THE EUROPEAN SOCIETY OF MEDICINE
Medical Research Archives

RESEARCH ARTICLE

Challenges with Systems Level Recovery Transformation in Westernized Cultures: Inpatient Psychiatric Settings in Public Mental Health and Avenues for Hope and Change

Erika Carr

Yale University School of Medicine, Department of Psychiatry, 34 Park St. New Haven CT 06511

OPEN ACCESS

PUBLISHED
31 July 2024

CITATION
Carr E., 2024. Challenges with Systems Level Recovery Transformation in Westernized Cultures: Inpatient Psychiatric Settings in Public Mental Health and Avenues for Hope and Change. Medical Research Archives, [online] 12(7). https://doi.org/10.18103/mra.v12i7.5386

DOI
https://doi.org/10.18103/mra.v12i7.5386

ISSN
2375-1924

ABSTRACT

There has been much written now in the field on recovery-oriented care, its empirical impact, and the need for systems transformation for working with those with serious mental illness across the globe. However, there is still a dearth of that systems level recovery transformation occurring within inpatient settings, as opposed to outpatient, in public mental health and effectively, as the literature reflects. There are even questions of whether it is possible to engage in systems level recovery transformation within inpatient settings that are so structured and set in form, while there is more evidence of recovery transformation systemwide within outpatient services in mental health. This article highlights challenges for recovery-oriented systems change and how inpatient psychiatric settings within public mental health may be experienced, including issues of power and control, violation of basic human rights, racist experiences and overuse of seclusion and restraints for patients with racial minority identities, exacerbation of intersecting oppressive experiences, challenges with civil commitment and conservatorship, arbitrary and inhumane rules, and a strong focus still on diagnosis, medications and symptom amelioration. Despite barriers this article advocates for continuing hope and effort into providing systems level recovery transformation and discusses mechanisms of change in the direction of that transformative process for systems and providers to engage. Such mechanisms include involving senior administration and others throughout systems towards this overall goal and effective manners of collaborative change across disciplines. The article details those skillful systems change strategies in leadership and practical applications to help systems conceptualize how they may make such transformation.

Keywords: Recovery-oriented care and systems change, serious mental illness, inpatient psychiatric care

Introduction

Buzz words come and go but one of the recent zeitgeists in public mental health settings, where those with serious mental illness (SMI) receive services is about systems change and recovery transformation[1]. Systems change in the direction of recovery-oriented care relates to the idea that people are not just patients and they have a right to live a life of meaning beyond the effects of mental illness[2] and fostering systems level recovery transformation (SLRT) reflects such new values and constructs. To expand, some of the basic constructs of recovery-oriented care include a holistic look at the person and recovery, recovery envisioned as a journey that is non-linear rather than focused on symptom amelioration, developing autonomy and choice, personal responsibility for one's own life, holding hope, partnering with others in recovery with lived experience, incorporation of cultural responsiveness, divorcing punitive measures from mental health services, and developing valued social roles in the community. These constructs and such a systemic outlook are still frequently quite different than the way most inpatient psychiatric settings in the public sector across the globe are set up to function with an enduring focus on symptoms, diagnoses, medications, and "adherence" to the medical community's view of psychiatric problems[3,4].

The need for SLRT appears quite evident to many, critical for the future welfare of those with SMI, and for a real recovery process to occur given the egregious accounts of trauma, deaths, sexual and physical aggression, violation of basic human rights, and other atrocities that occur regularly within inpatient psychiatric settings[5,6,7]. Others may discredit the need for SLRT and even advocate for days when people were in more asylums and the answer to homelessness itself is to make more psychiatric beds[8]. But if the raw proclamation of the need for SLRT seems too stark or is hard to stomach given one's own positionality within the helping field, it may be worth examining. Thus, one must contain the affect or perceive the situation in a way that is ego-syntonic to reckon with the inability to make change or take up the charge to help make change; be a part of the system as it is or seek to change it. But as Desmond Tutu[9] said, "If you are neutral in situations of injustice, you have chosen the side of the oppressor."

Thus this article, first discusses some of the challenges and barriers with making change related to SLRT and how that sets a difficult stage for change. However, this article also details the science that values the efforts of recovery-oriented care in the well-being for those seeking mental health services and then explores the idea of holding hope for SLRT within inpatient settings. The article also ends with practical strategies and mechanisms to engage in to foster SLRT within inpatient psychiatric settings for those with SMI.

Some Snapshots of Inpatient Psychiatric Settings in Public Mental Health

Since there is concern for the need to engage in SLRT or the belief that many settings have actually already achieved that higher goal, a snapshot of how many inpatient settings currently look across the globe is warranted.

Trauma

Within inpatient settings across the globe, the quantitative and qualitative data demonstrate high amounts of traumatizing events which occur in many different ways. This may relate to experiencing seclusion and restraints, witnessing others in seclusion and restraints or having a difficult crisis, having a lack of privacy, experiencing sexual, verbal, and/or physical abuse, experiencing power and control dynamics, and a number of other traumatizing experiences that people with lived experience report[5,10,11,12]. Sexual trauma is also higher among women within such settings and this is expressly concerning given many women with SMI already have a sexual trauma history[13].

Models Non-holistic

Despite the advancement and knowledge in models of care that are effective such as shared-decision making[14] and person-centered treatment planning, as well as collaboration with those with SMI in their recovery process, there is still a strong focus in most inpatient psychiatric settings on medical models that focus on symptoms, coercive methods of containment, taking medications and the medication being the primary focus of treatment[4,11]. This may be due to the nature of settings having a lack of beds, short lengths of stay, being understaffed, and innovations such as recovery ideals viewed as harder to implement in already distressed systems of care. Relatedly, though there are many evidence-based treatments out there for psychotherapy and even so for those with SMI, they are rarely offered in the public sector[15].

Racism and Disparities in Care

Studies indicate inequities in restraint use for racial minority groups across 4,000 inpatient stays, which is sustained after adjusting for confounding variables[16]. Similarly, involuntary commitment heightens the unjust police force and brutality against BIPOC individuals just as in our communities across the globe[17,18]. The literature indicates that Black people are still over diagnosed with disorders such as schizophrenia in comparison to White people and racial minorities are more likely to be on higher doses of antipsychotics and also less likely to receive lower-metabolic risk second generation antipsychotics than White people[19,20]. Despite there being noise about anti-racism efforts within mental health care there is little reflection of change within most inpatient settings[21].

Seclusion and Restraint Remains Highly Used

Though there is no evidence of seclusion and/or restraint as having a positive treatment outcome, but rather lots of evidence of its traumatizing nature and rather use as a containment method[4,11], it is still overly relied on to control behavior in most inpatient settings that are public and not privatized. Though many groups in mental health and of global human rights have done work calling for change such as the Council of Europe, United Nations[22], Substance Abuse and Mental Health Services Administration[23] and the American Psychiatric Association[24], there is still no positionality statement on the use of seclusion and restraint by many organizations (e.g., American Psychological Association) and therein related advocacy efforts and work products to effect change at unified global levels, and federal, state, province, community, and village levels within countries, which might impact mental health care and the lives of those facing such containment measures.

