). These studies highlight that, while sharing some similarities to people accessing community mental health services, the experience of recovery may be different during a hospital admission.

Similar to previous studies in the community, two studies identified the concept of hope (Bredski et al., 2015; Siu et al., 2012) and three studies found other CHIME elements, such as identity (Eldal et al., 2019), meaning in life (Siu et al., 2012) and empowerment through agency and opportunity (Bredski et al., 2015), were key to recovery during an admission. However, in hospital settings, recovery appeared to be experienced as a dichotomy between extremes rather than a process moving towards recovery in stages as suggested by previous conceptualisations (Andresen et al., 2003; Leamy et al., 2011). For example, inpatients experienced closeness/connectedness or distance in relationships (Eldal et al., 2019), and hopelessness or hope, with hopelessness being more prominent (Bredski et al., 2015).

These findings suggest that patients may be at different stages of recovery and that some recovery processes, like hope and connectedness, may be more important than others during an admission. However, with so few studies, there is no clear conceptualisation of personal recovery in hospital mental health services. Therefore, staff have limited guidance on how to support patients' personal recovery during an admission, not only as part of discharge planning for their return to the community.

Given the lack of clarity about the experience of recovery in a hospital setting, the researchers in the current study wanted to know whether the conceptualisation of personal recovery, developed in community settings, would fit the experience of patients during a private hospital admission. Researchers asked two questions: (1) What does personal recovery mean to patients during their hospital admission and (2) How can staff enhance their recovery-oriented practice in this setting? The first question is the focus of this paper. The second question is addressed in a dissertation (Lorien, 2021) with an article being prepared for publication.

AIM

The study aimed to understand patients' conceptualisation of personal recovery in the context of admission to a private hospital mental health service, to inform recovery-oriented practice.

METHOD

Participatory approach

This study was part of a larger Participatory Health Research project developed and implemented by private hospital staff to improve their understanding of recovery and to enhance their recovery-oriented practice. The researchers included four nurses, two psychologists, an occupational therapist, an administration officer, a patient advocate and an external researcher (PhD student/clinical psychologist who had previously worked at the private hospital). The researchers chose a qualitative methodology to enable them to explore this complex issue from the perspective of people experiencing the phenomenon of interest (Liamputtong, 2020). Focus groups were facilitated to understand patients' experience of recovery during admission to the private hospital's mental health service.

Setting

The study took place in a private, 24-bed private hospital mental health service in regional Australia that offered both inpatient and day-patient treatment. The service was open so patients could choose to leave at any time. Most patients presented with mood disorders and accessed medical treatment and group therapy programmes during their admission. The inpatient programme included two 1-h sessions each weekday and one-to-one appointments with each patient's psychiatrist and psychologist. The day-patient programme offered day programmes once a week for 8–12 weeks, on specific disorders (e.g., anxiety, depression, bipolar disorder) or personal recovery. Most day-patients had a previous inpatient admission.

Ethics

The university and private hospital Human Research Ethics Committees approved the study that was implemented from 14 August 2017 to 31 March 2019.

Procedure

Participant recruitment

All inpatients and day-patients accessing the mental health service at the time of the focus groups were invited to participate via an information flyer, with approximately half agreeing to participate.

Consent

All participants were given an information sheet describing the purpose of the research, the procedure, benefits and risks, the right to withdraw at any time and who to contact about any concerns or complaints. The consent form also included a statement to confirm that participation or non-participation in the research study would not affect the patient's admission. For inpatients, a nurse, who was not a researcher, also completed a 'consumer capacity to provide consent' form to indicate that the participant had the capacity to consent.

Focus groups

Participants were offered an individual interview or participation in a focus group. All participants chose the option of a focus group. Focus groups were designed to provide a forum for patients to share their collective knowledge, learn from each other through discussion and promote participant engagement in the project (Kamberelis & Dimitriadis, 2005). The facilitators followed Krueger and Casey's (2015) guide for research group facilitation, including how to structure the focus group discussion, present the questions and moderate the discussion so that all participants were comfortable and had the opportunity to contribute.