Lack of Beds & Incarceration more Prone than Treatment

Most of those with SMI are in jails and/or prison rather than in inpatient hospital settings with recovery principles helping them live a life of meaning[25]. In fact, across 24 countries there have been high rates of those with SMI being imprisoned with a trend in a rise of those with SMI in low-to-middle income countries, which is concerning given the lack of appropriate mental health treatment settings. In jail/prison settings those with SMI are not adequately treated, have lengthy sentences, and are at unique risk for traumatization[26]. Estimates in the United States indicate that more than 2 million people with SMI are booked into jails annually (e.g., approximately 15% are men and 30% are women) and having a SMI is a risk factor for incarceration[27,28]. Additionally, there are still major problems with those awaiting evaluation for competency to stand trial, while their mental health deteriorates inside locked bars, without appropriate treatment[25,26]. They are also frequently overmedicated and experience lengthier incarceration than those without SMI.

Civil Commitment and Conservatorship/ Guardianship

Civil commitment and conservatorship/ guardianship is a challenge globally. Studies show that 38% of patients in inpatient psychiatric settings

are admitted involuntarily globally, while 62% are voluntary[29]. There is not consistent data across U.S. states, as well as other countries, and a vast lack of public tracking of civil commitment statistics related to frequency of use, who is most affected, outcomes, length of commitments, rates of overturn of civil commitments, and trends over time[30]. Research also indicates that providers involved with civil commitment are not adequately educated on the laws behind civil commitment with 30% of 700 psychiatrists evaluated in the United States providing incorrect answers about the correct grounds for civil commitment[31]. Since there is not public tracking, there is an immense challenge with people knowing their rights regarding civil commitment, having any ability to overturn civil commitment, and ability to navigate such complicated legal frameworks[31]. Relatedly, a systematic review of more than 40 studies found that compulsory community treatment did not have a clear positive outcome on recidivism and use of inpatient beds[32]. There are problems in many countries such as there being no requisite for a court hearing for civil commitment in a mental health crisis such as each state within Australia having different rules for commitment, making it difficult for systemic and national regulation and rights of this process[33]. Additionally, in Australia, in some states, one can just have a mental health issue or diagnosis and not be at imminent harm to themselves or others for involuntary commitment, which is a softer requirement than in many nations and states. In Germany, there is now an increase in the use of the legal law on guardianship to involuntarily commit someone to a hospital and then the police can act on that instead of use of mental health law, thus making it easier for the guardian to decide the person needs treatment and have the authority to dictate that rather than a psychiatric professional[34]. In Switzerland, there is a high number of people that are civilly committed and some of which is related to being older, which canton of Switzerland they live in, and having schizophrenia[29].

There are similar problems with conservatorship among those with SMI that find themselves hospitalized involuntarily and conserved. Countries such as Denmark, Spain, Germany, and the Czech Republic have high conservator/guardianship rates and in the Czech Republic there is specifically a higher association with having schizophrenia, being conserved, and being a woman versus a man in the age bracket (40-59)[35]. In many states in the United States the legal statues uphold that though a person may be conserved the conservator should strike a balance between preserving the autonomy, will, best interest, and decision making of the individual being conserved while protecting the individual and/or others from harm[36] which is similar to other European countries. Despite this being the case, in practical application of conservatorship this is rarely true and unjust liberties for conservators can be taken, overrunning the wishes and autonomy of the individual with SMI, which can also make it impossible to overturn conservatorship. Though the Uniform Law Commission enacted the Uniform Guardianship and Protected Proceedings Act (UGPPA)[37] in the United States, which sought to strengthen the protections for people who had conservators in 1997, only seven jurisdictions adopted this Act up to 2014[36]. Following this Act, some jurisdictions required conservators to file more regular reports of the conserved person's condition and evidence of need for continued guardianship, authorized the court to have a third-party appointee to also report on the conservatorship process, provided limited guardianships/conservatorships rather than full conservatorships, and authorized removal of conservators that are not legally and appropriately following the best interest of the one conserved. However in 2017, there was an updated Act developed called the Uniform Guardianship, Conservatorship and other Protective Arrangements Act[37] to replace the UGPPA developed in 1997, with recognition that it was not being complied with well across states in multiple manners, including granting limited conservatorships, evaluation of

need for continued conservatorship and granting third-party oversight, among others.

In reality, beyond the statistics, the narratives and stories that most clinicians bear witness to when working with those with SMI in inpatient settings in public mental health settings is that conservatorship is extremely difficult to overturn, many conservators are hard to communicate with, and there are difficulties with having one's preferences honored. It is rare that systems and courts review conservatorship and the necessity for it. If it took Brittany Spears, a global star, an expansive length of time to regain her personhood[38], with her wealth and power, how much chance does a transwoman who is Black, experiences homelessness, and has a history of substance use and sex work have to rid herself of the chains of conservatorship, though she is now in the community, out of the hospital, healthy, and working?

The author is not opposing every form of involuntary treatment or conservatorship that may help a person from a recovery perspective and with access to human rights, but is strongly concerned about the way it is conducted typically on an everyday basis globally, with a lack of transparency, ability for basic rights, and standards. At the very least it is worth a heavy review of how much more human rights do systems take the liberty of vacating from their rightful owner and requiring legal consequences of such endeavors to obstruct basic human rights on a global platform.

Arbitrary Rules and Lack of Privileges

Though there are some guidelines and rules that are necessary for risk and safety within inpatient psychiatric settings there are others that mimic power and control dynamics and a "us versus them" mentality. This has long been studied[39] but not much has changed in the business of providing inpatient care in public mental health. To shed light on just a few of such rules the next sections will first discuss the strident nature of power and control dynamics within inpatient psychiatric settings, causing great challenges, and then provide examples. These are provided as a call to action for further leadership in recovery-oriented and citizenship perspectives across the globe. Lastly, some mechanisms for systems level recovery transformation in mental health systems will be offered.

Rules May be Arbitrary But Must be Abided By!

Hundreds and thousands of different rules exist within inpatient psychiatric settings in public mental health settings. These may exist across many different settings or countries, with no consistency or empirical merit and little to no evidence of their utilitarian nature. Seemingly, this may reflect the stigma and power and control being wielded in such settings and the ideology that those with SMI are locked up because there may be some fault within and a likening to badness or immorality or criminality[40]. This is easily demonstrated with the strident obsession with rules on the smallest details within many inpatient settings. The issues of power and control within these settings and the destructive nature of those dynamics has long been studied, but little transformation has occurred globally[41,42].

Technology and TV Time: Don't Touch the Remote Control!

There are strong elements of control by others[43] and one rule that demonstrates such relates to there being a sign up for TV time, typically, as there is likely one tv on most psychiatric unit, if at all, and it is highly controlled by others. Relatedly, this may be one of the only things centered in a barren milieu, lacking most amenities, as a means to entertain patients, but yet espousing conflict and greater control[44,45,46]. However, patients may not be able to use the remote control during their set time to use the TV or pick what they watch, creating a symbolic sign of revoking control to the point of not trusting individuals to push a button in such a simplistic but powerful and ironic way. If one is in a medical hospital there is typically a TV with a remote that is always there, day or night to use at one's will (e.g.,

one can watch golf, a romantic movie, cartoons, or the news, etc.). On an inpatient psychiatric unit, the content is likely to be highly censored, presenting an artificial and somewhat infantilizing environment.

Though most of the world cannot exist now without a cell phone most all inpatient psychiatric settings in public mental health do not allow people to have their personal cell phone, thus cutting them off from everyday life by being able to stay in contact with friends, review their social media, set their schedule, set timers for important events, read news, email for work and/or connection, check on their medical issues, and the list goes on. Ironically, this has also only minutely been studied regarding the true risks versus benefits of allowing inpatients to maintain cell phones on their person[47]. In this study in New South Wales, where 85 % of the country does not allow cell phone use within psychiatric inpatient settings, the benefits posed by people in recovery of having their cell phones were primarily about maintaining social connection and the staff's focus and concern primarily was on that cell phone autonomy was a violation of rules, despite patients noting it may be a basic human right and help them with social connection and thus their mental well-being.

Material Possessions are Not Important.

There are all types of material possessions which one cannot have within an inpatient setting due to the risk of harm to self or others when people may have a suicide risk or may have aggression. However, most frequently this is not reviewed per patient and typically this gets taken to an extraordinary manner. When one is locked within an inpatient setting, belongings, rightfully so, take on a new and very important meaning. Relatedly, an ethnographic study of the meaning of material possessions within inpatient settings highlighted strong meanings both in terms of wellness and relationship to others that is worth examining for its implications for recovery[48]. Despite this knowledge, even small material possessions like a bracelet, with a breakable, short elasticity may not be allowed, even though it is a soothing object for a patient. Magazines and snacks may not be allowed either, among others.

Food: Don't Eat too Much, too Little, Save it, Share it, or Complain About it.

Food is a basic need of survival and also a source of comfort, culture, and healing for people. It does not take much imagination to perceive that if a patient is locked up that food is important, vital, and comforting. However, this aspect of inpatient settings can be quite punitive. One study indicated how patients felt their food intake and the manner in which they were supposed to consume it was highly controlled, prison-like, and held arbitrary rules[49]. Many inpatient settings do not have healthy, desirable, culturally appropriate, large enough portions, or satisfying options for food intake according to inpatients. Also, it is highly monitored in that there are structured times for meals and snacks. Frequently there are also strict rules about not sharing food, not storing food for later, not buying food from others, and breaking such rules may lead to a volatile event[48]. Relatedly, if a family member or friend brings food the family member may be restricted from making it themselves but have to order it from a food service, denying cultural comfort. Some units also demand that the food can only be consumed then, at that time and any leftovers discarded, and cannot be shared with fellow patients. As one can imagine many conflicts on inpatient units occur due to the overregulation of food, a basic need and a comfort.

Timing: It's our Schedule not the Patients.

Time is not the patient's own within inpatient settings. It is owned by the schedule of the "therapeutic milieu." Medications are given at a certain time, vitals are as well, breakfast, lunch, and dinner times are set (sometimes being expected to eat dinner quickly for shift change)[45,49]. Relatedly if patients can not adhere to these basic structures, medications frequently cannot be given later, when one wakes up after a long nap, or another meal provided when

ready to eat, in contrary to typical medical hospitalization.

Level Systems: Earn Levels for Rights.

To prove one's merit on many inpatient settings there are also level systems that researchers are now questioning since the set-up of these models are infantilizing, punitive, and may just indicate how willing a patient is to abide with arbitrary rules, rather than an indicator of psychiatric improvement or wellness[50]. If a patient is not meeting expectations to gain levels they are typically deemed noncompliant and are likely not allowed to do things such as get fresh air, have visitors, go on outings, or have other special privileges (which would be basic rights in a medical hospital and in many prison settings they would be basic human rights).

Shower Up!: Despite the Lack of Privacy & Trauma Histories.

One way of monitoring the mental health of individuals within inpatient settings ironically relates to their frequency of showering or not. This also may relate to moving up in levels. Ironically, when people do not feel well and may be depressed and/or have other mental health problems their activities of daily living may decline but units may have a coercive dynamic around these activities of daily living[51]. Many inpatient settings have multiple roommates in a room and there also may not be a durable door due to safety features, for fear of ligature risk, and many patients do not wish to take showers. It may be due to the lack of privacy, noted by many with inpatient experience who note a lack of privacy as traumatic[5,46] or many other reasons such as psychosis or paranoia of water, past sexual trauma, etc. But in reality many people do not take frequent showers when in a medical hospital as they are also out of their comfort zone, but differently, the measurement of showering or not, does not deem one well enough or not to be discharged. This measurement of the increased wellness of individuals seems worthy of reexamining in light of the rationale of why people may have difficulty showering within such inpatient psychiatric settings and due to the fact that they may need other supports (and psychological safety) to perform their hygiene.

Milieu Therapy: Take Your Meds, Get Vitals, and Go to Groups!

In many inpatient psychiatric settings one of the primary mechanisms to get discharged is to "comply" with taking medications as prescribed and this is frequently noted as being medication adherent[52]. In fact, a review of studies does show statistically significant differences for those who took medication willingly versus those who received involuntary medication (termed coercive medication in some of the literature)[52,53]. Another road to discharge is engagement in the therapeutic milieu and attending groups. In fact the author at times has born witness to patients being very direct with other patients about the basic cliff notes on being discharged; "take your meds, tell the docs you will keep taking them when you get out, and attend the groups." It is extremely rare, for individuals to be hospitalized psychiatrically and be able to sustain the avoidance of taking medications in most psychiatric hospitals. Frequently, involuntary medications are likely to be sought via a court hearing, if a patient is unwilling to take medications, and such hearings are difficult for a patient to win[54]. The longer some patients disagree on taking medications they may face involuntary administration with an injection, at the hands of a court order, and/or longer hospitalizations, as many are there to get "stabilized" and the medical model remains predominant in most countries[53].

Whatever You do: Don't be Interested in Sex!

Though many people with SMI face chronic and lengthy hospitalization experiences related to increased symptoms and other intersecting experiences such as homelessness, trauma, intimate partner violence, and substance use there are little to no mechanisms to address the health of these individuals' sex life[55]. It is as if sexuality is nonexistent; the idea or stigma frequently is that if people experience SMI they are asexual or should be and

sexual activity or interest may be negatively viewed. There is little literature on how inpatient settings develop healthy mechanisms to address healthy sexual activity, discuss it with their patients, explore concepts such as consent, sexual identity, and sexual activity, though many with SMI are prone for risky sexual behavior and see it as an unmet need[56]. Though individuals may end up on a unit for a long time, the unspoken rule seems to be, 1) just don't do it, 2) don't talk about it, 3) and don't partner with another patient and try to have consensual sex with them, and 4) there is not a space to talk about your sexuality.

Just be a Good Patient While Inpatient!: That is Your Role.