Separate focus groups were facilitated for inpatients and day-patients, held in the group rooms at the private hospital so that participants were in a familiar environment and staff were close by if required. The groups were co-facilitated by the external PhD researcher and the patient advocate. The duration of each focus group was 1 h to minimise adverse impacts for any participants experiencing fatigue or concentration difficulties. The focus groups were audio-recorded with the informed consent of participants. Due to short admission times, participants did not review transcripts nor provide feedback on the findings.

At the beginning of each group, the facilitators introduced themselves and explained their reasons for doing the research, which was to understand patients' experience of recovery during an admission and to complete a PhD on this topic. Then, the facilitators asked the prompt questions to generate discussion, including the focus question for this paper: What is your understanding of recovery in mental health? In responding to this question, facilitators encouraged participants to share their experience of personal recovery (i.e., living well with or without symptoms) rather than focus on clinical recovery (i.e., symptom reduction), during their private hospital admission (Note: Other questions related to participants' perception of recovery-oriented practice during their admission are reported in Lorien et al., 2024). The facilitators encouraged each participant to share their personal experience of recovery, during their admission, and invited other participants to add to the discussion if they had similar or different experiences.

Four focus groups were completed which was sufficient to reach saturation as defined by Fusch and Ness (2015) as no new data and themes were identified by group four. No demographic details or information on diagnosis or acuity were collected, to protect participants' identity because, except for the focus group facilitators, researchers were staff working with participants during their private hospital admission.

Data analysis

Inductive thematic analysis (Guest et al., 2011) was chosen as researchers wanted to explore the meaning of recovery during an admission without limiting the scope to pre-defined conceptualisations from previous research. The external researcher transcribed the focus group audio recordings, numbered each quote made by participants, printed these and cut the paper into strips containing one quote per strip. Over four successive meetings, researchers sorted the quotes into themes, reaching a consensus agreement through discussion. In implementing the thematic analysis, researchers were guided by the DEPICT model (Flicker & Nixon, 2015), exploring what seemed to be the important themes, where there was agreement or the need for further discussion and changes, which quotes fitted with each theme, consideration of anything important that may have been missed, and how the findings would be shared.

The audit trail for data analysis comprised the audio recordings, verbatim transcriptions and tables showing the progressive coding by researchers.

RESULTS

Four focus groups took place between August and November 2017, two inpatient groups and two day-patient groups. Sixteen patients participated in the study, including ten males and six females. Ten participants were inpatients, and six were day-patients. No participants dropped out during the study. Some inpatients were not well enough to provide consent, and some day-patients were not available to attend.

The consolidated criteria for reporting qualitative research (COREQ) checklist were used for reporting the methods, analysis and findings of the study (Tong et al., 2007). Pseudonyms are used for reporting the results.

Three themes were identified in the analysis: different pathways, challenges and living well. Within these themes, nine overall sub-themes were identified reflecting the experience of participants. Table 1 provides an overview of the conceptualisation of recovery under the themes and sub-themes identified by the researchers.

Different pathways

The theme 'different pathways' recognised that recovery was an individualised journey where 'not one size fits all' (Emma). Four of the 16 participants conceptualised the recovery journey as developing a new way of living, with some ongoing symptoms, 'the recovery track'.

> My belief is that you can't ever be cured. The rest of our lives we're on a recovery track.
>
> (Kevin)

> I used to think, I'm going to get well, I'm going to be symptom-free… but you realise very quickly that that isn't the case. … For me, it's accepting that. You live with the disorder that you have and learn strategies and ways of dealing with it.
>
> (Emma)

Four participants talked about 'getting back to where we were' before the onset of mental health problems. However, there was a recognition that this desire was not wholly possible.