The idea that individuals with SMI might feasibly go from inpatient units to maintain a current job, obtain a job, do volunteer work, attend an intensive outpatient program, etc. is frequently obsolete and/or rare[21]. Most settings do not offer normative daily activities if hospitalized that hold valued social roles and a normalcy of life, thus further disconnecting people from society and disenfranchising them as citizens. Instead, the focus is predominantly on being a patient within that time frame. Relatedly, strong themes of boredom and that patients feel like they have nothing to do (but watch television) reiterate across many studies[45,46,49]. If individuals have a job and/or such a structured life before admission to the hospital it may be devastated after hospitalization, as many lose activities, jobs, and connections. One recent study, showed that as many as 30% of patients who were hospitalized for a psychiatric emergency, who were employed at the time of admission, did not return to work after discharge from the hospital[57]. Thus hospitalization can decrease the citizenship status of those with SMI and further marginalize them with increased poverty and unemployment status[58].

The Possibility – or Not - of SLRT in Inpatient Psychiatric Settings

One of the next big questions as we think about SLRT for many of us, is recovery-oriented care possible across all systems and within the most difficult spaces, such as inpatient settings? In other words, is there room and are there avenues to affect change or could it be too difficult or impossible? It seems that we know from the literature that it is already a difficult process and it has been difficult to see much, if any SLRT within most inpatient settings[21].

If SLRT is so hard to facilitate and seems so impossible, *why is it so hard*? Most of the people that work in mental health care organizations go to work and are well meaning people. Yet, such bizarre and unhealthy dynamics still occur within inpatient settings, causing trauma instead of healing[5]. So why are systems so stuck and why is it hard to make true SLRT occur in everyday services?

What the Science Says

Literature on Systems Level Recovery Transformation

Unfortunately, the literature is quite limited on SLRT within inpatient psychiatric settings. Little is known about many settings that have successfully made changes and a systemic review of relevant quantitative and qualitative studies with organizing themes around definitions and understandings of recovery within these settings, current practice, and challenges were reviewed[21]. The results of this review highlighted the limited number of inpatient recovery-oriented implementation science occurring and the finite extent to which SLRT is adequately integrated into public mental health. Such studies bring up concerns about whether recovery can possibly be integrated into these settings. Most positive outcomes and transformation have been limited to outpatient settings and practice[59,60,61].

Some of the challenges noted in SLRT within inpatient settings are understaffing making changes too difficult, crowded wards and insufficient beds, rapid patient turnover, high acuity levels, and unpredictable situations leaving settings prone to rely more heavily on foundational medical model procedures that

rely primarily on symptom resolution, containment, diagnosis, and medications[62,62,64,65].

Systems Change is Never as Easy as it Seems/ Layers of the Onion

Understanding systems, diagnosing systemic problems with change, and what it takes to foster transformation is incredibly complex. As Berg[66] unpacks this complexity it takes multiple layers of analysis to adequately understand all of the dynamics that may be at play in maintaining a system as it is or in facing barriers to change. It is imperative that the interconnectedness of us all is understood, including group dynamics, and despite a good strategic plan the complexity of delivering change is bent on how what affects one, affects all, and the ability for SLRT. So though many may think the system may not change because there is that one director who oversees the nursing department who is still stuck in the medieval ages, it is always more than what it seems and not just at the individual level of analysis of the problem. This is evident because as the layers of the onion are peeled back there may be realization that the director only blocks change due to their fear that if she supports a new initiative the only nurses she has will quit and understaffing and burnout is already a crisis. But outwardly, this is not apparent and instinctually this director would like to support innovative change.

At other layers of analysis of the system, especially within inpatient settings, those seeking SLRT have to think about the layers of trauma that covers all within a system that has been operating in unhealthy reenactments of trauma for years (due to enforcing inequitable rules of power/control of those with and without mental illness), leaning on Wachtel's cyclical psychodynamic theory[67] and realize that many individuals are far past a burnout stage and are traumatized. In fact, the literature reports that those providers working in inpatient psychiatry experience higher levels of burnout than in other parts of the medical field[68,69].

Other levels of analysis might tell the story that many people who seem resistant to change welcome more supervision and training to try innovative and more recovery-oriented and person-centered ways of working with individuals. Despite the desire, those opportunities may rarely be offered in public mental health settings, therefore, limiting psychic energy, motivation, and the tools individuals feel they can wield to support people in recovery.

Holding Hope in Recovery Transformation and Systems Change

Despite it being ridiculously hard, difficult, and arduous with systemic barriers, it is worth trying and the literature on shifting systems with more recovery-oriented care and less coercion in settings indicates hope for better outcomes[3]. The rationale is that the situation is still desperately in need of change and if hope is extinguished for the capacity to change, then our society is walking away from all of us. Because individuals are all interconnected; the way we value one human is the way we value each of us. As Dr. Martin Luther King said it best in 1965, "All I'm saying is simply this: that all mankind is tied together; all life is interrelated, and we are all caught in an inescapable network of mutuality, tied in a single garment of identity. Whatever affects one directly, affects all indirectly"[70]. The way communities, nations, and countries care for those that have the least, are the most marginalized, and are experiencing the most distress says the most about each of us and our societies.

How Does Science Provide us Hope?

Science does indicate recovery-oriented care makes a big difference[14]. We also have years of science that gives huge hints of the negative impact of hospitalization related to suicidality, since people are at such heightened risk of suicide when they leave the hospital and researchers are now questioning whether hospitalization itself is iatrogenic for individuals and fosters suicidality[70]. With such knowledge, it seems imperative to continue to transform systems to improve and be more recovery-oriented.

There is also science that letting people with their experiences lead their treatment and engage in person-centered treatment planning makes a huge difference, which is now an evidence-based practice[72]. Shared decision making also makes a difference and increases patient involvement in the recovery process and enhances decision making[73]. Relatedly, using person-centered models and evidence-based practices such as motivational interviewing, rather than a punitive and coercive approach to seeking something called "medication adherence" and traditional goals actually increases treatment engagement[14]. Trusting, collaborative relationships with providers, valued social roles such as jobs, education, and hobbies makes a difference in recovery, mental wellness, and meaning making in life for those with SMI[74,75]. There is also quantitative data that reports positive behavioral supports with a recovery-oriented foundation decreases aggression, lessens the likelihood of incarceration, and decreases harm to the self and others on inpatient settings[3]. There is an increasing and overwhelming amount of science that backs up the need to do mental health care quite differently and that it can make a difference, which is hard to ignore.

Let's Make "Good Trouble"

As John Lewis instigated the idea of "good and necessary trouble"[76] it is time for providers and witnesses of the situation in the mental health field to make good trouble. It is imperative that all stakeholders press towards change. One of the critical elements of SLRT is entwined with a social justice component that recognizes making shifts in our mental health systems is about the basic human rights for all to have equitable resources and services and the full rights of citizenship[15]. Engaging from such a perspective can make healthier systems, people, and societies.

Next the article will present some mechanisms for nudging the system towards SLRT in some practical ways using advocacy and social justice skills from a leadership perspective.

Strategic and Skillfulness to be Effective with Systems Level Recovery Transformation

Being strategic at SLRT may feel uncomfortable, but that may indicate change is occurring and homeostasis is always more comfortable. Advocacy for SLRT will definitely rock the boat but the evidence indicates a need for an inherent shift. Being skillful and strategic with advocacy for systems change is fundamental for effectiveness and can amount to many different strategies but many of those include: 1) finding allies to support the cause and help to speak up in meetings, therefore creating more support for shifts in care, 2) meeting individually with people who may be on the borderline of supporting positive shifts in care and need the space to process the possibilities, 3) asking for both top down and bottom up, as well as the middle out support and allies from all directions of systems, 4) strategically finding mechanisms that pull in senior administrators with power and fiduciary support that could provide a pathway for SLRT by identifying ways their projects, academic work, and/or goals could fit within and map on SLRT (though they may otherwise would have no interest), 5) understanding that change will also require allyship and support across communities outside of mental health such as social agencies, housing supports, employment agencies, judicial systems, and 5) taking pilot data on small initiatives that have positive outcomes to show evidence of impact for further support.

Lead with the Concept that Change is Possible

This author has seen unbelievable change in public mental health settings happen that tells an amazing story of how a system bent backward to do the right thing and support SLRT because it only made sense and it made a huge difference in someone's life[3]. Individuals have gotten out of institutionalization of 5-10 years, individuals have overcome personal management of suicidal thoughts and started their life again by getting back to work and in touch with their children, and others have reintegrated into the community, with valued social roles and education.

Does recovery and systems change happen? It does and can happen, but it takes organizers, people not willing to give up, from the ground up, from the top down, from the middle out, and all hands-on deck to make it happen[77]. It takes dismantling layers of the onion and all parts of the community.

Hold Hope: For People in Recovery and for Ourselves and Our System

One of the fundamental tenets of recovery-oriented care is holding hope and fostering that for each individual's recovery process[2]. That means maintaining hope as a team and organization and continuing to review how the system can partner with individuals to build valued social roles, empower autonomy, make personal choices, and make shifts to facilitate a recovery process. For instance, incorporating peer support more widely across organizations, may be more useful than reconsidering medication changes, once again, for people who face lengthy hospitalization. The evidence for peer support shows extensive and integrated effects of peer support implementation related to wellness, empowerment, recovery, and positively impacting whole health care systems in transformation[78].

Holding hope and being a social justice advocate also means communicating that to the team (we believe this person is recovering and has strengths and capabilities) and we can partner with them. So in essence to foster SLRT there has to be a parallel process with all teams that holds hope and helps staff process difficult affect related to feelings like patients may not be improving, while balancing hearing concerns and noting the strengths of individuals and their ability to recover. This also includes reinforcing and validating staff when they do something consistent with SLRT to make a difference to a patient[79].

Find Allies and then Build the Movement Out

When thinking about a charge to engage in SLRT it is fundamental to find allies. This means connecting with like-minded colleagues, connecting around initiatives, sharing the load, building positive relationships, and foundations that develop energy towards systems change. As SLRT allies connect, ironically more people will get on board and over time it is inevitable that it may be harder for more archaic forms of mental health care to take space. Ironically, individuals that may have been oppositional to SLRT are likely to shift over to the movement as it serves them less and they may see the positive outcome of systems change.

Parallel Process in Detail: Envisioning Systemic Strengths and Belief in Change Process

Fostering SLRT means that leaders are also thinking about how staff are valued and focus on taking care of staff. Too many times, as mentioned, staff have experienced years of trauma within mental health care and have become overworked, experienced burn-out, are not recognized for their skillful efforts, and may become complacent to the work and mission of an organization, with good reason[79]. To offer SLRT the staff have to be taken care of, heard, validated, and reinforced positively for their movement towards letting go of systems of power and control, while enhancing shifts towards collaborative, person-centered and humane efforts with individuals who experience SMI[3,79]. For example, when a staff member and/or members are effective at avoiding a power struggle with a patient about medications, taking a shower, and/or going to groups, but instead chooses to ask them to go get some fresh air and play checkers because they know this person has not come out of their room for a week, they are practicing recovery-oriented care. They are valuing the relationship and building collaborations, respecting personal responsibility for a person's recovery, and just supporting autonomy and community. Therein, that gives leadership that is focused on SLRT the opportunity to thank the staff member personally for being so effective and reinforce such acts by staff. This author has seen this repetitively, that instead of focusing on ineffective staff behavior, but noticing SLRT, consistent behavior and positively reinforcing

that, staff become more recovery-oriented and effective. All humans love to be respected and valued for what they do. Then they engage in even more SLRT.

Change May Happen Slowly

As a system embarks on SLRT, within an inpatient psychiatric setting, change will always be slower than anticipated. The gestalt of the whole plan is to turn a system that is quite concretized over many years, with many people, much history, and with many policies in a vastly different direction so it will take time. This means dealing with personal affects, personal egos, and feelings of fruitlessness on things called action items, projects, and quality improvement projects, while taking a long game approach.

On Being Astute and Decentralizing Ego

One of the most fundamental aspects of moving the needle with SLRT is avoiding letting ego get caught up in the process. This means supporting SLRT that is effective without concern for credit, an award, publications, or promotion. It has to be a life passion for individuals that see the call for enacting social justice, recovery, and citizenship for those with SMI[15]. The reality is that many people that are most effective at SLRT are good at connecting the right people, managing people and managing up, and even helping change happen, regardless of any credit they receive. For people that want to see a different system their passion is driven by the potential impact for persons that face injustices at the hands of mental health systems and egos have no place in that. For example, it may involve working strategically from a strengths-based perspective with a colleague, senior colleague, or person with lots of power in the organization who has previously been opposed to change and blocked SLRT. In this manner, one can create an opportunity to involve that person by noticing their strengths and what they bring to the table to make SLRT happen and be at peace with them receiving external credit for what they initially opposed. One has to reckon with the concept that: 1) It may only happen if a particular person is behind it and does not block it and 2) If that person is a part of the process and able to see themselves as guiding the process and receives notoriety for the process. A win for SLRT is a win in the right direction.

New Eyes on the System/Trainees

In this author's perspective having new trainees filtering in and out of her inpatient setting has constantly helped new questions be asked, kept a focus on why things are being done a certain way, and also helped maintain a responsibility to seek out finding ways to integrate and adapt evidence-based practices and stay current on enacting SLRT. Another effective tool for the system is to take data on new SLRT approaches[3] as the data of doing something innovative that is non-coercive, person-centered, and strategically SLRT that has positive outcomes will get more buy-in. Showing a team effective data that reflects shifts from coercion and control to strengths-based care, and promotion of patient autonomy in all aspects of their treatment, creates more allies and builds the SLRT movement[3].