> …We were trying to get back to where we were. As close as we could to where we were happy or close to being to that stage, that liveable state.
>
> (Myles)

> To … be recovered, I need to get back into the workforce, I guess. I haven't worked in a couple of years. [So, getting back to where you used to be?] Yes, or anywhere that resembles that.
>
> (Ben)

TABLE 1 Research themes and sub-themes.

Theme	Sub-themes
Different pathways	Recovery track
	Back to where we were
Challenges	Hopelessness and distress
	Ups and downs
	It's not easy
	Isolation and lack of support
Living well	Everyday living
	Hope and acceptance
	empowerment

Challenges

Challenges were a significant part of recovery for participants in the context of an admission. There were four sub-themes identified under challenges: hopelessness and distress, ups and downs, it's not easy, and isolation and lack of support.

Ten participants spoke about 'hopelessness and distress' associated with mental illness symptoms describing the loss of hope.

> It's a bitter pill. Everything's against you. You lose all hope.
>
> (Jenny)

> When I'm depressed … everything just seems meaningless … it just takes away the hope.
>
> (Ben)

> I was going across the bridge the other day and [thought] it would just be better if I jumped over the side.
>
> (Lance)

Participants also described how the symptoms of mental illness were distressing mentally and physically.

> When my thoughts are running wild, my whole body is tense, stomach is knotted, and you just feel like rubbish.
>
> (Jack)

> This all goes into the one big spiral. Once you start [thinking] negative, you lose sleep, you lose everything.
>
> (Doug)

Over half the participants talked about the 'ups and downs' of their experiences, reflecting the experience of cycling between living well and experiencing mental health challenges.

> I had a few ups and downs recently … I've been going really good until … [I] sort of crashed down and thought, 'what the hell?'.
>
> (Lance)

> You kind of feel well and you let … things creep up on you … and before you know it, you are really not well again.
>
> (Emma)

Eight participants talked about how 'it's not easy' and how hard they worked on their recovery. Participants struggled with having the agency to do everyday things that they knew would be beneficial.

> The dream is to go back to being great at everything. For me, that is something that's going to be … really hard to get to.
>
> (Kevin)

> There are things… I need to do to keep recovery on an even keel, like meditation, relaxation (Emma).
>
> (Emma)

At times participants said that they found it too difficult to do even simple things.

> It's too hard, even the little things
>
> (Ben)

> I can't get off the couch
>
> (Emma)

Twelve participants talked about how they experienced isolation and lack of support outside the private hospital.

> You feel so alone… When I'm bad, I go within myself, I don't annoy anybody, I tend to be almost in a cupboard.
>
> (Jack)

> I really dug myself a deep hole and just totally isolated myself from … external family.
>
> (Myles)

> The hardest part for me is that feeling of being alone… I don't connect with people … Life is just vanilla.
>
> (Emma)

Participants spoke about having difficulty talking about their experiences to people who would not understand, which added to their sense of isolation.

> Someone outside … doesn't have a clue.
>
> (Doug)

> Sometimes it's hard to talk to family … I've got a daughter … and son … and I have never spoken a word to them about it.
>
> (Kevin)

Participants also talked about the challenges of getting help when they were not unwell enough to be in the private hospital.

> That stage, where you are not critical, and you are not good … But they wouldn't admit you to hospital for that … so you are in no-man's land.
>
> (Emma)

Living well

Ten participants spoke about the concept of living well, which was about living a good life, with or without symptoms. The themes were identified for living well: everyday living, hope and acceptance, and empowerment.

Some participants wanted to get back to everyday living where they could participate in normal activities. Everyday living was similar to the theme 'back to where we were', with participants wanting to get back to doing the basics that most of us take for granted.