Don't Stop Asking Questions/Perspective Taking

As lightly mentioned above new people in the system sometimes ask many questions because they are innocently trying to learn how to work in that setting, have very diverse prior work experiences, and are not concretized into the systemic onion yet. So just like trainees keep asking a lot of questions it is fruitful for teams to generate an openness to ongoing questions and this can be a form of advocacy. Questions are also quite different than authoritatively declaring immediate change. Instead it helps all answer the basics of why medical teams do what they do and how it works, or does not work. It also helps all in a diversity of meetings to engage in perspective taking, developing a dynamic and green light to ask questions, which can lead to SLRT. In this pursuit of generating a question asking atmosphere it is great to get comfortable with being laughed at or challenged.

Ironically, within the inpatient setting that this author works those very strategies of asking questions helped change a level system and privileges based on earning personal rights and freedoms, as well as them being vacated as a form of punishment or "opportunity to learn from poor behavior", to privileges and rights freely provided, unless there were imminent safety concerns. The setting found that this shift led to more overall positive behaviors, less physical and verbal aggression, and growth than the prior model[3].

One consultant that works with systems change within large educational settings talks about using basically five constructive questions to help those in leadership foster systems change and support flexibility for growth. They are the following: 1) Where are we now?, 2) Where do we want to go?, 3) How will we get there?, 4) How will we know we are getting there?, and 5) How will we sustain the focus and momentum[80]? These questions have been very useful for this author in SLRT.

External Reviews and Consultants

Systems and the services provided can always improve so building teams that gets used to external reviews, new experts on training in new methods or treatments, and consultants can foster a stronger environment of flexible growth. In this author's work with building a Behavioral Intervention Service one of the fundamental elements has been to incorporate and bring in external consultants and reviews of very complex and challenging cases, as needed[3]. These cases might involve learning how the system can help decrease physical, verbal, and/or sexual aggression that historically has been dealt with primarily with more coercion, control, and ultimately forms of seclusion and/or restraint. As teams get used to consulting with experts this enhances self-growth, trying new things, shifting away from what feels comfortable and/or safe and starts to build systemic muscles and strength in fostering SLRT. Again setting aside ego is fundamental in these times.

Diligence & Never Give up: Accept Mistakes Will Happen Along the Way

As mentioned above SLRT is the long game. Therefore, it takes grit, fortitude, and endurance. It also does not mean that one has to devote their whole life to inpatient work in the public sector but it means holding space for what one can do with the time they are able to devote to the cause, not giving up on the idea that change is possible (and that it does not all begin and end with one person), and how they perceive their role in the mission. This mission will take years and generations just like any other social movement. One's role and ability to be part of different aspects of the mission may change but it is vital to never conceptually give up on the possibility of the mission and SLRT. Relatedly, it may seem overwhelming to tackle all the change that may be needed for SLRT to occur but as a system tackles a few of these challenges and barriers, with success and positive outcomes, it will make a pathway for other positive changes – as it also demonstrates to staff and a system the impact of such change.

It is essential to accept that mistakes will happen along the way. It is part of the process of stretching a system and if no mistakes are being made then change is not happening. So though new strategies of skillful SLRT may be embarked on it is important to not get discouraged with mistakes or failures. Those are frequently the biggest learning moments for how to make systemic shifts. Process such failures and struggles with allies and mentors and there are always learning lessons. At such times it is also helpful to reflect on the wins. These may be any number of things but could include remembering times when the team partnered in helping build a life of more personal meaning for a person in recovery, noting shifts in care over time (decreases statistically in seclusion and restraint use on a unit)[3,79], reading a thank you note, or reviewing data that reflects positive gains from SLRT. Such gems of SLRT can help maintain energy and passion for SLRT and social change.

Conclusion

In conclusion, SLRT has many challenges as noted throughout this article that make it difficult and very challenging to implement SLRT within inpatient settings, but it seems vital to the well-being of the recovery of individuals as they define and to reduce the traumatizing nature of mental health systems to continue to work fervently towards these goals of SLRT. There are also mechanisms and ways to skillfully work towards SLRT that do work. It seems most appropriate to leave readers with two quotes that can sum up many of the ideas in this article best. "Do not let what you cannot do keep you from doing what you can do,"[81] and "It's at the finishings that you must come to terms with the idea that perfection is a necessary goal, precisely because it is unattainable. If you don't aim for perfection, you cannot make anything great. And yet, true perfection is impossible… it's not perfect, you have to make your peace with that. How? Well, you sit at your board, you lay out your tools, and you start again."[82]

Impact Statement:

This article is meant to highlight the concerns that still exist within inpatient psychiatric settings in public mental health related to basic human rights and healing. It is also meant to be a call for systems level recovery transformation and delineate methods for making it possible.

Conflict of Interest Statement:

None

Acknowledgement Statement:

None

Funding Statement:

This work was supported in part by the State of Connecticut Department of Mental Health and Addiction Services through its funding of the Connecticut Mental Health Center.

References:

1. Piat, M, Sofouli, E, Wainwright, M, Albert, H, Rivest, MP, Casey, R et al. Translating mental health recovery guidelines into recovery-oriented innovations: A strategy combining implementation teams and a facilitated planning process. *Evaluation and Program Planning*, 2022; 91, 102054.

2. Davidson, L, Rowe, M, Tondora, J, O'Connell, MJ, & Lawless, MS. *A Practical Guide To Recovery-oriented Practice: Tools For Transforming Mental Health Care*. New York: Oxford University Press; 2009.

3. Removed for peer review. A pilot study: Positive behavioral support assessment and intervention for individuals with serious mental illness and criminal justice involvement. *Psychological services*, 2022,19:225-233. doi: 10.1037/ser0000614

4. Kidd, SA, McKenzie, KJ, & Virdee, G. Mental health reform at a systems level: widening the lens on recovery-oriented care. *The Canadian Journal of Psychiatry*, 2014; 59(5):243-249.

5. Frueh, BC., Dalton, ME, Johnson, MR, Hiers, TG, Gold, PB, Magruder, KM, & Santos, AB. Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. Administration and Policy in Mental Health. 2005; 28(2):147-154.

6. Weiss, EM, Altimari, D, Blint, DF, & Megan, K. Deadly restraint: nationwide pattern of death. *Hartford Courant*. 1998; Oct. 11-15.

7. Substance Abuse and Mental Health Services Administration. *Promoting Alternatives to the Use of Seclusion and Restraint—Issue brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services.* Rockville, MD: U.S. Department of Health and Human Services; 2010.

8. Inskeep, S, & Garsd, J. NYC's mayor faces backlash for planning to involuntarily hospitalize homeless people. National Public Radio. January 3, 2023. Accessed February 5, 2024. https://www.npr.org/2023/01/03/1146620873/nycs-mayor-faces-backlash-for-planning-

9. Tutu, D. (1931). Personal Quote. https://www.oxfordreference.com/display/10.1093/acref/9780191843730.001.0001/q-oro-ed5-00016497;jsessionid=83E2BDDF5F558EEFF624AC06522A5CD9 Accessed January 10, 2024.

10. O'Dwyer, C, Tarzia, L, Fernbacher, S, & Hegarty, K. Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units. *BMC Health Services Research*, 2019;19, 1-9.

11. Keski-Valkama, A, Sailas, E, Eronen, M, Koivisto, A M, Lönnqvist, J, & Kaltiala-Heino, R The reasons for using restraint and seclusion in psychiatric inpatient care: A nationwide 15-year study. *Nordic Journal of Psychiatry*. 2010; 64(2), 136-144.

12. Wu, KK, Cheng, JP, Leung, J, Chow, LP, & Lee, CC. Patients' reports of traumatic experience and posttraumatic stress in psychiatric settings. *East Asian Archives of Psychiatry.* 2020;30(1), 3. Retrieved from https://www.proquest.com/scholarly-

13. Removed for peer review. *Women with Serious Mental Illness: Gender-sensitive and Recovery-oriented Care*. New York: Oxford; 2021.

14. Dixon, LB, Holoshitz, Y, & Nossel, I. Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*. 2016; 15(1), 13-20.

15. Removed for peer review. Supporting mental health recovery, citizenship, and social justice. *Community Mental Health Journal*.2022; 1-9.

16. Schnitzer, K, Merideth, F, Macias-Konstantopoulos, W, Hayden, D, Shtasel, D., Bird, S. Disparities in care: the role of race on the utilization of physical restraints in the emergency setting. *Academy of Emergency Medicine.* 2020; 27, 943-950.

17. Bor, J, Venkataramani, AS, Williams, DR, & Tsai, AC. Police killings and their spillover effects on the mental health of Black Americans: a population-based, quasi-experimental study. *The Lancet.* 2018;392, 302–310.

18. Dotson, S, Ogbu-Nwobodo, L, & Shtasel, D. Demilitarizing hospital restraints: recognizing the stones in our glass houses. *Psychiatric Services*. 2022;3(1), 100-102.

19. Menand, E, & Moster, R. Racial disparities in the treatment of schizophrenia spectrum disorders: How far have we come? *Current Behavioral Neuroscience Reports*. 2021; (8)179-186. doi: 10.1007/s40473-021-00236-7

20. Pan, I. Association between race/ethnicity and the receipt of outpatient second-generation antipsychotic agents stratified by metabolic effects. *Thesis Presented to the Faculty of the Graduate School of The University of Texas at Austin in Partial Fulfillment of the Requirements for the Degree of Master of Science in Pharmaceutical Sciences*. Austin, TX: The University of Texas at Austin; 2016.

21. Waldemar, AK, Arnfred, SM, Petersen, L, & Korsbek, L. Recovery-oriented practice in mental health inpatient settings: A literature review. *Psychiatric Services*. 2016;67, 596-602.

22. Council of Europe, United Nations. *Statement on Seclusion and Restraint*. 2006; http://www.un.org>esa>socdev>enable>rights

23. Substance abuse and Mental Health Services Administration (2023). *Promoting Alternatives to the use of seclusion and restraint.* https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf

24. American Psychiatric Association. *New APA resource document highlights quality and safety considerations in the use of seclusion and restraint*. 2023; https://www.psychiatry.org/News-room/APA-Blogs/APA-Resource-on-Seclusion-or-restraint.

25. Fazel, S, & Seewald, K. Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry*. 2012; *200*(5), 364-373.

26. Fellner, J. A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights- Civil Liberties Law Review*. 2006; 41, 391.

27. Hall, D, Lee, LW, Manseau, MW, Pope, L, Watson, AC, & Compton, MT. Major mental illness as a risk factor for incarceration. *Psychiatric Services*. 2019; 70(12), 1088-1093.

28. Steadman, HJ, Osher, FC, Robbins, PC, Case, B, & Samuels, S. Prevalence of serious mental Illness among jail inmates. *Psychiatric Services*. 2009; *60,* 761–765.

29. Silva, B, Golay, P, & Morandi, S. Factors associated with involuntary hospitalization for psychiatric patients in Switzerland: a retrospective study. *BMC Psychiatry*, 2018; 18, 1-10.

30. Morris, NP. Detention without data: Public tracking of civil commitment. *Psychiatric Services*. 2020; *71*.

31. Brooks, RA. Psychiatrists' opinions about involuntary civil commitment: Results of a national survey. *Journal of American Academy of Psychiatry Law. 2007; 35,* 219-228.

32. Barnett, P, Matthews, H, Llyod-Evans, B, Mackay, E, Pilling, S, & Johnson, S. Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: A systematic review and meta-analysis. *Lancet Psychiatry*. 2018;5, 1013-1022.

33. Victorian State Government. Mental Health Act (Vic). Victorian Parliament, Melbourne, Austrailia; 1986.

34. Civil Code in the version promulgated on 2 January 2002 (Federal Law Gazette [Bundesgesetzblatt]I page 42, 2909; 2003 I page 738, last amended by Article 1 of the Act of 10 August 2021 (Federal Law Gazette I p.3515). Accessed from https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html

35. Juríčková, L, Filka, J, & Ivanová, K. Identification of topical problems in performance of public custodian function. *Health & Social Sciences*. 2012.

36. Barton, R., Lau, S., & Lockett, L.L. (2014). The use of conservatorships and adult guardianships

and other options in the care of the mentally ill in the United States. *World Guardianship Congress.* Accessed from: http://www.guardianship.org/IRL/Resources/Handouts/Family%20Members%20as%20Guardians_Handout.pdf

37. National Conference of Commissioners on Uniform State Laws. Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act; 2017. https://www.guardianship.org/wpcontent/uploads/2018/09/UGCOPPAAct_UGPPAct.pdf

38. Dalton, A. Judge dissolves Brittney Spears' conservatorship. *PBS News Hour.* 2021; https://www.pbs.org/newshour/arts/judge-dissolves-britney-spears-conservatorship

39. Ireland, J, & Snowdon, P. Bullying in Secure Hospitals. Journal of Forensic Psychiatry and Psychology. 2002;13(3):538–554.

40. Pescosolido, BA, Halpern-Manners, A, Luo, L, & Perry, B. Trends in public stigma of mental illness in the US, 1996-2018. *JAMA network open*, 2021; *4*(12), e2140202-e2140202.

41. Barret, R. J. The Psychiatric Team and the Social Definition of schizophrenia: Anthropological Study of Person and Illness. Cambridge, MA: Cambridge University Press; 1996.

42. Strauss, A. Psychiatric Ideologies and Institutions. London: Collier Macmillan; 2017.

43. Thibeault, CA, Trudeau, K, d'Entremont, M, & Brown, T. Understanding the milieu experiences of patients on an acute inpatient psychiatric unit. *Archives of psychiatric nursing*. 2010; *24*(4), 216-226.

44. Bowser, A, Link, W, Dickson, M, Collier, L, & Donovan-Hall, MK. A qualitative study exploring the causes of boredom for men with a psychosis in a forensic setting. *Occupational Therapy in Mental Health*. 2018;34, 32–48.

45. Kanyeredzi, A, Brown, SD, McGrath, L, Reavey, P, & Tucker, I. The atmosphere of the ward: Attunements and attachments of everyday life for patients on a medium-secure forensic psychiatric unit. *The Sociological Review*. 2019; *67*(2), 444-466.

46. Sumartojo, S, Pink, S, Duque, M, & Vaughan, L. Atmospheres of care in a psychiatric inpatient unit. *Design for Health*. 2020; *4*(1), 24-42.