> To be able to do your everyday things.
>
> (Emma)

> Being able to do things, shower, make meals … without feeling like they are big things,

> struggles … Being able to work … Trying to sort out my basics of coping with life in general.
>
> (Myles)

> It would be lovely to be able to control my moods or keep it in the comfortable zone where you can go out and have coffee with friends and do a day's work.
>
> (Trevor)

> Recovery to me is … where you can get on with your life and you can do most things… without having to think twice about it.
>
> (Olivia)

Four participants spoke about hope and acceptance as part of their recovery compared to almost two-thirds who spoke about hopelessness and distress. Surmising that hope and hopelessness are part of the same continuum, most participants discussed some aspect of hope, including the three participants who spoke about their experience of hope and hopelessness. For example, Ben described how his depression '*takes away hope*', but that he also needed '*something to look forward to*'.

Other participants spoke about self-acceptance, which was an aspiration rather than what their current experience represented.

> I have to accept that I've got this disease. That I have to somehow learn to love myself with it … I've got to learn how to love myself, as I am, not how I'd like to be.
>
> (Jenny)

> Learning not to beat the crap out of yourself over being different. Just accepting yourself.
>
> (Myles)

Nine participants spoke about empowerment as being part of their recovery, similar to the concept of empowerment identified by Leamy et al. (2011). Some participants talked broadly about taking responsibility for their recovery.

> You have to be invested in your own recovery. You have to want to recover.
>
> (Josie)

> The [staff] can guide you but it's up to you to make the effort. … If you want to get over it, you're going to have to do something yourself.
>
> (Kevin)

Other participants provided examples of how they took control of their recovery.

> I like hands-on work … It keeps [my] mind off what else is around, and I suppose I can regulate that … so that's how I can pull myself up.
>
> (Jack)

> I'm building a [mechanical device] … to keep me busy. I like to keep my brain active.
>
> (John)

Living well represented the positive components of recovery (the 'ups') at the other end of the spectrum to challenges (the 'downs').

In addition to analysing the overall themes, the researchers reflected on the holistic experience of personal recovery for each participant, in relation to the CHIME processes, and the additional process of 'Everyday Living' identified in the themes. For example, Figure 1 shows Emma's experience for each CHIME process. Emma was at different places on the continuum, for each CHIME process. She experienced more isolation and hopelessness, than connectedness and hope. She had become more accepting of life with the disorder and taken responsibility for maintaining her well-being through using strategies like meditation and relaxation. Despite this, Emma still described life as 'vanilla' lacking those things that made life more interesting or meaningful.

Figure 2 shows that participants were at different places on a continuum between getting back to everyday living and disruption to everyday living. Ben and Emma's talked about the disruption to everyday living, whereas Trevor and Olivia described experiences of getting back to doing everyday things.

DISCUSSION

This study found some similarities and differences to research on the conceptualisation of personal recovery in community settings, particularly in relation to the CHIME conceptualisation (Leamy et al., 2011). Two opposite but complementary themes were identified in the analysis: challenges and living well. The theme of 'challenges' aligned with the process of 'difficulties' identified in systematic reviews (Stuart, 2017; Van Weeghel et al., 2019). Challenges represented participants' experiences at the opposite end of the spectrum to living well identified in CHIME (Leamy et al., 2011).

Participant accounts indicated that their recovery journey was not unidirectional, instead moving up and down between challenges and living well. This finding is consistent with the CHIME conceptualisation (Leamy et al., 2011) and the finding of Ellison et al.'s (2018) systematic review. However, the current study findings suggest that recovery may not progress in stages across all recovery processes simultaneously as suggested by previous models (Andresen et al., 2003;

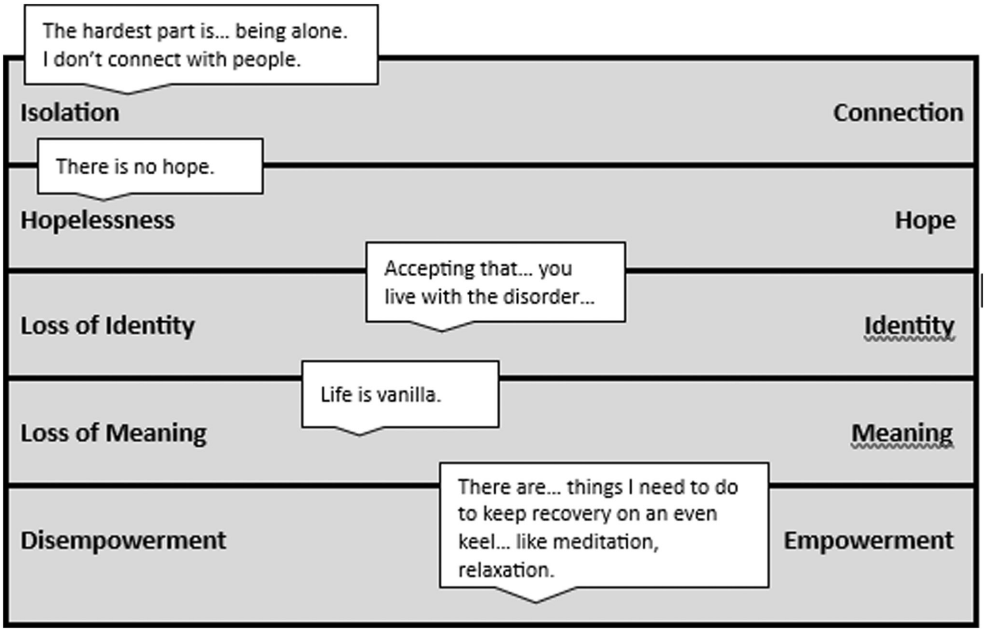

FIGURE 1 Emma's recovery spectrum on CHIME.

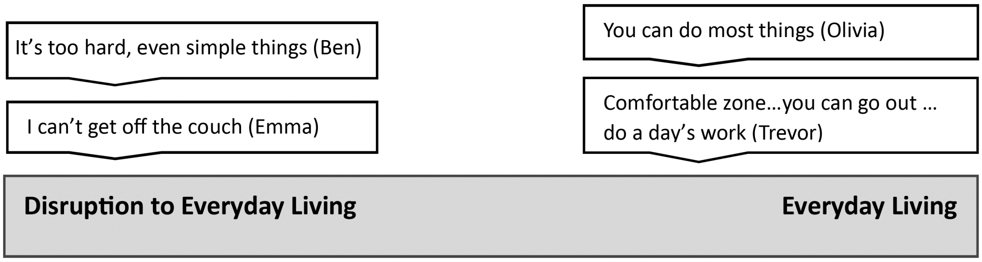

FIGURE 2 Recovery as a return to everyday living.

Leamy et al., 2011). Instead, participants experienced ups and downs at different times across each of the CHIME processes. This variability of experience across processes changes the conceptualisation of recovery moving in stages from moratorium to growth (Andresen et al., 2003) to seeing recovery as a dynamic spectrum. The spectrum conceptualisation recognises that recovery is bi-directional and that an individual may be at a different stage in each process (as exemplified by Emma's experience in Figure 1).

The study also identified specific CHIME processes (Leamy et al., 2011) on the spectrum. Hopelessness identified by participants was at the opposite end of the continuum to hope. Andresen et al. (2003, p. 591) describe the first stage of recovery, 'moratorium', which includes a sense of hopelessness and withdrawal from the world, and this fits with the experiences described by participants in this study. Bredski et al. (2015) also found that hopelessness rather than hope was the primary emotion experienced by inpatients.

Another CHIME process raised in focus groups was connectedness. However, participants primarily spoke about the challenges of disconnection, that is, isolation and lack of support. Participants also discussed the CHIME process of empowerment, which developed as participants felt they could take control of their recovery. A similar concept was also identified by Bredski et al. (2015) to describe goal-directed behaviour that inpatients identified as part of their recovery.