47. O'Connor, N, Zantos, K, & Sepulveda-Flores, V. Use of personal electronic devices by psychiatric inpatients: Benefits, risks and attitudes of patients and staff. *Australasian Psychiatry*. 2018; *26*(3), 263-266.

48. Parrott, FR. 'Real Relationships': sociable interaction, material culture and imprisonment in a secure psychiatric unit. *Culture, Medicine, and Psychiatry*. 2010; *34*, 555-570.

49. Shattell, MM, Andes, M, & Thomas, SP. How patients and nurses experience the acute care psychiatric environment. *Nursing inquiry*. 2008; *15*(3), 242-250.

50. Mohr, WK., & Pumariega, A J. Level systems: Inpatient programming whose time has passed. *Journal of Child and Adolescent Psychiatric Nursing*. 2004;17(3), 113-125.

51. West, M. Why depression can make it hard to shower and maintain personal hygiene. *Medical News Today. 2022;* https://www.medicalnewstoday.com/articles/cant-shower-depression.

52. Greenberg, WM & Attia, S. Nonemergent forcible medication in an acute hospital. *Bulletin of American Academy of Psychiatry and the Law.* 1993; 21(4), 465–473.

53. Jarrett, M, Bowers, L, & Simpson, A. Coerced medication in psychiatric inpatient care: literature review. *Journal of advanced nursing*. 2008;*64*(6), 538-548.

54. Gong, N. "That proves you mad, because you know it not": impaired insight and the dilemma of governing psychiatric patients as legal subjects. *Theory and Society*. 2017;*46*, 201-228.

55. McCann, E, Donohue, G, de Jager, J, Nugter, A, Stewart, J, & Eustace-Cook, J. Sexuality and intimacy among people with serious mental illness: a qualitative systematic review. *JBI Evidence Synthesis*. 2019; *17*(1), 74-125.

56. Bonfils KA, Firmin RL, Salyers MP, & Wright ER. Sexuality and intimacy among people living with serious mental illnesses: Factors contributing to sexual activity. *Psychiatric Rehabilitation Journal*. 2015; 38(3):249.

57. Mernyi L, Hölzle P, & Hamann J. Berufstätigkeit und Rückkehr an den Arbeitsplatz bei stationär-psychiatrisch behandelten Patienten. *Psychiatr Prax*. 2018;45:197–205.

58. Provencher, HL, Gregg, R, Mead, S, & Mueser, KT. The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal*. 2002; 26, 132–44.

59. Compton, MT, Reed, T, Broussard, B, Powell, I, Thomas, GV, Moore, A, Cito, K, & Haynes, N. Development, implementation, and preliminary evaluation of a recovery-based curriculum for community navigation specialists working with individuals with serious mental illnesses and repeated hospitalizations. *Community Mental Health Journal. 2014;50,* 383-387.

60. Salyers, MP, & Tsemberis, S. ACT and recovery: integrating evidence-based practice and recovery orientation on assertive community treatment teams. *Community Mental Health Journal.* 2007; *43*, 619-641.

61. Whitley, R, Gingerich, S, Lutz, WJ, & Mueser, KT. Implementing the illness management and recovery program in community mental health settings: Facilitators and barriers. *Psychiatric Services.* 2009;60, 202-209. journals/patients-reports-traumatic-experience/docview/2581860840/se-2

62. Aston, V, Coffey, M. Recovery: What mental health nurses and service users say about the concept of recovery. *Journal of Psychiatric and Mental Health Nursing.* 2012;*19,* 257-263.

63. Chen, SP, Krupa, T, Lysaght, R., McCay, E., & Piat, M. The development of recovery Competencies for in-patient mental health providers working with people with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research.* 2013;40,96-116.

64. Cleary, M. The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*. 2004;*13,* 53-60.

65. Cleary, M, Horsfall, J, O'Hara-Aarons, M, & Hunt, GE. Mental health nurses' views of Recovery within an acute setting. *International Journal of Mental Health Nursing*. 2013;22, 205-212.

66. Berg, DN. *Levels of analysis: Diagnosis & Intervention*. Creative Commons Attribution 4.0 International License. https://ysph.yale.edu/ghli/what/research/4g.levels

67. Wachtel, PL. *Cyclical psychodynamics and the contextual self: The inner world, the intimate world, and the world of culture and society*. Routledge; 2014.

68. Jacobowitz, W. PTSD in psychiatric nurses and other mental health providers: A review of the literature. *Issues in Mental Health Nursing.* 2013;34, 787-795. doi: 10.3109/01612840.824053

69. Yoshizawa, K, Sugawara, N, Yasui-Furukori, N, Danjo, K, Furukori, H, Sato, Y. et al. Relationship between occupational stress and depression among psychiatric nurses in Japan. *Archives of Environmental & Occupational Health*. 2016; 71 (1) 10- 15, 10.1080/19338244.2014.927345

70. King, M.L., (1965). Commencement. Oberlin College Archives. https://www2.oberlin.edu/external/EOG/BlackHistoryMonth/MLK/KingAutograph.html#

71. Ward-Ciesielski, EF, & Rizvi, SL. The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research. *Clinical Psychology: Science and Practice*. 2011;*28*(1), 60

71. https://doi.org/10.1111/cpsp.12332

72. Marchand, K, Beaumont, S, Westfall, J, MacDonald, S, Harrison, S, Marsh, DC, ... & Oviedo-Joekes, E. Conceptualizing patient-centered care for substance use disorder treatment: findings from a systematic scoping review. *Substance abuse treatment, prevention, and policy*. 2019; *14*(1), 1-15.

73. Drake, RE, Cimpean, D, & Torrey, WC. Shared decision making in mental health: prospects for personalized medicine. *Dialogues in clinical neuroscience. 2022*; *11*(4), 455-463.

74. Dunn, EC, Wewiorski, NJ, & Rogers, ES. The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. *Psychiatric rehabilitation journal*. 2018;*32*(1), 59.

75. Lucksted, A, Essock, SM, Stevenson, J, Mendon, SJ, Nossel, IR, & Goldman, HH. Client views of engagement in the RAISE Connection Program for early psychosis recovery. *Psychiatric Services. 2015;66*, 699-704.

76. Lewis, J. *Speech atop the Edmund Pettus Bridge*. Selma, Alabama; March 1, 2020.

77. Rowe, M. *Citizenship and mental health*. NY: Oxford University Press; 2015.

78. Shalaby, RAH, & Agyapong, VI. Peer support in mental health: literature review. *JMIR mental health*. 2020;*7*(6), e15572.

79. Removed for peer review. Positive behavioral support planning in the inpatient treatment of severe disruptive behaviors: A description of service features. *Psychological Services*. 2016;13 (2), 178.

80. Holcomb, EL. *Asking the right questions: Techniques for collaboration and school change*. Corwin Press; 2001.

81. Howes, L. 10 Lessons for Entrepreneurs from Coach John Wooden. *Forbes*. 2012;October 19.

82. Moore, G. *The Outfit*. [Film.]Focus Features Universal Pictures; 2022.