The findings identified a new recovery process, which is the process of getting back to everyday living and being able to do normal, everyday activities. Getting back to everyday living was particularly important as these activities had been disrupted by a hospital admission. Patients did not talk about living their best lives (i.e., living well) but about simply being able to do everyday activities like having coffee with friends, going to work and being able to *'do most things'* (Olivia). Similar to Stuart et al.'s (2017, p. 301) finding that some people wanted a *'return to normality'*, participants in this study wanted to return to the normal activities of everyday living that most people take for granted.

The most validated conceptualisation of recovery, CHIME (Leamy et al., 2011), does not reflect the importance of a return to everyday living that was critical to participants during a private hospital admission. Therefore, the findings suggest that extending CHIME to include 'everyday living', that is, CHIME-E, may better reflect participants' perception of recovery during an admission. The other CHIME processes reflect the concept of living well but do not cover being able to do the practical tasks of everyday living (see Figure 2).

Limitations and strengths

This study had some limitations and strengths related to the design and methodology. A limitation was that the findings were interpreted primarily by professionals rather than patients who were study participants. However, a strength of the researchers comprising mental health professionals and a patient advocate was that the private hospital managers trusted researchers to talk with patients, who were a vulnerable population. To counter their biases, the researchers consciously used direct quotes from participants to demonstrate the evidence on which conclusions were based and sought feedback from the hospital consumer reference committee.

A limitation of the study was its limited generalisability to other hospital mental health services. While the setting is similar to other private mental health services, each service has differences relating to size, location, patients' diagnoses and interventions provided. Also, demographic information was not collected, to protect the privacy of participants; however, this limited the transferability of the findings. However, a strength was that the researchers described the context and process of the research so that other researchers could decide whether the process or outcomes were relevant to their setting.

Another limitation of the study was that only one researcher had lived experience as a patient. Having current patients and staff working together as researchers raised an ethical dilemma about how to manage dual relationships. In hindsight, more patient researchers who had previously had an admission could have been invited to participate, so they were familiar with the context but were not current patients.

CONCLUSION

At the commencement of the research, researchers expected that participants' descriptions of recovery would mirror Leamy et al.'s (2011) CHIME conceptualisation. However, the findings indicate that the conceptualisation of recovery, based on research in community settings (Bird et al., 2014; Leamy et al., 2011; Slade et al., 2012; Stuart et al., 2017; Van Weeghel et al., 2019), may need to be updated with the inclusion of patients' experiences of recovery during a hospital admission. Challenges were less about the concept of 'living well' and more about wanting to return to everyday living. Depicting recovery as a spectrum may provide a more holistic and relevant representation of recovery incorporating each of the recovery processes on a continuum from challenges to living well, while recognising that each person may be at a different stage on each process at any point in time.

Further research is required to validate the conceptualisation of recovery as a spectrum, incorporating challenges and living well, including whether the additional process of 'everyday living' can be generalised to other patients who are accessing hospital mental health services.

RELEVANCE FOR CLINICAL PRACTICE

Based on the conceptualisation of recovery identified in this study, there are several recommendations to improve recovery-oriented practice in hospital settings:

1. Professionals need to acknowledge the challenges associated with personal recovery and listen to patients' lived experiences, particularly concerning challenges which are particularly salient during an admission.
2. Connectedness and hope are key to recovery. Professionals can help by creating opportunities for patients to connect with others and by holding hope for patients when they are experiencing hopelessness.
3. Patients have experienced significant disruption to everyday living during an admission. Providing opportunities for patients to start doing some activities of daily living (e.g., self-care and socialising) may support their recovery.

AUTHOR CONTRIBUTIONS

Conception and design of the study, and acquisition of data: L.L. and D.M. Analysis and interpretation of data: All authors. Drafting the manuscript: L.L. Revising the manuscript critically and contribution to the intellectual content: All authors. Approval of the version of the manuscript to be published: All authors.

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CONFLICT OF INTEREST STATEMENT

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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